EDUCATION COMMITTEE

REPORT OF THE VISIT TO THE UNIVERSITY OF OXFORD SCHOOL OF MEDICINE

22 AND 23 FEBRUARY 2001

We should like to express our thanks to the Vice-Chancellor, the Head of the Medical Sciences Division, the Director of Pre-Clinical Studies, the Director of Clinical Studies, 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

Foreword i-ii

Introduction. 1

Part 1: The undergraduate curriculum. 1

Background information. 1

Form of the visit relating to undergraduate medicine. 1

The Oxford undergraduate curriculum. 2
Curricular development 2
Structure and content of the curriculum 2
The Accelerated Graduate Entry course 5

The management of change (Principal Recommendation 13) 5
Supervisory structures 5
The contribution of students 6
Staff development 7
The promotion of teaching as a valuable activity 7

Aspects of the core curriculum (Principal Recommendations 1,2,5 and 7) 8
Defining the core curriculum 8
Reducing the factual burden on students.......................…............... 9
Integration…………….. 9
Learning through curiosity.. 11

Special study modules (Principal Recommendation 6) 11

Delivery of the curriculum (Principal Recommendation 11) 13
Teaching methods 13
Learning resources 14

Changing patterns of health care (Principal Recommendation 10) 14

The goals of undergraduate education –attitudes, skills and knowledge 16
Attitudes (Principal Recommendation 3) 16
Essential skills (Principal Recommendations 4 and 8) 17
IT skills 17
Communication skills 17
Clinical skills 18
Teamworking skills 19
Basic and advanced life support 19

Aspects of the knowledge base 20
Public health medicine (Principal Recommendation 9) 20
Legal and ethical issues 21
Medicine in a multicultural society 22
Complementary medicine 22
Infectious diseases and antibiotics 23

Assessment of the process and the product (Principal Recommendation 12) 23
The outcome of the course 23
The scheme of assessment 24
Fitness to practise 26
Preparation for the pre-registration year 26

Other issues 27
Student selection 27
Student support 28
Feedback to students 30
Quality control 31

Areas of good practice 31

Areas for further consideration 32

Conclusion 34

Part 2: General clinical training 35

Background information 35

Form of the visit relating to general clinical training 35

Organisation and management of the PRHO year 35
Supervisory structures 35
The approval of posts 36
Communicating the aims and objectives of the PRHO year 36
The selection of PRHOs 36
Monitoring the quality of PRHO posts 37

Components of a high quality PRHO post 37
Induction 37
Educational opportunities 37
Educational supervision 38
Clinical training and supervision 39
Monitoring the progress of PRHOs 40

Professional development and personal well-being 41
Careers advice 41

Support for PRHOs 42
Accommodation, catering and personal safety 42
Contractual matters 43

New PRHO rotations 44

Areas of good practice 44

Areas for further consideration 45

Conclusion 46

Annexes

Major developments in the School since 1997 Annex A

Outline proposal for the modified Patient and Doctor course Annex B

Suggestions for the possible revision of the First BM course Annex C

Diagrammatic representations of the curriculum and its assessment structure Annex D

Objectives of the pre-clinical course Annex E

Outline description of the new Accelerated Graduate Entry course Annex F

Committees responsible for managing the undergraduate curriculum Annex G

UNICON course for teachers of clinical medical students Annex H

Description of the SSM programme Annex I

Assessment policy for the SSM programme Annex J

Outline of the SSM in Medical Education Annex K

The MSB's Code of Conduct for Medical Students Annex L

The essential skills required of a graduating student Annex M

The MSB's fitness to practise procedures for medical students Annex N

Details of the application and selection processes for candidates wishing to read medicine at Oxford Annex O

The role of the Colleges in Years 1-6 Annex P

Summary of general clinical training provision Annex Q

Description of the PRHO matching scheme Annex R

Deanery checklists for annual visits to Trusts Annex S

End of placement confidential assessment form Annex T

Medic Support scheme Annex U

Foreword to the visit reports 1998-2001

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

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

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

officers.

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

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

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

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

Introduction

1. Our visit had two purposes:

   To review progress made by the School towards implementing the recommendations in *Tomorrow's Doctors* since our last visit in 1997, with a focus on the predominantly clinical years of the course.

   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, Chairman of the Education Committee. The other members were Mr David Ferguson, Medical Director of the Central Sheffield University Hospitals NHS Trust, Ms Sue Leggate, a lay member of the GMC, Professor Sam Leinster, Dean of the Medical School at the University of East Anglia, and Professor Robert Stout, a member of the Education 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 School'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. Prior to the visit the School provided us with helpful background material.

Form of the visit relating to undergraduate medicine

7. Following our initial meeting with the Vice-Chancellor, the Head of the Medical Sciences Division and senior staff of the Medical School, we were joined by other members of the curriculum team for discussions about course development since our last visit and the implementation of the recommendations in *Tomorrow's Doctors*. Later in the morning we had the opportunity to view some of the clinical skills teaching facilities and learning resources within the Medical School. In the afternoon we talked with a group of students drawn from each year of the undergraduate course before meeting some of the staff involved with the new graduate-entry programme to discuss the progress of that initiative.

The Oxford undergraduate curriculum

Curricular development

8. We were impressed by the many positive changes which had taken place in the School since our last visit. These are detailed in the summary at **Annex A**.

9. The School envisages a programme of curricular development, which is consonant with our recommendations in *Tomorrow's Doctors*. Among the School's future plans we noted in particular:

- the proposed introduction of a modified Patient and Doctor course in Years 1 and 2. Further details can be found at **Annex B** and in paragraph 46 of our report

- the possible revision of the First BM course. More detailed information is provided at **Annex C** and in paragraph 40 of our report.

10. We encourage the School to press ahead with its proposals for curricular

change and look forward to hearing how these are progressing.

Structure and content of the curriculum

11. Diagrammatic representations of the curriculum and its assessment structure are at **Annex D**.

12. The Oxford undergraduate programme comprises a pre-clinical (Years 1-3) and clinical (Years 4-6) course. The successful completion of the pre-clinical course leads to the conferment of a BA Honours degree in Physiological Sciences. Students wishing to continue their studies and to graduate from Oxford with the BM BCh degree (which entitles them to provisional registration with the GMC) are required to apply for admission to the clinical course. Not all do so; each year a number of Oxford students will complete their clinical training elsewhere, usually in one of the London medical schools or at the University of Cambridge. Similarly, a cohort of students who have undertaken their 'pre-clinical' training outside Oxford, normally at the universities of Cambridge or St Andrew's or one of the London medical schools, is admitted every year to the Oxford clinical course.

13. For the first five terms of the pre-clinical course all students follow the First BM programme, which is designed to prepare them for clinical education and the degree course in physiological sciences. Students are expected to develop an integrated understanding of how the body works and of the different disease processes, including infection, cardiovascular disease and cancer. They are also encouraged to consider clinical conditions in the context of basic science and to gain an appreciation of scientific method, experimental techniques and data interpretation.

14. The final four terms of the pre-clinical course are set aside for students to follow options of their own choosing within the Final Honour School of Physiological Sciences (FHS). There are twelve optional subjects to study at advanced level within the physiological sciences, and a range of choice within each option. Nearly all students select three options, one advanced practical class, and a dissertation. Further information about the FHS and the options available to students can be found in paragraphs 50-56 and **Annexes I** and **J**.

15. The objectives of the pre-clinical course have been clearly set out for students. These are reproduced at **Annex E**.

16. Teaching in the clinical course is delivered primarily within the Oxford hospitals and local general practices and builds on the scientific training provided in the pre-clinical course.

17. In Year 4 all students undertake the following courses:

a six-week Foundation course providing a gentle introduction to the hospital environment. This is described in paragraphs 65 and 78 of our report

General practice (a two-week residential placement with one-to-one tuition)

Laboratory medicine (8 weeks)

Surgery including radiology and anaesthetics (8 weeks).

Medicine including clinical pharmacology and radiology (8 weeks)

a four-week attachment at a district general hospital

‘Thread’ courses on evidence-based medicine and information skills, clinical skills in general practice, ethics and law and communication skills. Teaching on these topics is interwoven into the clinical curriculum.

18. Year 5 comprises six eight-week blocks in each of the following:

Psychiatry
Paediatrics
Obstetrics and gynaecology and genito-urinary medicine
Neurology, neurosurgery, ENT and ophthalmology
Clinical geratology, public health medicine, palliative care and primary health care
Accident and emergency medicine, trauma and orthopaedics, and rheumatology.

During this year ‘thread’ courses deliver teaching on communication skills and ethics.

19. Generic learning objectives for this year require students to be able to:

‘Focus the history and examination on the patient’s presenting symptoms
Formulate a simple differential diagnosis and management plan
Talk to patients and relatives with more confidence
Discuss the relationship between primary and secondary care
Discuss the impact of disease on the patient, family and community
Perform defined practical skills taught in the specialties’.

20. The aims of the final year (Year 6) are to:

‘prepare students for the duties of a pre-registration house officer by consolidating clinical knowledge and ensuring that essential clinical skills, including skills in communication, have been acquired
provide opportunities for students to augment their organisational skills, to design their own learning agenda and to pursue their particular clinical or research interests

develop curiosity and critical abilities

develop a capacity for self-audit and awareness of the need for continuing professional development

broaden the students' horizons by providing opportunities to study clinical medicine or pursue research anywhere in the world'.

21. In order to meet these stated objectives, students complete the following attachments or assignments in Year 6:

General medicine (5 weeks)
General surgery (5 weeks)
Elective (10 weeks)
Dermatology (2 weeks)
Advanced Life Support course (2 ½ days)
a 3000-word essay on any topic related to medicine
a six-week district general hospital attachment shadowing pre-registration house officers (PRHOs)
Special Study Modules and Clinical Options (14 weeks). Students choose from 60 options
Revision course (3 weeks of ward-based teaching and lectures).

The Accelerated Graduate Entry course

22. The School has developed a four-year accelerated medical course open to graduates. This will run for the first time in September 2001 with an initial intake of ten students, which will rise to twenty in 2002. The first intake has been restricted to graduates in bioscience but the School is keen to widen access in future to graduates in other science subjects and to those with an arts background.

23. The first two years of the accelerated course are new, taking an integrated approach to basic medical science and clinical skills. An outline description of these years is provided in the document at **Annex F**. The final two years of the course are identical to the final two years of the conventional six-year programme. Students following both courses will be fully integrated during this period, and will sit the same final examination.

24. We will be interested to learn how this new programme evolves, and in particular to discover whether its evaluation will reveal differences in the characteristics of its graduates from those following the six-year curriculum.

The management of change (Principal Recommendation 13)

Supervisory structures

25. A major restructuring of the governance of the University of Oxford has resulted in the recent creation of a new central Council and five divisions. The Medical Sciences Division (MSD) is one of these five divisions and, for the first time in Oxford, now unifies within a single managerial structure, the Faculties of Physiological Sciences, Clinical Medicine and Experimental Psychology.

26. The committees responsible for managing the undergraduate curriculum within the MSD are shown in the diagrams at **Annex G**. The Medical Sciences Board has delegated to the Educational Policy and Standards Committee (EPSC) the responsibility of providing an integrated strategic oversight of the organisation, development and delivery of curricula for all degrees within the MSD. The EPSC defines and reviews policy in these areas, and establishes the mechanisms (for example, the committee structures) which ensure implementation of these policies. We were told that the EPSC can take decisions on behalf of the Medical Sciences Board in the areas of its remit except that it must refer problems which entail significant financial implications or require major changes in University legislation.

27. The three Education Committees are chaired by the Directors of Pre-clinical and Clinical Studies and by the Director of the Graduate-entry course and are responsible to the EPSC for the discharge of broad executive and strategic roles. Their task is to keep under review and to amend as necessary the content and delivery of the curriculum while maintaining an oversight of the related examinations. All three directors sit on each of the Education Committees to allow dissemination of information and ideas and to facilitate a co-ordinated approach to their work. We noted that the Postgraduate Dean is a member of both the Clinical Education Committee and the EPSC. All three Education Committees are required to report to the EPSC and to seek that body's approval for any major curricular changes.

28. The Departmental Teaching Committees implement the arrangements for teaching agreed by the Education Committees, and also make proposals for course modifications for consideration by the Pre-clinical Course Committees and the Clinical Tutors' Groups. We were pleased to learn that the Pre-clinical Course Committees include clinicians among their membership whose role is to assess the clinical appropriateness of the courses and to advise on clinical input in Years 1-3.

29. We congratulate the School on the major changes it has introduced since our last visit to aid integration and consolidation of its management framework. However, the School acknowledges that this restructuring is itself an evolutionary process; for example, we learned that its future plans to strengthen its management base include the appointment of a Director of Medical Education and of a Deputy Director of Undergraduate Education. Impressed though we were at the progress made thus far, we too consider that there is scope for future refinement of the supervisory structures, which could be effected by confirming the central role of the ESPC in overseeing curricular development and by streamlining the number of committees currently reporting to it. We therefore invite the School to consider simplifying still further its management structure. This approach will, we believe, lead to lines of accountability and responsibility being more clearly defined.

The contribution of students

30. We were left in no doubt that students in Oxford are actively encouraged to contribute to curricular reform; indeed we were told that no major change is introduced without their views first being sought and considered. There are several

ways in which this is managed, including:

joint student/staff committees

structured questionnaires which enable students to provide feedback anonymously on each course component

an 'exit' questionnaire on the entire curriculum sent to all Final Honour School finalists and clinical graduates

clinical student 'focus groups' in Years 4-6

web-based feedback-forms. These have been established in the pre-clinical school allowing individual students to make their observations on the course

a telephone 'feedback hotline' set up in the clinical school.

Additionally there are appointed student representatives on all key committees in the MSD, including the Medical Sciences Board, the EPSC, the three Education Committees and the Joint Consultative Committees.

31. Students spoke very positively about the School's willingness to respond to their requests for curricular modification. For example, we learned that a pathology practical class and some lectures on pharmacology and the endocrine system in Years 1
and 2 had recently been abandoned in the light of student concerns.

Staff development

32. We were impressed by the commitment shown by both University and School to promoting the professional development of their teachers.

33. The University's Staff Development Service organises a wide range of seminars and training programmes open to all University staff, and also devises courses to meet special needs as these arise. For example, we learned that in September 1999 a training programme for the various Colleges' admissions selectors was introduced which included specific tuition in equal opportunities in the wake of national concerns about medical student selection raised in the McManus report. A more recent development has been the establishment of the Institute for the Advancement of University Learning, which aims to support excellence in teaching, learning and research. The Institute runs a part-time course leading to a diploma in learning and teaching in higher education, which is available to all University teachers. The objectives of this programme are 'to offer an intellectually stimulating exploration of professional practice in high education, and to foster an informed and critical appreciation of the processes of student leaning in participants' disciplines, alongside an inquiring and self-aware approach to participants' own teaching.'

34. The School, in collaboration with the Postgraduate Department, provides a series of training programmes for both University and NHS staff. Its course for teachers of clinical medical students, UNICON, briefly described in the document at **Annex H**, has been attended by 290 clinicians in the two years since its inception. We were told that all teachers in the School are required to complete staff development training within five years of their appointment. Among the other training initiatives introduced by the School, we noted in particular courses covering the design of training programmes, clinical training, appraisal and assessment.

The promotion of teaching as a valuable activity

35. The University employs a number of strategies to ensure that teaching excellence is encouraged and recognised. These include:

special training programmes organised by the University Staff Development Service to support and advise on tutorial teaching

making all initial teaching appointments probationary. Final confirmation is conditional upon five years' satisfactory performance

an annual self-evaluation programme for all academic staff, with compulsory appraisal interviews every five years. We understand that the University and local Trust are also planning to introduce annual assessments of the delivery and the quality of teaching

the conferment of the title of Reader, Professor or Honorary Senior Clinical Lecturer. The criteria for the appointment of Honorary Senior Clinical Lecturers have recently been modified to reflect the importance attached to high quality teaching and continuing professional development

the election of 'Teacher of the Month' by clinical students. The results of these elections are disseminated throughout the School and the local Trust.

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

Defining the core curriculum

36. The current core curriculum has been defined in terms of learning objectives, describing the essential knowledge, skills and attitudes to be acquired at each component of the course. The teaching and assessment methods to be applied for each curricular element have also been stipulated. We were told that this identification of core material was the result of an extensive consultation exercise involving specialists, general practitioners, NHS colleagues, junior doctors and students. Information was also collected from other medical schools, and some schools were visited. We learned that the curricular review committees were deliberately constituted to promote discussion between departments and to break

down interdepartmental barriers.

37. The School has taken steps to ensure that its students and staff are kept up to date about the core curriculum. This is published on the medical school website, while any new curricular developments are publicised via the medical school newsletter. Handbooks produced specifically for teachers provide information about learning objectives, teaching methods and assessment.

38. The School will continue to monitor and modify the curriculum in the light of student feedback. Further refinements, as indicated in paragraphs 40 and 46, are planned in order to address issues of horizontal and vertical integration and reduction in the factual load in the course. We look forward to the rapid implementation of these proposals and of other initiatives designed to increase the application of the recommendations in *Tomorrow's Doctors*.

Reducing the factual burden on students

39. The School has been working steadily over a period of years to ease the factual load on its students. At the time of our last visit it was able to illustrate the progress it had made by pointing to a 31% reduction in the number of lectures in the Year 2 Neuroscience course.

40. Since 1997 further refinements have been made to the core syllabus in order to eliminate redundant or duplicated material. In the pre-clinical course this has resulted in a 44% reduction in core information in the Biochemistry course and 10% in the Morphology, Reproduction and Development module. Further modification of the First BM programme is planned, as outlined in the document at **Annex C**. These proposals entail substantial changes to the teaching of gross morphology, significantly reducing the amount of factual detail in the course and the time allocated for practical classes in the discipline. We welcome the intention to make these revisions to the anatomy programme, which will enable the School to introduce clinically-related material chosen for its association with other aspects of the Year 1 curriculum (for example, the cell biology of cancer, and haemostasis and thrombosis).

41. Clearly defined learning objectives have allowed the School to reduce didactic teaching in the predominantly clinical years of the course. We were informed of recent decreases in the number of lectures in clinical pharmacology (from 22 to 10) and surgery (from 32 to 20), while the shortening of the laboratory medicine module from 10 to 8 weeks has resulted in 24 fewer lectures being held. A one-week lecture programme in dermatology, unpopular we were told with both staff and students alike, had been abandoned in favour of a clinical attachment.

42. We were pleased to learn that it is now established practice within the School for any request for an increase in core material or teaching to be matched by a proposal for a corresponding decrease elsewhere. We congratulate the School on the progress it has made thus far and encourage it in its future plans to constrain factual overload.

Integration

43. The School has taken particular pains to raise the profile of clinical medicine during the early years of the curriculum. This has been achieved through the extensive involvement of practising clinicians in both course development and teaching in
Years 1-3.

44. All First BM Course Committees are required to include a practising clinician among their membership; indeed one of these committees has a clinician as its chairman. The Director of Clinical Studies has a seat on the Pre-Clinical Education Committee, while the ESPC benefits from considerable clinical representation.

45. We were told that approximately 10% of teaching in the First BM Course and indeed for Years 1-3 as a whole is delivered by the staff of the clinical departments, while many of the non-clinical staff contributing to teaching during the first five terms are clinically qualified; a figure of 50% was quoted. Students following the pre-clinical course are specifically advised in their handbooks to 'develop the habit of thinking about clinical conditions in a scientific background', while teachers stress clinical relevance during lectures, practical classes and clinical demonstrations.

46. The School's plans to increase clinical input in Years 1 and 2 through the introduction of the modified Patient and Doctor course in October 2001 are described in the papers at **Annex B**. We were told that this new programme is a customised version of the course currently being delivered in Year 4. The plan is that the students will receive twice–termly small group teaching with general practitioners to demonstrate diseases in patients in conjunction with instruction in the underpinning biomedical science. In addition to introducing students to the key concepts of *Good Medical Practice*, it is hoped that the modified programme will give students an insight into the impact of disease on individuals and their families, aspects of public health, and the range of people and services supporting health care in the community. We applaud this initiative.

47. We learned of a number of approaches which enable students to continue their studies in the sciences basic to medicine in the later years of the curriculum. For example:

- basic sciences are re-explored during tutorials in clinical pharmacology, anaesthetics and radiology

- the principles of anatomy are taught by surgeons and radiologists in both the early and later years of the course

- pathophysiology teaching demonstrates relevance of basic sciences to clinical medicine, as indeed does the laboratory medicine course which is delivered by variety of teachers including many with predominantly non-clinical backgrounds

- students have the opportunity to re-examine scientific concepts learned

during the pre-clinical years in the light of their clinical experience in some of their SSMs (for example, immunology, transplantation).

48. While we welcome the steps that have been taken, and those that are planned, in order to co-ordinate the curriculum, we encourage the School to press for further vertical integration of clinical teaching and basic sciences, particularly in Years 1 and 2.

Learning through curiosity

49. In addition to the SSM programme which is described in detail in the next section of this report, Oxford students have a number of opportunities to develop an enquiring and critical approach to medicine. These include:

tutorial teaching in Years 1-3, which encourages students to work beyond the core and to begin thinking for themselves about the experimental basis of the science they are studying

practical classes, some of which take a problem-based approach to learning. Further information is provided in paragraph 59 of the report.

teaching in the Centre for Evidence-Based Medicine and the Institute for Health Sciences in Years 4-6, which is designed to promote an interest in evidence-based health care. Students are expected to apply the concept of evidence-based practice to justify clinical decisions.

oral presentations 'on take' and on routine ward rounds during the clinical years. Students select patients whose illnesses particularly interest them for further study in depth. They are expected to carry out a critical appraisal of the relevant literature relating to the patient's condition before submitting their written care reports or case presentations for assessment.

Special Study Modules (Principal Recommendation 6)

50. The aim of the Oxford SSM programme, which includes the four-term Final Honour School of Physiological Sciences (FHS), is 'to equip students with transferable skills that will fit them well for medical practice and a career of life-long learning.' The programme itself and the options it provides for students are set out in the papers at **Annex I**, while a more detailed description of the assessment methods applied to its different components can be found at **Annex J**.

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

Year 2-3	67%	The FHS is full time for four terms, ie, it occupies 44% of the entire pre-clinical course
Year 4	15%	
Year 5	10%	under development
Year 6	50%	

52. The FHS is obligatory and comprises a series of optional courses and practical classes chosen by the students. Comprehensive information packs describing the arrangements for the FHS course are sent to all students while details of each option or dissertation are posted on the School website, which is updated every term. The Director of Pre-Clinical Studies and options organisers are on hand to provide advice to students at a specially convened 'Options Fair' or guidance may be given by college tutors. Students visit potential dissertation supervisors to discuss the projects advertised on the website. They then submit a list of their chosen dissertation topics ranked in order of preference. We were told that every effort is made to accommodate student choice, with most applicants obtaining their first or second preference. Any student unhappy with their allocation is free to seek an alternative. None of the students we spoke to expressed any concerns about this process or that involved in the allocation of SSMs in the clinical years described in the following paragraph.

53. Modules in Years 4-6 are listed in student handbooks, and on the School website, while a 'Module Fair' gives Year 4 students the opportunity to meet potential supervisors to discuss their choice of SSMs. Feedback from previous students on the quality of these modules is retained by the School and is used by new Year 4 students to guide and inform their selections. Students are invited to rank their choice of options and allocation is made by a computer programme, though we were assured that there is some flexibility in the system if a student is dissatisfied with the outcome of this process.

54. Students may propose and devise their own options with guidance from their potential supervisor. These arrangements are personally approved by either the Director of Pre-Clinical Studies or of Clinical Studies.

55. Academic and pastoral support to students undertaking SSMs in the early years of the course is provided by designated options organisers and dissertation supervisors, who are personally recommended for this role by the Director of Pre-Clinical Studies. In Years 4-6 project supervisors, endorsed by the Director of Clinical Studies, take on this responsibility. The students we consulted were satisfied with the level of support available to them during the SSM programme.

56. All students must satisfactorily complete the FHS and the SSM programme in Years 4 and 5 in order to progress through the undergraduate course. However, we were told that the number of options in Year 6 may be reduced or weaker students may have to forfeit some of their final–year elective to undertake remedial work. While we understand the need for time to be made available for weaker students to undertake remedial work, it is unacceptable, particularly for less able students, that this should be completed at the expense of optional elements other than electives.

57. The student perception at Oxford is that the SSM programme is educationally rewarding and diverse, a view which we share. We believe that the FHS remains a major strength of the School, providing as it does an invaluable opportunity for students to pursue topics of interest to them under the guidance of recognised leaders in the field. We were also impressed by the quality of the Year 4 SSM poster assessments which we viewed during our visit and were very interested to learn of the new SSM in Medical Education devised for Year 6 students. Outlined briefly at **Annex K**, this module enables final year students to mentor and to assist in the training of Year 4 students commencing their clinical studies. We listened as students enthusiastically recounted for us how they worked together to design an introductory clinical course, including its assessment methods and timetables, for their junior colleagues as well as introducing them to some of the practical aspects of clinical training, such as the correct protocols to be followed on the wards. We congratulate the School on its imagination in introducing this exciting and innovative development.

Delivery of the curriculum (Principal Recommendation 11)

Teaching methods

58. The School uses a variety of teaching methods to enable its students to acquire the knowledge, skills and attitudinal objectives of the curriculum. The following table details in percentage terms the various types of learning opportunities available to students in each year of the course:

Teaching & learning mode	**First BM (terms 1-5)**	**FHS[1] (terms 6-9)**	**Year 4**	**Year 5**	**Year 6**
Lectures	16.8%	4.5%	10.5%	7.1%	5.3%
Practical classes	13.2%	2.0%	1.6%		0.8%
Seminars and tutorials	1.5%	0.5%	13.9%	11.3%	9.5%
Clinical Demonstrations	1.5%				
Clinical			28.2%	29.1%	20.7%
Skill-based teaching			4.3%	1.3%	0.6%
Private study (ie the balance, including work for tutorials & dissertations)	67.0%	93.0%	41.5%	51.2%	63.0%
Total	100.0%	100.0%	100.0%	100.0%	100.0%

59. We noted with interest the way in which the format of some of the practical

classes had been specifically adapted in order to stimulate student curiosity and to demonstrate the clinical relevance of the basic science which they were studying. Certain classes took a problem-based learning approach; for example during immunology in Year 2 students worked in groups following a patient-orientated problem-solving format. In another class, three or four volunteer patients were presented as case demonstrations by a clinician (usually the consultant responsible for their treatment) in order to highlight the realities of hypersensitivities or transplantation. This clinical insight was provided at the same time as the basic science was being covered in the curriculum.

Learning resources

60. The School has invested heavily in ensuring that its students have access to a wide range of high quality resources designed to assist their learning. These include:

- Excellent library facilities
- Well-equipped teaching accommodation
- The Medical School website, which includes information about the constituent courses of the undergraduate medical curriculum.

61. In Years 1-3 the individual colleges provide and equip computer rooms for the use of students who do not have their own computers, as well as installing networked computers in or near their libraries to assist with information retrieval. We were informed that approximately 20% of clinical students possess their own computers. Network access is provided for this group. For other clinical students there are currently 104 PCs available within libraries and departments, of which 25, recently installed in the Cairns Library and the John Radcliffe Hospital, are reserved solely for student use. A further 20 computers are accessible to students in teaching general practices.

62. We learned that locally produced computer software and commercial CDs are used to support teaching and self-directed learning in anatomy, while further teaching software is being developed for pharmacology and pathology. Computer-assisted learning (CAL) packages and videos are being increasingly introduced during the clinical years in order to complement mainstream teaching. We saw the plans for the new Medical Sciences Teaching Centre scheduled to be opened in October 2002. We were told that this will include a CAL room with accommodation for 90 students as well as office space for an IT Teaching Officer, whose task will be to develop software to meet the needs of teaching staff.

Changing patterns of health care (Principal Recommendation 10)

63. In spite of many difficulties, not least the mounting clinical, administrative and academic pressures on its teachers, the School has sought to adapt to the changing face of health care by providing its students with opportunities to learn in a variety of different settings.

64. The students we spoke to were particularly appreciative of the experience they gained in primary care during the last three years of the curriculum.

65. Year 4 currently presents students with two distinct opportunities to obtain this contact. The Foundation course includes a two-week individual placement in general practice designed to introduce students to broad aspects of primary care and the work of the healthcare team in the community. Over 100 practices (56 outside Oxfordshire) are involved in delivery of this teaching. As well as developing their clinical skills under the supervision of their GP tutor, students spend time with a chronically ill patient, taking a history from the individual and the family and investigating the social and psychological impact of the problem on both. They present and discuss the case at an end of term seminar in Oxford. Students also undertake the Clinical Skills in General Practice course which takes place over 8 half-days throughout Year 4. This programme complements hospital-based teaching and is supported by 26 general practitioners (GPs) in twenty practices during the medicine and surgery attachments while a further fifteen practices provide clinical skills teaching during the district general hospital rotations. Patients with selected conditions are brought in for dedicated small group teaching. Students interview and examine these patients, while tutors are on hand to provide immediate feedback on their clinical and communication skills. We were told that it is this programme, in its modified form, which will be introduced in Years 1 and 2 from October 2001 as the new Patient and Doctor course.

66. In Year 5 students completing the primary health care attachment are able to explore the impact of disease on the patient, the family and community. Twenty GPs in nineteen practices provide one-to-one teaching over the six-week placement. Students spend three days each week in the practice and one day per week in the University Department of General Practice for seminar teaching. During this period they learn about a range of issues, including handling uncertainty, teamwork, the management of disease, as well as completing a family case-study of their choice. Their experience is enriched, we were told, by the contact they make with district and practice nurses, health visitors, community pharmacists and other members of the health care team.

67. The two-week SSM in primary care in Year 6 is primarily intended for students who are planning a PRHO placement or are considering a career in general practice. Each student is assigned to a tutor, and together they agree the programme to be followed during the module.

68. The School also ensures that appropriate attention is paid to the role of the community medical services in providing health care. In addition to the contact referred to in paragraph 66, students gain direct experience of the work of these agencies during many of their Year 5 rotations, (for example, in public health medicine, geriatrics, paediatrics, psychiatry and neurology), while SSMs in Years 4 and 6 provide additional opportunities to work more closely with professionals in the community. We were told that community provision is discussed regularly and that students are expected to understand the discharge process and the importance of liaison with the healthcare team in the community. Participation in

admission, management and discharge of ‘their’ patient is encouraged, particularly in the final year medical attachments.

The goals of undergraduate education – attitudes, skills and knowledge

Attitudes (Principal Recommendation 3)

69. The School makes clear right from the very start of the course the attitudes and professional behaviour it expects from its students. Widely accessible on the School website, the Medical Sciences Board’s (MSB) Code of Conduct for Medical Students, reproduced at **Annex L**, reminds students of the special responsibilities placed on them, and links these specifically with the precepts of *Good Medical Practice*. A serious breach of this Code is likely to result in a student being referred for investigation under the new fitness for practise procedures being developed by the MSB. These are mentioned in paragraphs 106 and 107 of our report and are reproduced at **Annex N**.

70. Historically, copies of *Duties of a Doctor*, which includes *Good Medical Practice*, have been issued to students during the six-week Foundation course at the start of Year 4. Thereafter, the principles of *Good Medical Practice* have been used to inform much of the teaching in the clinical placements as well as delivery of communication skills training and medical ethics and law teaching. However, we learned that this year for the first time *Good Medical Practice* had been distributed to students in Year 1. This has enabled students, with input from their teachers, to focus on the development of a number of personal attributes and skills, including:

> ‘the need for clear oral and written communication
>
> honesty, and a readiness to admit the need to take advice from others
>
> the ability to work effectively with others and to treat them with respect and sensitivity
>
> an awareness of the importance that a doctor’s health must not put his or her patients at risk.’

Student exposure to the tenets of *Good Medical Practice* in the early years of the curriculum will be substantially increased following the introduction of the modified Patient and Doctor course in October 2001.

71. Students are asked to reflect on their experiences and their behaviour when completing course reports; their tutors also have an input into this process. This information, together with that produced through Objective Structured Clinical Examinations (OSCEs) is used by the School to assess student attitudes and behaviour.

72. The students we met were fully 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. In the event of a poor role model

being discovered, students were confident of receiving every assistance from the School. For example, we heard that swift and decisive action had been taken by the Director of Clinical Studies when a student reported her concerns about a registrar who was behaving inappropriately.

Essential skills (Principal Recommendations 4 and 8)

73. The School has compiled a list of core skills and practical procedures in which students must have demonstrated competency prior to graduation. This list is at
Annex M. A combination of techniques is used to record acquisition of these skills, including:

OSCEs in Years 4-6

course reports, completed jointly by student and tutor, which specifically seek comments about professional behaviour (including attendance), knowledge and clinical skills

clinical presentations

certification of competency by teachers in student clinical logbooks.

IT skills

74. Although most students joining the Oxford course are computer-literate, this assumption is not made by the School. An induction programme at the start of Year 1 introduces students to the different information systems available in Oxford, while in Year 2 all students receive formal teaching in information retrieval and attend a workshop in the Radcliffe Science Library. This learning is both reinforced and enhanced in the Foundation course and the Evidence-Based Medicine course in Year 4 when students are shown how to access clinical information using the hospital computer systems. During this year students are expected to use their IT skills to produce at least two critical appraisals of clinical trials or systematic reviews (CATs). These CATs are assessed by the Centre for Evidence-Based Medicine.

75. Additional IT training sessions are available for students requiring extra support when completing their CATs, while we were told that any time during the course students wishing to do so may enrol for a course in IT or computing organised by the University Computing Service.

Communication skills

76. In Years 1-3 students are mainly encouraged to develop their communication skills in their tutorial sessions. Not only are students expected to express themselves precisely and effectively in discussion, but they are also usually required to produce a weekly essay, a task which regularly exercises their skills in writing clearly and concisely. At the end of Year 3 the FHS examinations are

designed to test their ability to construct arguments supported by evidence, whilst also rewarding originality and powers of critical discussion.

77. Videotaped consultations, simulated patients and role play scenarios are some of the techniques employed to enhance oral communication skills in the clinical years. The communication skills course comprises eight half-day sessions in Year 4 and two additional sessions in Year 5, covering a range of areas including:

breaking bad news
negotiating lifestyle change
sex and sexuality
obtaining consent
dealing with complaints from an angry or aggressive patient.

The aim of the course is to develop effective patient-centred consultation skills. Students receive feedback on their performance from actors specially trained to be simulated patients. This enables them to identify and rectify any deficiencies in their approach before they are formally assessed in the OSCEs in Years 4-6. The various clinical attachments in Years 5 and 6 allow students further opportunities to enhance their communication skills and they are able to benefit from immediate feedback on their progress, for example through bedside tutorials, at OSCE stations, or, in the case of the primary care attachment, by review of video-recordings of their consultations.

Clinical skills

78. Clinical skills training begins in earnest with the Foundation course at the start of Year 4. The approach adopted in this course is similar to that taken in the later clinical placements in order to develop clinical skills. Initially the student may be expected to observe a procedure, then train, practise and pass an assessment in the Clinical Skills laboratory before finally demonstrating competence on a patient. In addition to the experience they gain in the Clinical Skills laboratory and on their ward-based attachments during the Foundation course, students are taught to develop their clinical skills by GP tutors. GPs also conduct a formative assessment during the last week of the course, in the form of a mini-OSCE, which, students told us, provided valuable feedback on their early progress.

79. Students continue to refine their clinical skills during the various clinical placements they undertake in Years 4-6. The facilities of the Clinical Skills laboratory are available to those wishing to practise these skills in a protected environment, while supervised teaching occurs at the bedside, on ward rounds, in tutorials and in clinics.

80. Proficiency in the key skills described in the list at **Annex M** must be demonstrated in order for students to progress to the next phase of the course. New logbooks, identifying the essential skills to be acquired during each clinical placement, have recently been introduced for this purpose. Clinical competence is also assessed in the OSCE examinations in Years 4-6.

81. Although students freely admitted that Years 1-3 of the undergraduate curriculum did not currently render them clinically competent to carry out a physical examination of a patient, they were confident that the teaching and learning opportunities provided for them during Years 4-6 would furnish them with the practical and clinical skills necessary to function effectively and safely as a PRHO. This view of their fitness for purpose was confirmed by the chief executives and medical directors with whom we later spoke.

Teamworking skills

82. Students at Oxford are given every encouragement to understand the importance of working effectively together as a team. During practical classes in Years 1-3 they work with each other in small groups while many tutorials deliberately involve collaborative work. However, this emphasis is particularly evident during the primarily clinical years, when students interact with other healthcare professionals and can see and value the contribution they make to the care of patients. This experience occurs in many settings including:

- clinical firms, when students work as part of the ward team, particularly in Year 6 when they shadow PRHOs in Oxford and in the district general hospitals

- the operating theatre, where they observe co-operative working between the entire surgical team

- their accident and emergency attachment, when they work with nurses and paramedics

- the Advanced Life Support course in Year 6

- their obstetrics attachment, where they work with midwives

- their primary care placement, where they participate in the work of the primary health care team.

Basic and advanced life support

83. Training in basic life support skills, including cardio-pulmonary resuscitation techniques, is introduced in Year 1 and is later revisited during the Foundation course in Year 4 where student proficiency is formally assessed.

84. Attendance at the two-and-a half day Advanced Life Support (ALS) course, fully accredited by the UK Resuscitation Council, is compulsory for all students in Year 6. We were told that funding for this course had been provided by the local Trust, using SIFT money.

85. We were greatly impressed by the School’s commitment to teaching basic and advanced life support skills. Perhaps more significantly, students regarded the

acquisition of these skills as an important and necessary step in their professional development.

Aspects of the knowledge base

Public health medicine (Principal Recommendation 9)

86. The dedicated teaching which takes place in the public health medicine course in Year 5 is described later in this section, but the School was keen to point out to us that a range of public health issues are considered at different points of the curriculum. We noted the following examples:

- during the Medical Sociology course in Year 2 student learning includes, among other topics, the epidemiology of infectious disease and of cardiovascular disease and cancer, immunisation, and the rationing of healthcare in the NHS

- issues surrounding alcohol and drug abuse are specifically addressed in communication skills, psychiatry (management of self-harm) and clinical pharmacology teaching

- osteoporosis and its prevention are considered in the combined orthopaedic/rheumatology/accident and emergency attachment

- paediatric head injury is covered in the neurosurgery block in Year 5

- the issue of disease prevention is formally assessed by an OSCE during the primary healthcare block in Year 5. This block also includes core teaching on cardiovascular risk, asthma and diabetes

- recently-introduced SSMs in management, global health, public health and the community provide students with opportunities to investigate issues such as communicable disease, nutrition, government policy-making, management of a Trust, teenage health, healthcare and refugees, and the impact of war and poverty.

87. The Year 5 public health course addresses the broad social determinants of health, the scope for health promotion, epidemiological concepts and methods as well as specific topics such as population-level needs and risk assessment, and health protection by evaluation of environmental hazards. Working in small groups, students consider and discuss alternative strategies for achieving attainable targets in priority areas relating to the health of the public. We were told that the priority day during the course is given over to consideration of the services available to patients who have suffered a stroke. This year the Director of Public Health conducted a series of teaching ward rounds, introducing small groups of students to government priorities and policy in this area. We were interested to learn that the School intends to develop this concept further by engaging specialist registrars in public health medicine to provide integrated teaching during ward rounds at district general hospitals.

88. The post of Chair of Public Health Medicine in the School has been vacant for the last two years. We were told that the School had identified a suitable candidate for this position many months previously. The candidate had accepted the School's offer but had requested time to see out his current contract. Unfortunately just a few weeks prior to our visit the candidate had withdrawn his acceptance of the post. The position had now been re-advertised. While we appreciate this situation, we believe that the School should continue its efforts to ensure that public health medicine remains a strong curricular thread. Strengthening links with the regional NHS Public Health department would be one means of achieving this outcome.

Legal and ethical issues

89. The Medical Ethics and Law course comprises a series of seminars in Years 4 and 5, which take place in the Foundation course and during the clinical attachments in medicine and surgery, psychiatry, obstetrics and gynaecology and paediatrics. Each seminar focuses on issues relevant to the clinical teaching students are receiving at the time. Topics include:

- an introduction to English law
- an introduction to *Duties of a Doctor*
- Confidentiality
- Seeking consent
- End of life issues
- Treating patients without consent
- Ethical issues in assisted reproduction
- Child maltreatment, legal issues and children's consent to medical treatment.

90. Each seminar opens with a didactic component, usually written material for students to consider. They then form into small groups for discussion of the topic under consideration. The seminar ends with a plenary session with immediate feedback to students from the tutor on the quality of the arguments they have advanced.

91. Students' ethical understanding and their ethical and legal reasoning skills are assessed in a written paper at the end of the course. The issue of consent is revisited during the orthopaedic/accident and emergency block in Year 5. Students told us that this teaching is linked back to the principles set out in *Good Medical Practice*. An OSCE station at the end of this block tests their ability to take informed consent.

Medicine in a multicultural society

92. Oxford is not to any major extent a multicultural society, and thus

opportunities for its students to come into contact with patients from different ethnic and cultural backgrounds are limited. The School is hopeful that new district general hospital attachments in Northampton, Reading and Swindon will go some way to increasing student experience in this respect.

93. Within the curriculum cultural issues are specifically addressed in the communication skills course and during the community attachments in primary care. We learned that the School plans to strengthen teaching on multicultural health during the primary care attachment by introducing a seminar run jointly by medical anthropologists and general practitioners. Many Year 6 students also take their electives in developing countries. Before travelling they are required to demonstrate to their elective supervisor that they have considered the difficulties they may face while working in a different culture and how these should be handled.

94. The School provides further opportunities for its students to explore multicultural issues by offering SSMs on the following topics:

medical anthropology
miracle cures
refugees in the UK.

Complementary medicine

95. A series of lectures in the Year 4 Foundation Course introduces students to the range of alternative therapies available to patients, while their experience on the communication skills course, the primary health care attachment and their hospital placements involves consideration of how to manage patients requesting treatments that do not conform to the conventional orthodoxies.

96. We were told that teaching on art therapy and music therapy is delivered during the palliative care course in Year 5, while SSMs in Year 4 and/or Year 6 offer students additional opportunities to investigate these and other supportive or alternative therapies in greater depth. The various topics covered in these SSMs are:

Evaluating Complementary Therapy
Plants and Medicine
The British Medical Society Acupuncture Course
Spiritual Care
Belief in Supernatural Medicine
Music Therapy
Art Therapy

If they wish, students may also arrange their own SSM in some aspect of complementary medicine.

Infectious diseases and antibiotics

97. Students first learn about antibiotic resistance and infectious diseases in Year 2. This learning is reinforced during the laboratory medicine course in Year 4 and in the series of clinical pharmacology seminars held weekly during medical firms in Years 4 and 6.

98. The teaching methods applied in the eight-week laboratory medicine course include:

- lectures
- small-group tutorials
- clinical case-based practical classes and clinico-pathological demonstrations
- case presentations and student-led seminars.

Working under the supervision of a pathology tutor, students are required to prepare two case commentaries during their attachment. One may be an oral presentation, the other a written clinico-pathological case discussion.

99. Teaching in the clinical pharmacology seminars is clinically orientated. During Year 4 students are expected to be able to formulate a therapeutic action plan and to be able to explain the basic mechanism by which drug therapy may work, to discuss efficacy and to outline significant adverse effects. By Year 6, in addition to devising a basic therapeutic action plan, students should be capable of managing the practical drug therapy of common or important medical conditions with particular emphasis on the following aspects:

- which patients should be treated and when should this treatment start?
- which drugs should be used first and how are these prescribed?
- in what ways should efficacy and toxicity be monitored?
- when should treatment be discontinued or changed or additional agents added?

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

The outcome of the course

100. The essential knowledge, skills and attitudes required of the graduating medical student in Oxford have been determined in the light of GMC guidance in *Tomorrow's Doctors, Duties of a Doctor* and *The New Doctor*.

101. The standard of graduation in medicine in Oxford is satisfactory attainment of the defined objectives of the course, as tested through an extensive programme of formative and end-of-stage summative assessment.

The scheme of assessment

102. The School has devised an assessment strategy which recognises three distinct categories for the learning which it is delivering. These areas are described as follows:

‘**Essential learning**: relating predominantly to patient safety, all students must demonstrate competence in these areas. The essential knowledge, skills and attitudes to be acquired at each stage of the course are set out in handbooks and logbooks, as well as in the core curriculum

Important areas constitute the remainder of the core curriculum. Although failure to demonstrate competence in all areas may not automatically lead to failure, the pass mark should be set at a high level

Inspirational topics, for example SSMs. All students should have opportunities for this type of self-directed study once the essential and important topics have been covered. Students should set their own learning objectives which should be reflected in the assessment methods applied.’

103. The School employs a range of assessment techniques to ensure that its students are fit for purpose as a PRHO. The diagram at **Annex D** shows the various stages at which these methods are applied throughout the curriculum. The School also provided us with details of the different areas which it believes that these systems of assessment are testing. These are described as follows:

‘Short Notes and Short Answer format – to assess knowledge and understanding, including its application to problem-solving and data interpretation: answers are assessed with reference to model answers prepared in advance

MCQs – to test knowledge

Practical Books – to assess understanding and ability to record and analyse observations

Essay answers in written examinations – to assess knowledge, understanding, critical thought, ability to develop and sustain a logical argument, written communication skills, etc

Dissertations, prepared essays and case reviews – to test ability to think critically and appraise evidence, as well as testing depth of knowledge

Oral presentations, including case presentations on ward rounds – to test communication skills as well as clinical knowledge

Short and long cases – to test clinical ability and the ability to communicate

with patients

Poster presentations – to test ability to communicate concisely and to present a clear analysis

CATs (critically appraised topics) – to test ability to use IT tools to find and appraise evidence for clinical interventions

Objective Structured Clinical Exams (OSCEs) – to test skills and attitudes. The assessors in each station are encouraged to provide the student with immediate feedback, thus including a formative component

Videotaped consultations – to assess communication skills

Check sheets and logbooks – to assess clinical competence either in a skills laboratory or on patients

Course Reports – to assess attitudes including aspects of professional behaviour (attendance, communication, teamwork, flexibility)

Oral examinations (vivas) – to test knowledge and understanding of data'.

In addition, self-assessment is included on course reports and reflective logs assess progress during attachments, particularly in Year 4.

104. Assessment criteria are made widely known to both students and teachers, appearing in course handbooks and logbooks as well as on the School website. The students we spoke to confirmed that they were kept fully aware of assessment arrangements. They appreciated the explicit learning objectives laid down for each phase of the curriculum, which left them in no doubt of their required areas of study. The structured formative assessments administered termly during Years 1-3 allowed them regular feedback on their progress, and they welcomed the efforts of the School to build a formative component into most assessments during Years 4-6. Preparation for their First BM examination in Year 1 was greatly assisted by the prior receipt of specimen questions and answers for the short notes section of the examination. They also told us that although much of their teaching was delivered in an integrated fashion its assessment was often conducted in terms of discrete disciplines.

105. The School is well aware that one of the difficulties inherent in utilising a variety of assessment techniques to measure student progress is ensuring consistency of assessment across the curriculum. We understand that the EPSC has been asked to look into this matter with particular reference to the clinical years of the course. While welcoming news of this initiative, we believe that this review should be extended to cover all six years of the curriculum and should include an evaluation of assessment methods to ensure that these remain fit for purpose. We also take the view, as stated in *Tomorrow's Doctors*, that assessment systems should reflect the integrated nature of the curriculum. We therefore invite the School to consider introducing more integrated assessments into the curriculum to reflect

the increasing co-ordination of the teaching being delivered.

Fitness to practise

106. The School is aware of its responsibility to promote high standards of conduct and appropriate attitudes in its students. We have already alluded in paragraph 69 of our report to one of the positive measures taken by the MSB in this respect, the creation of a formal Code of Conduct for Medical Students. The MSB has also been active in developing procedures for dealing with questions of fitness to practise amongst medical students. Reproduced at **Annex N**, these include an appeals mechanism. We understand that the procedures have recently received approval from the Council of the University.

107. While we were pleased to note this information, we pointed out to the School that the procedures related only to medical students and did not link in with the arrangements for PRHOs, for whom the University is also responsible under the Medical Act 1983. We therefore invite the School to consider adapting its new fitness to practise procedures so that these include PRHOs as well as medical students.

Preparation for the pre-registration year

108. All final year students spend six weeks at a district general hospital; their time there is divided equally between shadowing a medical and surgical PRHO. The aim of this attachment (which is not necessarily undertaken in the Trust where the trainee will be employed following graduation) is to help students develop the skills required in the PRHO year.

109. By the end of the placement students are expected to be competent to perform a range of tasks, including:

assess a sick patient rapidly to determine the severity of illness
identify the most significant symptoms and signs
formulate a management plan
interpret investigations
communicate with patients and relatives in a range of situations
work in a multidisciplinary team
obtain informed consent
keep clear and accurate hospital records
complete a drug chart
write a discharge letter to a general practitioner
write a death certificate
write a cremation certificate
perform routine tasks associated with the work of a PRHO, under supervision
carry out the essential practical procedures described in **Annex M**.

Acquisition of key skills is recorded in student logbooks. Competency is formally certified in these logbooks by a clinician on the firm to which the student is attached.

110. The feedback we received from students and trainees suggested that they found this integrated experience to be helpful grounding for their work as PRHOs. However, the concept of undertaking a shadowing period after the Second BM Examination in Year 6 in the post where they would be employed after graduation was enthusiastically received by trainees and commanded the full support of the teachers we met.

111. We hope that the School and Deanery will continue to work closely together to ensure that the final year of the undergraduate course adequately prepares students for the PRHO year. Introducing students to the assessment and appraisal systems now being implemented for PRHOs is one approach which we invite both parties to consider.

Other issues

Student selection

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

113. The application and selection process for those candidates, including graduate applicants, wishing to read medicine at Oxford are clearly and comprehensively described in the papers reproduced at **Annex O**. This information can also be accessed by prospective applicants via the School's website. It was evident to us that the School operates scrupulously fair and transparent selection and admission procedures.

114. We were impressed by the efforts made by the School to attract applicants from a wide range of backgrounds, particularly through the Oxford Access Scheme. Established in 1993 by a group of students from multicultural backgrounds and admissions tutors from the University, the scheme aims to encourage students from inner-city areas, especially those of ethnic origin, to enter higher education in general and the University of Oxford in particular. We heard that the numerous projects, ranging from afternoon school visits to weeklong summer schools had been instrumental in guiding many students from urban or socially-deprived areas towards and through their university applications.

Student support

115. Students in Oxford considered themselves particularly well served in terms of the provision of academic and pastoral support. We noted that the individual Colleges of the University contribute generously to this process, as described in the enclosure at
Annex P.

116. Among the support services available to medical students are:

- an extensive induction programme for new students. We were told by students that this comprised both an informative and welcoming introduction to the life of the Medical School

- a ‘parenting’ scheme, operated through the University Medical Society, whereby first-year students are befriended by a ‘parent’ or second-year student

- the allocation of a college tutor in Years 1-3 who is on hand to offer regular academic guidance and pastoral support

- the academic tutor system in Years 4-6. Academic tutors provide clinical instruction and supervision. Their work is supported by the Director of Clinical Studies (DCS) and her deputy, who monitor students’ reports and arrange to see any student who is experiencing academic or clinical difficulties, attending poorly or is in need of pastoral care. In addition the DCS or her deputy interviews each student individually in both Years 4 and 5

- a weekly ‘Drop-in Clinic’ held by the DCS for students in difficulty

- pastoral supervisors, appointed by the DCS, for each clinical student. We were assured that supervisors and students meet once each term.

117. Within the University there are a number of other sources of support for Oxford students. These include:

- the University Counselling Service

- Oxford hospitals (which include psychiatric services)

- University Careers Service

- The Samaritans

- The Libra Project, which provides counselling on alcohol and drug abuse

- Nightline – a counselling service run by specially-trained students

- Oxford University Students Union (OUSU) Welfare Centre

- OUSU Student Alcohol and Drugs Advice

118. New clinical students receive a ‘protected’ and supportive introduction to clinical work through the six-week Foundation course at the start of Year 4. From September 2000 each group of four students on each ‘Foundation’ firm has been allocated a trained final year student (who had completed the SSM in Medical Education described in paragraph 57 of this report). These Year 6 students

assisted their peers with an introduction to the hospital environment and with basic skills training for the first two weeks of the course. We understand that Year 4 students have continued to use these mentors for support.

119. Students who had completed their pre-clinical training both in Oxford and elsewhere in the UK confirmed that they considered themselves well integrated into the clinical course. We had learned earlier that some curricular initiatives had been deferred while consideration was given to their likely impact on students entering the Oxford clinical course from other medical schools. While the School should be aware of the different needs of students transferring to or from other medical schools, this should not be regarded as a constraining factor to desirable curricular development. We urge the School to create the curriculum which it considers most appropriate for its own students.

120. Tutors have been appointed at each district general hospital to monitor the teaching programme, while a named administrator, usually located in the postgraduate centre, ensures that students have appropriate facilities, including accommodation. Feedback from students is collected at the end of each attachment. We were told that the DCS communicates directly with these tutors if problems are identified either with individual students or through the feedback which is gathered.

121. Any student considering changing course or withdrawing from the School, or in danger of having to leave the University through examination failure is counselled. In Years 1-3 this task is undertaken by small panel of counsellors, including both clinicians and non-clinicians, while clinical students are interviewed by the DCS or their individual supervisor. The University Careers Service provides advice and assistance to any student wishing to leave medicine and take up another course within the University or elsewhere. All Oxford medical students who have successfully completed Years 1-3 of the course receive an honours degree, which enables them to embark on a full range of careers.

122. From the feedback we received in our discussions with students and staff, it was evident that the School has created a friendly and caring environment for its students. They considered themselves both valued and supported.

Feedback to students

123. We thought that the number of systems through which students in Oxford could gain rapid feedback on their progress was impressive.

In Years 1-3 we noted:

- the University's termly formative assessments. These assessments are voluntary and use an MCQ and short answer format to focus on core material in the First BM course

- feedback on practical work written up by students. Demonstrators check and approve this written work. They may also invite students to come and

see them if necessary for advice on content or presentation

- College formative examinations. Known as ‘collections’, these examinations usually require students to write an essay on core material covered each term

- the weekly tutorial allows students the opportunity to discuss both their academic performance and the general progress they are making in College. At regular intervals tutors also prepare written reports evaluating their tutees’ progress, and review these with the student concerned.

124. In Years 4 to 6 comments and views about student performance are disseminated in the following ways:

- through informal feedback from clinicians delivering core teaching or engaging in supplementary clinical teaching at the bedside

- through formative feedback after each assessment. In the case of OSCE examinations we were told that this feedback to students is immediate

- through formal written feedback in course reports and logbooks, recording student progress at each stage of the clinical course. Tutors are asked to discuss and agree these reports with students before they are sent to the Medical School.

125. The students we met were greatly appreciative of the efforts made by the School and the University to ensure that they received rapid and constructive feedback on their performance as doctors in training. In the light of the comments made by the visitors
in 1997 about the need to improve levels of feedback in the clinical years, it was encouraging to learn from students that one-to-one feedback sessions, at which their performance is discussed and agreed with their tutor, were common practice after each assessment in Years 4-6.

Quality control

126. The new management structure within the Medical Sciences Division is described in the diagrams at **Annex G**.

127. It seemed to us that the School had introduced sound mechanisms for ensuring the quality of teaching and learning. These included:

- Seeking student feedback on each course component through anonymous structured questionnaires

- Student representation on all key committees of the School

- Termly reports and recommendations from course committees

Annual quality assurance reports from clinical tutors

Feedback from external examiners on assessment standards

Divisional and central University reviews of departments, which predominantly include reviewers external to Oxford.

Areas of good practice

128. *The contribution of students*: We were pleased to learn that students play a full and active part in the development of the curriculum. They spoke very positively of the speedy and willing response of the School to their requests for curricular modification (paragraphs 30 and 31).

129. *Staff development*: We were impressed by the commitment shown by both University and School to promoting the professional development of their teachers (paragraph 32).

130. *Reducing the burden of factual information*: We congratulate the School on the progress it has made thus far in eliminating much redundant or duplicated material from its core curriculum and encourage it in its future plans to constrain factual overload (paragraph 42).

131. *Patient and Doctor course*: We welcome the School's intention to increase clinical input in Years 1 and 2 and to engage students at an earlier stage in the key concepts of *Good Medical Practice* through the introduction of the modified Patient and Doctor course in October 2001 (paragraph 46).

132. *The Final Honour School (FHS)*: We believe that the FHS remains a major strength of the School, providing as it does an invaluable opportunity for students to pursue topics of interest to them under the guidance of recognised leaders in the field (paragraph 57).

133. *The Special Study Module in Medical Education*: We applaud the School on its imagination in introducing this exciting and innovative development, which enables final year students to mentor and to assist in the training of Year 4 students commencing their clinical studies (paragraph 57).

134. *Basic and advanced life support:* We were greatly impressed by the School's commitment to teaching these skills, and in particular by the provision of a fully accredited two-and-a half day Advanced Life Support (ALS) course which is compulsory for all students in Year 6 (paragraph 85).

135. *Student selection*: It was evident to us that the School operates scrupulously fair and transparent selection and admission procedures. The ways in which efforts are being made to attract applicants from a wide range of backgrounds to read medicine at Oxford are both novel and exciting (paragraphs 113 and 114).

136. *Student support*: It was clear from our discussions with students and staff that the School has successfully created a friendly and caring environment for its students. They considered themselves both valued and supported (paragraph 122).

137. *Feedback to students*: We thought that the number of systems through which students in Oxford could promptly gain information about their progress was commendable (paragraph 123). The students themselves were greatly appreciative of the efforts made by the School and the University to ensure that they received rapid and constructive feedback on their performance as doctors in training. In the light of the comments made by the visitors in 1997 about the need to improve levels of feedback in the clinical years, it was encouraging to learn from students that one-to-one feedback sessions, at which their performance was discussed and agreed with their tutor, were now common practice after each assessment in Years 4-6 (paragraph 125).

Areas for further consideration

138. *Supervisory structures*: We congratulate the School on the major changes it has introduced since our last visit to aid integration and consolidation of its management framework. Impressed though we were at the progress made thus far, we consider that there is scope for future refinement of the supervisory structures which could be effected by confirming the strategic role of the ESPC in overseeing curricular development and by streamlining the number of committees currently reporting to it. We therefore invite the School to consider simplifying still further its management structure. This approach will, we believe, lead to lines of accountability and responsibility being more clearly defined (paragraph 29).

139. *Integration*: While we welcome the steps that have been taken, and those that are planned, in order to co-ordinate the curriculum, we encourage the School to press for further vertical integration of clinical teaching and basic sciences, particularly in Years 1 and 2 (paragraph 48).

140. *Public health medicine*: We appreciate the complexity of the local situation as it pertains to academic public health medicine, but we believe that the School should continue its efforts to ensure that this discipline remains a strong curricular thread. Strengthening links with the regional NHS Public Health department would be one means of achieving this outcome (paragraph 88).

141. *Assessment*: We understand that the EPSC has been asked to look into the question of consistency of assessment with particular reference to the clinical years of the course. While welcoming news of this initiative, we believe that this review should be extended to cover all six years of the curriculum and should include an evaluation of assessment methods to ensure that these remain fit for purpose. We also take the view, as stated in *Tomorrow's Doctors*, that assessment systems should reflect the integrated nature of the curriculum. We therefore invite the School to consider introducing more integrated assessments into the curriculum to reflect the increasing co-ordination of the teaching being delivered (paragraph 105).

142. *Fitness to practise procedures*: We invite the School to consider adapting its new fitness to practise procedures so that these include PRHOs as well as medical students (paragraph 107).

143. *Preparation for the PRHO year*: We hope that the School and Deanery will continue to work closely together to ensure that the final year of the undergraduate course adequately prepares students for the PRHO year. Introducing students to the assessment and appraisal systems now being implemented for PRHOs is one approach which we invite both parties to consider (paragraph 111).

144. The concept of undertaking a shadowing period after the Second BM Examination in Year 6 in the PRHO post where they would be employed after graduation was enthusiastically received by students and trainees and commanded the full support of teachers (paragraph 110). We hope the School will give consideration to introducing a dedicated 'shadowing' attachment of this type.

145. *Proceeding with curricular initiatives*: We learned that some curricular initiatives had been deferred while consideration was given to their likely impact on students entering the Oxford clinical course from other medical schools. While the School should be aware of the different needs of students transferring to or from other medical schools, this should not be regarded as a constraining factor to desirable curricular development. We urge the School to create the curriculum which it considers most appropriate for its own students (paragraph 119).

Conclusion

146. The School deserves congratulation for the many positive changes it has introduced since our last visit. In our view these have served to enhance Oxford's reputation as a strong medical school.

147. We hope that the School will continue to maintain the pace of curricular change reported to us during the visit. We will be seeking an update on progress in a year's time. In addition to the areas specifically highlighted in our report, we will be interested to hear at that time how the new four-year accelerated programme is evolving, and to discover in due course whether its evaluation will reveal differences in the characteristics of its graduates from those following the six-year curriculum.

Part 2: General Clinical Training

Background information

148. Prior to the visit we were given helpful background information about the arrangements for general clinical training in the Oxford Deanery. This included a summary, reproduced at **Annex Q**, showing the number of PRHO posts in the region and the extent to which the recommendations in *The New Doctor* have been implemented to date.

Form of the visit relating to general clinical training

149. After an initial overview of general clinical training provision by senior staff from the Deanery and the Medical School, we met members of the Postgraduate team involved with PRHO training. We then had discussions with a large group of PRHOs, drawn from a variety of locations and specialties, before talking to clinical tutors based at different NHS hospitals throughout the region. After lunch we had a meeting with chief executives and medical directors representing the various NHS Trusts in the Deanery, before reporting back to the Postgraduate Dean and his team on our impressions of the day.

Organisation and management of the PRHO year

150. There are eight acute NHS Trusts in the region involved in the training of PRHOs.

Supervisory structures

151. The Postgraduate Dean is tasked with the overall management of the PRHO year. To assist him in discharging this responsibility he has assembled a Postgraduate Dean's team. The main functions of this team are to assess PRHO training posts and to monitor educational provision, appraisal and assessment of trainees.

152. In addition to the Postgraduate Dean himself, the team comprises:

the Associate Postgraduate Deans
the Director of Clinical Studies (DCS)
representatives of the clinical tutors in the region.

The Associate Postgraduate Deans have no fixed term of membership of the team, whereas clinical tutors normally serve for a period of five years.

153. We noted that there was no PRHO or student representation on the Postgraduate Dean's team. It seemed to us that the membership of that body could be usefully augmented by inclusion of a PRHO or final year medical student. We therefore invite the Deanery to give consideration to this suggestion. The Postgraduate Dean told us that he currently maintains links with the Medical School through his membership of the MSD's Education Policy and Standards Committee

and the Clinical Education Committee.

The approval of posts

154. The Postgraduate Dean, with the support of his Deanery team, is responsible for approving and monitoring the quality of PRHO posts in the region. The criteria for approval of new PRHO posts include those set out in *The New Doctor*.

155. All Trusts in the Deanery are visited on an annual basis and, we were told, more frequently if necessary. During these visits trainees are interviewed in private by the Postgraduate Dean and by members of his team. Information gained is fed back verbally at the end of the visit to educational supervisors, the clinical tutor and the medical director and chief executive in each Trust, and is later confirmed in writing. These written reports, which are used as the basis for identifying and stimulating change, are circulated to Trust offices, Medical School offices, the Regional office, clinical tutors, and associate clinical tutors as well as to supervising consultants and trainees within the Trust which has been visited.

Communicating the aims and objectives of the PRHO year

156. All trainees receive copies of *The New Doctor*. The objectives of general clinical training, as expressed in that publication, are also flagged up for PRHOs in the Deanery's educational framework booklets which are issued to them at the start of their training. We noted that trainees are questioned on their knowledge and understanding of the key themes in both documents by the Postgraduate Dean and his team on their annual visits to Trusts.

157. The various members of staff we met during our visit, which included clinical tutors, chief executives and medical directors from the major Trusts in the region, were all familiar with and supported the aims of *The New Doctor*.

The selection of PRHOs

158. The Deanery operates a matching scheme which guarantees a PRHO post to every Oxford graduate. The scheme, which is briefly described in the papers at **Annex R**, is restricted in its first round to Oxford graduates but open to graduates of other medical schools in its second round. Students can make application to the scheme as early as January in Year 5, selecting up to 50 possible choices of post, which, we were told by students, are not classed in order of their preference. Consultants may choose to interview candidates before allocating a rank or may make that decision based on the completed application form and CV produced by the student.

159. The Deanery believes that the appointment process is fair, with no discrimination on the grounds of race or sex. Although the clinical students we spoke with had all been 'placed' in PRHO posts under the scheme, some expressed disappointment that they had not been given the opportunity to rank their preferred posts on the application form, while others considered it would have been more equitable if all candidates were interviewed prior to being allocated a

post. We share these views, and have concerns about the fairness of a process which gives preference to Oxford graduates. However, we understand that the entire appointment system is currently under review.

160. Students wishing to undertake a PRHO post outside the region are guided by the Deanery team, which keeps a list of vacant posts elsewhere, including those previously occupied by Oxford graduates.

Monitoring the quality of PRHO posts

161. The Deanery uses the annual visits to Trusts made by the Postgraduate Dean’s team to assess and guarantee the quality of general clinical training in the region. During this process, which has been briefly described in paragraph 155, the Postgraduate Dean’s team meets with trainees, educational supervisors, clinical tutors and Trust chief executives and medical directors, using the checklists reproduced at **Annex S**, to record its findings.

162. Examples of good practice identified as a result of this monitoring exercise are made known to clinical tutors throughout the region and are ‘rolled out’ to other Trusts during subsequent visits. Any deficiencies noted by the visiting team are immediately brought to the attention of the Trust, which is given a specific timeframe within which to resolve these issues. We were told that failure to take satisfactory remedial action had resulted in approval being withdrawn from four PRHO posts at Heatherwood and Wexham Park hospitals in recent years.

Components of a high quality PRHO post

Induction

163. Each Trust offers trainees two-day’s induction in preparation for the particular post which they will be taking up in August. For PRHOs commencing their training in February this programme is normally reduced to one day. Guidance to staff organising induction programmes is contained in handbooks prepared by clinical tutors and Postgraduate Centre staff in each Trust in collaboration with other colleagues.

164. In paragraphs 108 to 110 of our report we describe the current arrangements for PRHO ‘shadowing’. We renew the invitation made to the School in paragraph 144 of our report to give consideration to introducing a dedicated ‘shadowing’ period of this type.

Educational opportunities

165. PRHOs in Oxford welcomed the educational opportunities provided for them. Core topic teaching for trainees in medicine and surgery is supplemented by a weekly programme of formal educational sessions dedicated to PRHOs, which is organised by the clinical tutor in each Trust. These sessions vary in format between Trusts but usually last one hour and address issues identified in *The New Doctor*, including the development of generic skills and coping in particular emergency

situations.

166. The trainees we spoke to confirmed that they were all receiving protected teaching sessions each week on topics which they regarded as relevant to their professional development. Attendance at these programmes is high (on average between 70-75% we were told) and is assisted by the arrangements made by the Deanery for ensuring that this is on a ‘bleep-free’ basis. Bleeps are left with duty SHOs and Registrars or with Postgraduate Centre staff. A register is taken at these formal sessions, usually by the Postgraduate Centre Manager on behalf of the clinical tutor. The consequences of regular poor attendance is an investigation by the clinical tutor, including an interview with the PRHO in question and discussion with the educational supervisor.

167. We were disappointed to discover, however, that trainees were routinely expected to carry out a range of duties with little or no educational value, which included portering. PRHOs bemoaned the lack of a regular phlebotomy service at most centres and continued to experience difficulties in obtaining the results of radiological investigations. Some told us that the task of attempting to locate X-rays without the assistance of a computerised logging system was particularly irksome. Other PRHOs revealed that their excessive ‘bleeping’ by junior and/or inexperienced nursing staff, requesting them to carry out tasks which could have been undertaken by experienced nurses, meant that the educational aspect of their training was being constantly downgraded. For example, we heard that one trainee had been ‘bleeped’ no less than fifty times by junior nursing staff one Saturday morning during a post-take ward round. When we questioned the Deanery on this matter we were told that, as a result of the national recruitment crisis affecting nursing, many senior nurses had recently left Oxford Deanery hospitals to be replaced by junior nurses, who looked to PRHOs to support them in their initial inexperience. We wondered why local Trusts had not followed the example of many other hospitals throughout the UK, which had effectively employed advanced nurse practitioners to perform those routine tasks previously carried out by PRHOs. We urge all the Trusts in the Oxford region to give serious consideration to this suggestion.

Educational supervision

168. Clinical tutors in each Trust identify consultants whom they believe will be suitable to act as educational supervisors, and make a recommendation to that effect to the Postgraduate Dean. They are also responsible for ensuring that educational supervisors and trainees meet within the first month of the placement to discuss the PRHO’s performance and that a further meeting takes place before any formal assessment documentation is completed.

169. Each PRHO is allocated an educational supervisor who is usually the consultant for whom the trainee initially works. Unless a request for a change is made, PRHOs are likely to retain the same educational supervisor throughout the pre-registration year, though they may rotate through other consultant teams. This is a deliberate policy which the Deanery believes encourages a more supportive one-to-one relationship between trainee and supervisor. Certainly, all the PRHOs

we consulted knew and had met their educational supervisors. Although trainees confirmed that appraisal interviews were occurring, many found these unhelpful as they were often conducted by a consultant for whom they were no longer working and who therefore could not comment with any great authority on their current performance. Although some PRHOs (predominantly those undertaking the general practice and paediatric rotations) had been fortunate to receive timely and constructive comments on their progress from their supervising consultants, the prevailing view of the trainees with whom we spoke was that regular feedback on their general performance was not readily provided; rather this had to be actively sought by PRHOs themselves.

170. The Postgraduate Dean recognises the importance of ensuring that educational supervisors are trained to a consistently high standard so that they are fully equipped to carry out the key tasks which they have been assigned. He told us that the Deanery offers a range of courses to enable trainers to develop these vital skills. Our attention was drawn in particular to The Doctors as Educators training programme which focuses on enhancing assessment and appraisal techniques and encourages trainers to gain evidence of the effectiveness of their teaching. We noted that no less than 450 consultants had completed this course at the Oxford Radcliffe group of hospitals. The Deanery anticipates that all educational supervisors in the region will have undertaken similar training by the end of 2002. We thought this was commendable.

171. The Deanery is confident that it is quickly able to identify evidence of any unsatisfactory performance by clinical tutors and educational supervisors. Clinical tutors are subject to annual appraisal from the Postgraduate Dean, while educational supervisors are monitored by their local Trust; any problems are noted by the clinical tutor and are reported to the Postgraduate Dean. Poorly performing educational supervisors may be required to retrain, or to relinquish their role if their unsatisfactory performance persists.

Clinical training and supervision

172. The Deanery satisfies itself that core generic training, as defined in *The New Doctor* and *Good Medical Practice*, is being delivered through its annual visits to Trusts and through the assessment and appraisal process administered by clinical tutors and educational supervisors in individual Trusts.

173. Most trainees considered that any opportunities available to them to further their clinical training were seriously compromised by the intensity of their service commitments. The majority were working beyond their contracted hours, covering a large number of beds, carrying out a series of random tasks and receiving little or no feedback on their general clinical performance, whether this be completing drug charts, devising treatment plans or presenting patients during ward rounds.

174. Levels of clinical supervision, particularly in surgery, were also deemed to be less than adequate. PRHOs on call in hospital at night recalled being told by surgical registrars not to disturb them at home. Fortunately they were able to seek help from colleagues in other departments of the hospital. This criticism did not

apply to the medical placements, where we were told that registrar cover was both willing and available. We heard that at one centre a trainee was left alone at night holding two crash bleeps; he had to call on the emergency haematologist for assistance. At another hospital a PRHO was required to care for 50 patients for three weeks with no direct supervision due to staffing problems which had first been identified two months previously. She was forced to call on SHOs in other units for help. We were dismayed by this information, which contravenes the recommendation we make in paragraph 33b of *The New Doctor*, that PRHOs 'must have available to them in the hospital, at all times of the day or night, a more senior member of staff in an appropriate specialty who can provide cover and help.' We urge the Deanery to take rapid steps to ensure that this recommendation is implemented without further delay.

175. When we asked clinical tutors and Trust chief executives and medical directors how they were responding to these difficulties, both groups assured us that they were fully committed to the aims of general clinical training, as expressed in *The New Doctor*. However, they admitted that they were often unable to deliver on many of these objectives, particularly in relation to clinical teaching and supervision, because of the intense service pressures under which they were labouring. In direct response to this situation, some medical managers advocated a complete overhaul of existing staffing arrangements, permitting them to recruit more employees at more levels than hitherto. Whilst this suggestion was welcomed in many quarters, it was pointed out that it did not take account of the limited physical resources of hospitals in the region.

176. We hope that the Deanery, in conjunction with local Trusts and, if necessary the DH, will be able to work together to resolve these resource-based issues so that clinical teachers have the time and opportunity both to educate and to supervise their trainees. In turn, the intensity of work pressures on PRHOs in Oxford must be relaxed so that they can benefit from this training and supervision. One possible way forward might be to limit trainees' workload to the care of patients on their own firm. They would thus be better placed to receive more regular feedback on their performance from their clinical supervisor.

Monitoring the progress of PRHOs

177. All PRHOs are monitored by their educational supervisor and by the clinical tutor in the Trust where they are employed. Each trainee is expected to have an appraisal interview with their educational supervisor at the beginning and at the mid-point of their appointment. A further session may take place but this is usually replaced by the formal assessment required at the end of each placement. The Confidential Assessment Form used for this purpose is reproduced at **Annex T**. This is completed by the educational supervisor and is countersigned by the clinical tutor on behalf of the Postgraduate Dean. At this point the clinical tutor has the opportunity to make further enquiries if a candidate's performance has been rated as borderline in any capacity, before the form is returned to the Deanery.

178. If serious difficulties occur in post, we were told that the Postgraduate Dean is immediately notified of these by the clinical tutor. The Postgraduate Dean

interviews the trainee and agrees the remedial action to be taken; the educational supervisor, clinical tutor and Trust management are also involved in this process.

179. If trainees miss more than two weeks of their post through ill-health or are absent for more than one month (including annual leave), they are required to complete their appointment in accordance with current GMC guidance. If these problems are ongoing, the PRHO may be removed from their training post until their good health is restored and an ad hominem programme is created to enable them to complete the pre-registration year and obtain a satisfactory assessment. We noted a number of instances in which PRHOs, whose training had been interrupted through ill-health or other reasons, had successfully managed to complete the PRHO year in part-time training posts developed by the Deanery. These included two PRHOs with previous health problems, who undertook specially-designed house officer posts at Horton Hospital, Banbury, and two other doctors, both out of medicine for between five to ten years, who agreed to begin their retraining for clinical practice by completing part-time PRHO posts in Reading and Wycombe. We were pleased to learn that this period of retraining had been successfully negotiated and that both doctors had fully regained their confidence.

180. We thought that the Deanery had developed effective procedures for identifying and supporting poorly performing PRHOs and enabling those with health-related problems to complete the PRHO year at a pace appropriate to their capabilities. These systems are underpinned by the informal meetings which regularly take place between the Postgraduate Dean and the DCS to exchange information about students and trainees who may be in difficulty. We believe that these links would be further strengthened if the School were to embrace the suggestion made in paragraph 107 of our report and extend its new fitness to practise procedures to cover PRHOs as well as medical students.

Professional development and personal well-being

Careers advice

181. General careers information is available to trainees on the Medical School website and includes advice on:

- writing CVs
- applying for jobs
- getting a reference
- surviving interviews.

182. PRHOs are actively encouraged to discuss career choices with their educational supervisors or clinical tutors while the Postgraduate Dean and the Associate Postgraduate Deans can be approached by any trainee seeking specific guidance.

183. Most of the PRHOs we spoke to told us that they obtained careers advice informally from other trainees.

Support for PRHOs

184. For advice on the practical aspects of the PRHO year, trainees can contact a range of staff, including educational supervisors, clinical tutors and postgraduate centre managers. The Postgraduate Dean also makes himself available to trainees requiring help. In the case of those with health problems, we have already commended in paragraphs 179 and 180 of our report the flexible and supportive arrangements which exist to enable the Deanery to tailor further training according to the PRHO's needs.

185. We were interested to hear of a very recent Deanery initiative to improve levels of support to doctors in training who are experiencing difficulty for personal or career reasons. Depending on need, Medic Support provides access to:

- trained counsellors, drawn predominantly from the health care professions, who listen to the problems of trainees and offer assistance. If necessary, they can also arrange for doctors to attend a series of sessions with a clinical psychologist

- clinical psychologists, who have been specially selected for their interest and expertise in helping doctors

- a full range of psychiatric services.

Further information about this scheme can be found in the paper at **Annex U**.

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

Accommodation, catering and personal safety

187. The Deanery monitors the standard of accommodation and catering and ensures the safety of its PRHOs through its annual visits to Trusts. Any unsatisfactory findings are immediately brought to the attention of Trust management with a request for urgent remedial action.

188. Deanery staff admit that the provision of out-of-hours catering is a significant problem, though each Trust does supply freezer and microwave facilities for its trainees. This view was shared by PRHOs, one of whom described the general standard of catering as 'atrocious and expensive'. The Deanery has been active on this issue; we learned that the Postgraduate Dean had recently withheld funds of £10,000 and £5,000 respectively from two Trusts who had consistently failed to provide food out-of-hours.

189. Accommodation at some hospitals in the region, such as Wexham Park and Northampton General, drew praise, though this was not the case in Oxford where clinical tutors agreed with PRHOs that it had been a source of concern for many years. One trainee residing in hospital accommodation in Oxford revealed that,

despite making repeated requests for repairs, she had been without a properly functioning shower for the last six months. We heard that the quality of accommodation in Ivy Lane, Oxford could be best described as ‘poor’ despite the best efforts of the Postgraduate Dean to secure improvements by making a personal visit to the scene and writing several letters to the local Trust. We think that it is unacceptable that this situation has been allowed to continue over such a long period of time, and hope that the Trust concerned will now take immediate action to bring the accommodation in Ivy Lane up to a satisfactory standard for doctors in training.

190. Although all Trusts in the region are asked to provide trainees with personal alarms and to ensure that hospital grounds are fully illuminated at night, some PRHOs pointed out an absence of such security measures at some centres. However, this was nor perceived to be a common problem; for example, we learned that in places such as Reading and Banbury arrangements were regularly made for porters to escort trainees in poorly-lit areas at night.

191. We hope that the Deanery and all the Trusts in the region will continue to investigate ways of securing speedy improvements to the living and working conditions of its trainees. Of course, this objective cannot be achieved without concerted input from PRHOs themselves. We heard that in many centres, such as Northampton, junior doctors had established implementation groups which met regularly with Trust management to identify and to seek solutions to problem issues. However, we were disappointed to learn that, although membership of these groups was open to all grades of trainee doctors, none were attended by PRHOs. It seemed to us that the trainees whom we met, though well-motivated, conscientious and articulate, considered that they were powerless to alter the status quo. We firmly believe that if they were to raise issues affecting their living and working conditions (including those described in the next section of our report), in a direct and co-ordinated way with Trust management, their prospects of effecting change would be greatly increased.

Contractual matters

192. All the PRHOs with whom we spoke were working beyond their contracted hours, except those trainees undertaking the rotations in general practice. Some PRHOs were working on average between 85 to 101 hours per week, with out-of-hours and weekend working contributing dramatically to this figure. While the lack of sufficient rest periods at weekends was of particular concern to many trainees others, mainly those in the medical specialties, complained that they could not obtain an adequate amount of rest during the day or early evening due to work intensity.

193. Trust managers acknowledged that PRHOs were indeed working in excess of their contracted hours, attributing this to the changes to the New Deal requirements on Junior Doctors’ Hours which came into effect on 1 December 2000. Most PRHO posts, which had been fully compliant with the requirements in force prior to that date, now did not meet the new objectives set down by the National Health Service Executive. We anticipate that the Deanery will want to

continue to work closely with Trusts to ensure swift implementation of New Deal targets on junior doctors' hours.

194. We were concerned to discover that PRHOs in many different Trusts were routinely expected to obtain consent from patients for major surgical procedures about which they had little or no prior knowledge. They were therefore unable to inform patients about any potential risks involved in the treatment. The School and Deanery will wish to take appropriate action to ensure that all medical staff are fully informed about issues of consent, and conform with current GMC guidance on this matter.

New PRHO rotations

195. The new rotations in general practice and paediatrics have proved very popular with PRHOs, who told us that they had been fortunate to benefit from high calibre teaching and constructive feedback from supervisors on their all-round performance. Few of these trainees could identify with the concerns expressed by their peers in the more established PRHO posts.

Areas of good practice

196. *Educational sessions*: The Deanery is to be congratulated for ensuring that all Trusts offer formal educational programmes which are perceived by PRHOs to be of high quality and relevant to their professional development (paragraph 166).

197. *Educational supervision*: We support the aim of changing the culture from that in which all consultants have a house officer to one in which some consultants are recognised as PRHO trainers. All the trainees we spoke to knew and had met their educational supervisor (paragraph 169).

198. By the end of 2002 the Deanery expects to have arranged for all educational supervisors in the region to have undergone dedicated training to assist them in carrying out the key tasks associated with their role. We thought this was commendable (paragraph 170).

199. *Supporting poorly performing trainees and those with health problems*: The Deanery has developed effective procedures for identifying and supporting poorly performing PRHOs and enabling those with health-related problems to complete the PRHO year at a pace appropriate to their capabilities (paragraph 180).

200. *New PRHO rotations*: The new rotations in general practice and paediatrics were thought to be an unqualified success, in particular because of the high quality teaching and helpful feedback on their performance which trainees regularly received from their trainers (paragraph 195).

Areas for further consideration

201. *Inappropriate tasks*: Trainees were routinely expected to carry out a range of duties with little or no educational value and some PRHOs were being excessively

bleeped by inexperienced nursing staff in order to perform these tasks. We urge all the Trusts in the Oxford region to give serious consideration to employing advanced nurse practitioners to undertake these routine duties (paragraph 167).

202. *Work intensity for PRHOs*: Most trainees considered that their desire to further their clinical training was seriously compromised by their overwhelming service commitments. We believe that the intensity of work pressures on PRHOs in Oxford must be relaxed so that they are able to benefit from the educational opportunities available to them. One possible way forward might be to limit trainees' workload to the care of patients on their own firm (paragraphs 173 and 176).

203. *Clinical supervision*: Levels of clinical supervision, particularly in surgery, were deemed to be less than adequate, with many PRHOs feeling isolated when on call and others being left without direct cover for a considerable period of time. This is unacceptable and we urge the Deanery to take rapid steps to ensure that the recommendation we make in paragraph 33b of *The New Doctor* about the need for continuous and appropriate clinical supervision of PRHOs is implemented without further delay (paragraph 174).

204. *Service pressures on clinical teachers and supervisors*: Clinical supervisors and Trust managers admitted that they were often unable to deliver fully on key tasks, such as clinical training and supervision, because of the intense service pressures under which they were labouring. We hope that the Deanery in conjunction with local Trusts and, if necessary the DH, will be able to work together to resolve these resource-based difficulties so that clinical teachers have the time and opportunity to train and to supervise their trainees (paragraphs 175 and 176).

205. *Accommodation and catering*: The PRHOs we met considered the quality of food and its availability out of hours to be poor, a description which they asserted could also be justly applied to the general standard of hospital accommodation in Oxford. We are sure that the Deanery and all the Trusts in the region will wish to continue to investigate ways of securing speedy improvements to the living and working conditions of its trainees. We particularly hope that the Trust in question takes immediate action to bring the accommodation in Ivy Lane up to a satisfactory standard for doctors in training (paragraphs 188 and 189).

206. *Contractual matters*: The vast majority of PRHOs with whom we spoke were working beyond their contracted hours, with out-of-hours and weekend working contributing dramatically to the overall total. We anticipate that the Deanery will wish to press for speedy implementation of revised New Deal targets on junior doctors' hours (paragraph 193).

207. We were concerned to discover that PRHOs in many different Trusts were routinely expected to obtain consent from patients for major surgical procedures about which they had little or no prior knowledge. They were therefore unable to inform patients about any potential risks involved in the treatment. The School and Deanery will wish to take appropriate action to ensure that all medical staff are fully informed about issues of consent, and conform with current GMC guidance on this

matter (paragraph 194).

Conclusion

208. On our return to Oxford we were pleased to learn of some of the recent initiatives taken to improve the PRHO year. These include the provision of a formal programme of educational sessions for all PRHOs and the undertaking to deliver training to each educational supervisor in the region by the end of 2002.

209. However, a number of issues, for example the requirement to carry out too many inappropriate tasks and the intensity of their service commitments, are diminishing the enjoyment and educational benefits of this period of training for many PRHOs. We look forward to hearing in twelve months' time how the Deanery intends to address these and other problems we have identified.