

Report of visit to Queen's University Belfast Faculty of Medicine and Health Sciences

27-28 October 1998

We should like to express our thanks to the Dean of the Faculty of Medicine and Health Sciences, 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.

Introduction

1. Our visit had a dual purpose:
 - a. to review progress made by the Faculty towards implementing the recommendations in *Tomorrow's Doctors* since our last visit in 1995, with a focus on the predominantly clinical years of the course;
 - b. to monitor progress towards implementing our guidance on the pre-registration year, as set out in *The New Doctor*.
2. Our team was led by Professor Sir Charles George, Chairman of the Education Committee. The other members were Professor James Drife and Professor David Hatch, both members 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 made for general clinical training. On both days we worked in collaboration with a team from the Quality Assurance Agency (QAA) which was simultaneously conducting a review of medicine at the University. We have provided information about the nature of this collaborative working where this is pertinent.
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*. We also discuss the Faculty's plans for future development. Where appropriate, we refer to the principal recommendations in *Tomorrow's Doctors* in the section headings. 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 our visit the Faculty provided us with a completed questionnaire and other supporting information including the Self Assessment Document prepared for the QAA reviewers. The Faculty also made available to the QAA copies of the questionnaire which it had compiled for us.

Form of the visit relating to undergraduate medicine

7. The day began with a meeting with key staff. These included members of the Medical Education Unit (MEU), which is charged with the task of overseeing the development and implementation of curricular initiatives. Later we met members of the Undergraduate Medical Education Committee (UMEC), the body responsible for endorsing the overall strategy and recommendations of the MEU. We also had a lengthy and enjoyable dialogue with a large group of students representing each year of the curriculum.
8. We were joined at all these meetings by members of the QAA team, who wished to pursue issues relevant to their consideration of undergraduate medical education.

9. During the day we were also able to view some of the excellent clinical facilities available to students and to study some of the documentation prepared by the Faculty for the QAA visitors.

The current curriculum

Summary of recent curricular developments

10. When we last visited in November 1995, the Faculty was just completing its latest and most radical curricular review, with the intention of introducing a new curriculum in September 1996. On our return visit we were able to see the tremendous changes which had been made over the past three years. The new curriculum has been swiftly and successfully introduced so that from September 1998, all students were following the new course. This has been achieved by rolling out years one and three of the new curriculum simultaneously.

11. Among the many features of the new course, we noted in particular the following points:

- didactic teaching has been substantially reduced and has been replaced by self-directed learning activities
- case-based learning is now used for both basic science and clinical teaching
- clinical and basic science subjects have been integrated vertically and horizontally throughout the programme
- the curriculum has been organised and delivered as a systems course with a "first pass" through the systems of the body in years one and two, and a "second pass" through these in year three
- approximately 25% of curricular time has been allocated to Special Study Modules (SSMs)
- basic clinical skills training begins in year one
- students are introduced to basic clinical examination and communication skills in a Clinical Skills Education Centre
- community-based clinical settings play an important role in the teaching of clinical skills
- during year three the teaching of laboratory sciences has been integrated with the teaching of clinical subjects in the peripheral hospitals
- students complete the core curriculum by the end of year four
- during their final year students spend four weeks "shadowing" the PRHO in the unit in which they will be employed following graduation. They will carry out under supervision a range of tasks commonly performed by preregistration house officers.

12. We were greatly impressed by the changes which had been made since our last visit and the positive way in which these had been managed.

Structure and content of the curriculum

13. An overview of the curriculum, describing its structure and content, is at Annex A.

14. The curriculum is delivered in five consecutive phases.

15. Phase one accounts only for the first semester of year one but introduces students to the scientific basis of medicine whilst allowing them the opportunity to acquire self-directed learning skills. Communication skills training begins during this phase, as does the Early Medical Contact Programme, during which students pay regular visits to a family under the supervision of a general practitioner. One or more members of the family will be suffering from a chronic illness or disability.

16. Extending throughout the second semester of year one and all of year two, phase two encompasses the study of the normal structure and function of each body system. Clinical skills training begins and students complete three SSMs during this phase.

17. In phase three (year three) students study each of the body systems again, but this time the focus

is on abnormal structure and function. Clinical skills are further developed, and two more SSMs are undertaken.

18. During phase four (year four) students gain further clinical experience in a series of specialty attachments. By the end of this phase the core curriculum will have been completed.

19. At the beginning of the autumn semester of phase five (year five) students sit their final written examination. Following their six week overseas elective, students must submit a project on an aspect of clinical medicine which interests them. A series of elective clinical attachments is undertaken in the spring semester but we were told that students must spend at least two weeks attached to both a medical and a surgical unit. In addition to the four-week PRHO "shadowing", the Faculty arranges a number of study days during the spring semester. The topics chosen are pertinent to the work of a PRHO and include:

- Medico-legal aspects of medical practice
- Stress management
- HIV and other infectious diseases
- Professional practice of medicine
- Use of the laboratory and common problems in electrolyte and acid base management
- Prescribing

20. Students must complete each phase satisfactorily in order to progress successfully through the course.

21. The following themes have also been integrated throughout the teaching programme:

- Clinical method, practical skills and practical care
- Communication skills
- Human biology
- Human disease
- Man in Society
- The public health
- Handicap, disability and rehabilitation
- Finding out: research and experimentation
- Medical ethics
- Clinical Pharmacology and Therapeutics

22. The Faculty has appointed co-ordinators to monitor the integration of the themes of communication skills, the public health, handicap, disability and rehabilitation, medical ethics and clinical pharmacology and therapeutics in the curriculum.

23. We were pleased to note that the curriculum had been based on the recommendations in *Tomorrow's Doctors* and that clear aims and objectives had been set for each component of the course.

The management of change (Principal Recommendation 13)

Supervisory structures

24. A diagram, prepared by the Faculty, outlining the way in which the undergraduate curriculum is managed, is included at Annex B.

25. Effective supervisory structures are essential to drive through curricular change. We were satisfied that the Faculty had robust mechanisms in place to oversee the curriculum and to monitor the quality of student learning opportunities. These are known to both staff and students.

26. Overall responsibility for the curriculum is vested in the Undergraduate Medical Education

Committee (UMEC), under the chairmanship of the Dean of Faculty. The Medical Education Unit (MEU) has the task of ensuring the implementation of UMEC's policies. Specifically the MEU's remit is to:

- plan and co-ordinate delivery of the undergraduate curriculum
- conduct an annual review of the curriculum in the light of staff and student feedback and to report to UMEC
- to undertake research in medical education
- to arrange for staff development in medical education.

27. A co-ordinator has been appointed for each phase of the course and an organiser for each course module. We were told that co-ordinators and module organisers meet regularly. As a result of DHSS funding the Faculty has recently been able to appoint a SUMDE (Supplement for Undergraduate Medical and Dental Education - equivalent to SIFT or ACT) Co-ordinator to monitor the quality of undergraduate teaching in hospitals.

The contribution of students and junior doctors

28. One of the most agreeable and interesting features of our visit was the time we spent with the students. They were an articulate and highly motivated group who were clearly enjoying and benefiting from their studies in Belfast. We believe that the Faculty has acted with great wisdom in seeking and taking account of student input in planning, implementing and managing change.

29. In addition to having a voice on UMEC and the Joint Consultative Committees, students have, with junior doctors, been able to influence curricular development.

30. At an early point in its curricular review, the Faculty conducted a survey of recent graduates, seeking information about the value, quality and relevance of the education and training they had received at Queen's University. The outcome of these enquiries, and input from student representation on the Faculty Curriculum Policy Committee which was in being at that time, helped to inform certain aspects of curricular development. We understand that the Faculty also took pains regularly to brief students who would be directly affected by any proposed change.

31. Students currently complete evaluation forms on their experience as they progress through the course. The student perception is that the Faculty is responsive to criticism and proposals for change, and takes action where necessary.

Staff development

32. Both University and Faculty are committed to promoting staff development and training.

33. In addition to running a series of courses on a range of educational topics for staff, the University Staff Training and Development Unit requires all newly appointed academic staff to attend its induction course. Every encouragement is also given to staff to complete the recently established Certificate and Masters programme on Education for the Health Professions. We were told that staff are asked to attend at least two educational events in every five years and that financial support was made available to those wishing to attend courses on a wide range education, management and professional development themes organised by bodies allied to medical education and training in the UK and overseas. Some members of staff are developing their learning from these courses by initiating research projects in medical teaching methods and we learned that two members of staff have been awarded Harvard Macy Scholarships.

34. Within the Faculty the Medical Education Unit has conducted an extensive staff development training programme related to teaching within the new curriculum. This was attended by 80% of staff, including NHS colleagues. We understand that all tutors involved in the delivery of self-directed learning are required to attend a one-day workshop on experiential learning.

35. We were left in no doubt of the importance attached to teaching within the Faculty, having learned of recent promotions of both medical and dental staff to professorial posts predominantly on the basis of teaching ability.

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

Defining the core curriculum

36. We were impressed by the positive changes which have stemmed from redefinition of the core curriculum. The introduction of a system-based teaching programme, integrated both horizontally and vertically, has facilitated the removal of much redundant material from the course. Formal teaching time has been reduced by one-third throughout the curriculum and we were told that there are now only twenty-seven weeks of teaching in year one. Currently there are no more than five lectures in any one week. This has freed up valuable time for small group teaching and has permitted further development of communication skills teaching as well as the introduction of Special Study Module (SSM) programme.

37. The core curriculum itself is described in the study guides for each component of the course. Integrated across disciplines, they define the knowledge, skills and attitudinal objectives to be met on completion of each stage of the programme. We were assured that curricular review remains very much an ongoing process, with new study guides being produced annually following discussion by teaching quality groups and staff/student consultative committees.

Integration of clinical teaching and basic science

38. During the second semester of year one and throughout years two and three the curriculum is taught as a systems course. During their first study of each of the body systems in years one and two students are introduced to the basic principles of pathology, biochemistry, medical genetics and pharmacology relevant to each body system. This integration continues in year three, where clinical science is integrated with clinical teaching. We were told that in the later stages of the course basic scientists contribute to teaching (for example in obstetrics and child health in year four) and scientific aspects of medicine are taught to students as part of their clinical education.

39. Clinical skills teaching is integrated with teaching on the systems course and begins during phase two, in February of year one.

Learning through curiosity

40. In describing the philosophy underpinning the curriculum, the Faculty has stipulated two main aims: "to foster the development of self-directed learning skills and to encourage learning through curiosity." A variety of methods is used to realise these goals.

41. Study guides, stating the objectives of each component of the course as well as methods of assessment and relevant reading lists, encourage students to take responsibility for their own learning. Participation in student-led tutorials, Special Study Modules (SSMs) and the use of clinical scenarios during facilitated tutorials are designed to stimulate student curiosity as is the preparation and presentation of essays and project reports. In years three and four students are expected to research the material for their case presentations/reports. Lectures are used sparingly, with the object of introducing students to key concepts and principles. Staff are encouraged to make lectures interactive, where possible, to discourage passive learning. Students are expected to broaden their learning base through private study, tutorial discussions, laboratory work and clinical experience.

42. Students in good standing have the opportunity to intercalate a year of study leading to the award of a Bachelor of Science degree on completion of either phase two or three of the curriculum.

43. The subjects offered at the end of phase two are:

- anatomy
- biochemistry
- medical genetics
- physiology

In addition to the above subjects students completing phase three may study for a Bachelor of science degree in microbiology or therapeutics and pharmacology.

44. We were disappointed to learn that recently there had been a decrease in the number of students taking up this option. We were told that this might have been attributable to student concern about rejoining a new curriculum but we also acknowledge that during the simultaneous rolling out of years one and three of the new curriculum opportunities for intercalation have necessarily been constricted. As all students have been following the new curriculum since September 1998 we would hope that the take-up rate will now increase. However, some students with whom we spoke considered that their opportunities to undertake intercalated degrees were still limited. We would encourage the Faculty to promote this option more vigorously as we believe that it provides students with the opportunity to develop generic skills not readily acquired in the standard five-year course.

Special Study Modules (Principal Recommendation 6)

45. Students must undertake five SSMs during phases two and three and are required to prepare and present a project in phase five on an aspect of clinical medicine which is of interest to them. The SSM programme is delivered primarily as a taught course, with a co-ordinator assigned to each SSM to provide support and two general co-ordinators who oversee the programme for phases two and three respectively. Students completing the clinical project are allocated a supervisor.

46. In addition to the maximum of six hours' contact time assigned each week to the SSM programme, students are expected to dedicate forty-eight hours per semester to private study for this part of the course.

47. Each semester students have the opportunity to select from a choice of six to eight modules. A list of SSMs offered during phases two and three can be found at Annex C. Students complete a form indicating their first, second and third choices of module from those available. In the event of a module being oversubscribed all students enter a "lottery". Those who are unsuccessful are considered for their second or third choice and, we were told, arrangements are made to ensure that they will be allocated their preferred SSM in the subsequent semester. However, some students with whom we spoke complained that they had not received their first choice of SSM in consecutive semesters. The Faculty has acknowledged the problem and we were assured that steps had already been taken to prevent its recurrence. Students are now weighted according to their first, second and third choice in the Faculty computer database.

48. The number of students admitted to each SSM varies between ten and fifty, depending on the resources available.

49. The Faculty expects that on completion of the SSM programme students will have enhanced their skills in information-retrieval and evaluation, oral and written presentation, teamworking and self-directed learning. To ensure that these expectations are met, end-of-semester examinations will no longer be used to assess competence in SSMs. From January 1999 assessment will be formative, through project work, essays and literature evaluations. The assessment methods and objectives of each SSM are contained in the study guides but common to all students is the requirement that they undertake and satisfactorily complete the entire SSM programme if they wish to proceed to the next phase of the course. Separate criteria have been established for assessment of the preparation and presentation of the seven-thousand word clinical project in phase five, using a five point rating scale.

50. Credits are allocated to students on the basis of outstanding performance in SSMs and each year the Faculty awards a prize to the student who has amassed most credits. We were also informed that the SSM in medical informatics had been awarded the 1997 National Informatics Prize sponsored by the NHS Education Programme.

51. Whilst we were pleased to note the high profile accorded to SSMs in the new curriculum, we discovered that it was theoretically possible for students to complete the SSM programme by confining their study to one particular subject area. We therefore invite the Faculty to review its requirements, ensuring that students are obliged to study in breadth as well as depth.

Delivery of curriculum (Principal Recommendation 11)

Teaching methods

52. Teaching is delivered and learning is encouraged through a variety of methods. These are chosen on the bases of their appropriateness for the subject material, class size and learning objectives. Teaching methods include:

- small group work
- tutorials
- laboratory practicals
- simulated clinical skills training
- early clinical contact in the community
- clinical attachments in hospitals and primary care settings
- computer assisted learning (CAL)
- lectures and discussion classes
- SSMs and project work
- work-shadowing of preregistration house officers (PRHOs)

53. As an example of innovation during the clinical years we commend the perioperative and emergency medicine programme in phase four. By the end of their eight-week attachment to the accident and emergency wards students are expected to be able to:

- demonstrate competence in advanced cardiopulmonary resuscitation
- recognise a seriously ill patient and demonstrate an understanding of the principles of initial management
- demonstrate an understanding of the principles of fracture management and healing
- interpret biochemical, haematological, radiological and other information
- demonstrate an understanding of the physiological and pharmacological principles of good perioperative care.

Computing facilities

54. We were told that there are in excess of 500 personal computers (PCs) for all students of the University, housed in eight Open Access Centres (OAC) which provide a standard working environment at all locations. Two OACs are located within the medical school itself. Although students believe the number of PCs available to be sufficient, some concerns were voiced about the speed and reliability of the system.

55. The well-equipped Clinical Skills Education Centre has its own CD-ROM network, as has the anatomy museum.

56. That aside the Faculty regards its Computer Assisted Learning (CAL) facilities as limited and is anxious to develop these further. Currently CAL is used as part of the anatomy teaching programme in years one and two and to teach musculoskeletal medicine in year three. A CAL Project Officer has been

appointed to integrate and extend CAL facilities and to support the creation of Electronic Study Guides. We also understand that an ambitious project has recently commenced with the object of integrating all IT-based learning resources with curricular themes and topics, using IT and Internet technology. The first phase of this project will provide all students with core information on each module for the entire undergraduate curriculum through the medical web pages.

Other learning resources

57. In 1996 the Clinical Skills Education Centre (CSEC) was founded in a converted ward in Belfast City Hospital. This facility is managed by a senior lecturer, with three nurses employed on a part-time basis as teaching assistants. The CSEC is used extensively for basic clinical skills and communication skills training and for Objective Structured Clinical Examinations (OSCEs).

58. In addition to the Medical Library on the Royal Victoria Hospital site and the Biomedical Library located in Belfast City Hospital, students have access to library facilities in each of the peripheral teaching hospitals. We learned that the Faculty had recently secured funding to build a new library on the Royal Victoria Hospital site. Work on this is expected to begin in spring 1999.

59. The Faculty is justifiably proud of the fact that it uses all thirty-four hospitals within the province to provide clinical teaching. This is particularly evident in year three of the curriculum where clinical training is integrated with the teaching of laboratory medicine. In this way the Faculty has been able to deliver a systems-based course by means of dispersed teaching facilities. A video link has been established between the medical school and Altnagelvin Hospital, Londonderry enabling students to receive core teaching outside Belfast and yet maintain contact with academic departments. This project is currently being piloted but if successful the plan is to extend the video link to other major sites such as Antrim and Craigavon Hospitals.

Keeping up to date with educational theory and practice

60. The Faculty is conscious of the need for all its staff to keep up to date with current educational theory and practice. The MEU is a key player in this area, running a series of seminars on various aspects of medical education. As mentioned earlier in the report, staff are encouraged to attend these educational events and others organised by both national and international medical education networks and professional associations.

Changing patterns of health care (Principal Recommendation 10)

61. The Queen's curriculum allows students ample experience of primary care and of community medical services.

62. Twenty-four general practices within the Greater Belfast area are used to provide places for students undertaking the thirty hours Early Medical Contact Programme in phases one and two. Currently half of the Introductory Clinical Skills Course in phase two is delivered in a primary care setting and we learned that the Faculty hope eventually to offer the whole of this course in this environment. In phase four students complete a four-week attachment in Primary Care, the first week being spent in the Department of General Practice and the other three in one of the ninety approved general practices across the province. The Ageing and Health attachment is taught in collaboration with the Primary Care attachment and is also of four weeks' duration. During this attachment students work as part of a clinical team and, as such, are expected to examine patients, attend ward rounds and meetings, and to accompany consultants on domiciliary assessment visits. As part of the eight-week Health of Children attachment, also in phase four, students spend some time in the community child health service. Teaching in outpatient and community facilities as well as ward-based teaching, is used to deliver this programme. We learned that in phase five students have the opportunity to undertake an elective in primary care and that this discipline is formally assessed in the final written and clinical

examinations.

63. Staff told us that the shortened stay of patients in hospitals now means that clinical teaching in hospitals is no longer the instructive tool it used to be. For this, and other reasons, the Faculty has moved more teaching into primary care and indeed hopes to increase this amount still further.

64. The efforts which the Faculty has made to ensure that students gain experience in general practice and of community medical services are commendable. We would, however, suggest that it gives some consideration to using hospital-based day case procedures to enhance the learning experience of its students.

The goals of undergraduate education - attitudes, skill and knowledge

Attitudes (Principal Recommendation 3)

65. The Faculty has defined the aims and objectives of the undergraduate programme in terms of knowledge, skills and attitudes. This definition is attached at Annex D.

66. The Science, Society and Medicine module in phase one introduces students to the sociological, ethical and scientific aspects of medical practice. The delivery of this module includes a weekly keynote lecture, seminars and tutorials. The first lecture is given by the Dean, who acquaints students with the principles underpinning *Good Medical Practice*. The issues raised are subsequently discussed by students during tutorials. We were pleased to see *Duties of a Doctor* and *Good Medical Practice* being used in this way, to provide a focus for legal and ethical matters. We were also told that some of the Special Study Days in phase five are given over to consideration of the issues raised in *Duties of a Doctor* and to offering advice on how to manage stress at work.

67. Other topics covered in the Science, Society and Medicine module include: the role of the GMC, ethical principles of medical practice (truth telling, confidentiality and consent), the structure and delivery of health care in the UK, alternative medicine, the role of social, cultural and psychological factors in the experience of health and illness and the ethics of medical research. The Faculty has appointed a theme leader to ensure that medical ethics continues to play an important role throughout the course particularly during phase four where it is a feature of the specialty attachments.

68. Students are given an early opportunity to meet and to develop appropriate attitudes towards the chronically sick and their carers during the Early Medical Contact Programme in phases one and two. Clinical skills training also begins early in the course, during the second semester of year one, and extends throughout year two. Students' attitudes to patients and to clinical activities are carefully monitored and assessed during this early clinical skills programme and they receive guidance on how appropriate attitudes to patients are best inculcated.

69. During the primarily clinical years of the course students are taught by a wide range of clinical teachers in a variety of settings. The students with whom we spoke were aware of the importance 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. The Faculty has shown itself to be responsive to student comment and criticism and operates a rigorous and extensive feedback system for clinical teaching, with students completing course evaluation questionnaires at the end of each semester. It is often the junior medical staff who act as role models for students. Because at Queen's the vast majority of students are from Northern Ireland and the majority of junior medical staff are Queen's graduates, the Faculty believes that this provides a strong incentive for appropriate role modelling.

70. Following our visit in 1995 we suggested that the Faculty should give further thought to the assessment of attitudes in the undergraduate course. We believe that the Faculty has made a useful start in tackling this difficult task. Attitudes can be formatively assessed during the small-group

discussions which take place on a range of ethical issues during the Science, Society and Medicine module in phase one. Students must also complete two essays during this module. The first is assessed formatively with students receiving individual feedback on their work. The second essay is summatively assessed with the mark contributing to the final assessment score for the module. In phases two, three and four the Faculty makes extensive use of Objective Structured Clinical Examinations (OSCEs) to assess attitudes whilst in the final examinations this purpose is served both by setting Modified Essay Questions designed to elicit attitudinal responses and by observing the behaviour of students towards patients as they undertake their structured long case assessment.

Essential skills (Principal Recommendations 4 and 8)

Study skills

71. During phases one and two students receive experiential training in the acquisition of self-directed study skills which will allow them to develop the competencies required of effective active learners. These skills include the use of the library and information technology, essay writing and critical evaluation of literature. The SSM programme permits further development of self-directed learning skills, in particular information retrieval and evaluation. Regular assessments requiring problem-solving and decision-making ability as well as recall of factual information ensure that students continue to practise and hone their study skills throughout the course. The clinical project in the final year allows them the opportunity to deploy the data retrieval and analysis skills which they have acquired earlier in the course.

IT skills

72. Although in recent years the Faculty has found that most students are computer-literate on admission to medical school, it requires all students to complete a course on basic computing in one of the University's Open Access Computer centres as part of the Science, Society and Medicine module in phase one. The course comprises training in the use of Word, Excel and Electronic Mail. Students are required to construct and send an email message as a mark of their competence. It is Faculty policy that all written and project course work must be wordprocessed.

73. The Faculty also runs a highly successful SSM on Medical Informatics (see paragraph 50).

Communication skills

74. Communication skills training enjoys a high profile in the Queen's curriculum, and is integrated throughout the undergraduate programme. The Faculty has also appointed a theme leader to monitor its delivery.

75. The facilities in the Clinical Skills Education Centre are used for communication skills training in phases one and two, when students attend six workshops. These small group sessions are facilitated by specially trained staff and provide students with an opportunity to practise basic communication skills in a safe environment and to receive constructive feedback on performance. During phase one students also attend a lecture given by a member of staff from the Eastern Health and Social Services Council. The Council represents patients' interests and the lecture highlights the significance of effective communication in preventing problems arising in the doctor-patient relationship.

76. By the end of their phases one and two communications skills training the Faculty expects each student to be able to:

- describe the range of communication channels used by the doctor
- demonstrate an understanding of the importance of good communication skills in health care
- demonstrate proficiency in the following communication skills-
appropriate introduction to patients

history taking
explaining
use of open and closed questions

- demonstrate an understanding of the difficulties experienced by health care professionals when breaking bad news to patients
- discuss the problems associated with the consultation where more than one family member is present

77. Communication skills continues to be taught as a theme throughout the rest of the course, particularly in some of the later specialty attachments such as psychiatry, child health and care of the elderly. OSCEs are used to assess competence in communication skills on completion of these attachments.

78. The students with whom we spoke thought that communication skills training was well delivered and enjoyed due prominence in the curriculum.

Clinical skills

79. The Introductory Clinical Skills Course extends throughout phase two and is delivered partly in the Clinical Skills Education Centre and partly in one of the approved general practices in the Greater Belfast area, where students complete a clinical attachment. The focus is on the individual student and every effort is made to ensure that each is given the opportunity to learn and practise the basic clinical examination techniques relevant to each body system. Clinical and communication skills are assessed by an OSCE at the end of each semester during this phase. During subsequent phases of the course students' clinical skills training is specialty-based, with OSCEs again employed to assess competence. The curriculum has been deliberately constructed so that all core material is completed by the end of year four, leaving the final year free of theoretical teaching and allowing students to concentrate on developing their clinical skills in preparation for the preregistration house officer year.

Teamworking

80. The Queen's curriculum affords students ample opportunities to develop interprofessional team working skills as, apart from the SSM programmes, medical and dental students follow the same course in phases one and two. We learned that the medical school has recently secured the contract for preregistration nurse education in Northern Ireland. A Project Officer is soon to be appointed to develop a multidisciplinary education programme for students of medicine, dentistry and nursing.

81. Other opportunities for the acquisition of teamworking skills occur in the preparation and presentation of projects and other course work and in laboratory training. Students work in groups whilst undertaking their clinical attachments and some clinical specialties stipulate that course work must be completed and presented in groups or pairs.

Aspects of the knowledge base

Public health medicine (Principal Recommendation 9)

82. Although public health medicine is not taught as a distinct subject, issues associated with it such as health promotion, illness prevention and the environmental and social factors in health and disease are addressed in the Science, Society and Medicine module in phase one and by some of the clinical departments in the course of their teaching.

83. We consider that public health medicine should be accorded a higher profile than it currently enjoys in the curriculum. We suggest that thought be given to ways of integrating it more widely throughout the curriculum, and especially in the systems courses. Aware of this shortcoming, the Faculty has recently appointed a Professor of Public Health Medicine whom it has charged with this task.

Multicultural medicine/alternative medicine

84. Northern Ireland is not to any great extent a multicultural society and this has caused the Faculty difficulty in introducing multicultural medicine into the curriculum. We understand that currently the only opportunity for students to gain experience of the practice of medicine in other cultures is during their overseas electives. We were told that the Faculty is drawing up plans for incorporation of a multicultural medicine programme in the Queen's curriculum and we strongly support this initiative.

85. A discussion session on alternative medicine forms part of the Science, Society and Medicine module in phase one.

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

The outcome of the course

86. The Faculty derives the overall goals and objectives of the course from those identified in *Tomorrow's Doctors*. As the aims and objectives of each stage of the course are set out in the excellent study guides students can gauge their progress against the objectives and attainments expected of them on completion of the course.

87. The Faculty believes, and we have no reason to dispute this, that the rigour of its assessment scheme allows only graduates who are fit for purpose to proceed to the preregistration year.

The scheme of assessment

88. When we visited in 1995 we commented favourably on the assessment scheme which the Faculty had devised but noted that details of the scheme had yet to be developed.

89. We were therefore pleased to find that an assessment policy document, setting out the Faculty's philosophy on assessment and describing the weighting of marks for each assessment had recently been produced. A copy is at Annex E. The paper also contains details of the Standard Grading System endorsed by the University for all assessments in the medical curriculum, with the exception of the criteria for assessment of the clinical project in phase five which is attached at Annex F. By way of additional background information, a copy of the Faculty's Regulations governing the admission of candidates to its examinations in medicine is enclosed at Annex G.

90. The assessment scheme is well publicised with details of each assessment appearing in the appropriate study guide. Certainly the students with whom we spoke had a clear understanding of the various assessment methods and the weighting of marks applied at different stages of the course.

91. Currently, the final written examinations are undertaken in September, at the very start of the final year. We were told that this arrangement had been made to allow students more time to focus on developing their clinical skills in preparation for the preregistration house officer year. A few students complained to us that this reorganisation of the Final year made for a summer heavy with revision. We are, however, making no suggestions for change to the current arrangements, which appeared to work well for other students.

92. The Faculty is to be commended for designing a scheme of assessment which reflects the integrated curriculum and matches the knowledge, skills and attitudinal objectives of the course. As such, it is consistent with the current thinking of the Education Committee.

Preparation for the preregistration year

93. The policy of completing all core material in the curriculum by the end of year four means that students can devote their time in the final year to refining the skills which they will need to function successfully as preregistration house officers. Final year students spend four weeks shadowing the

preregistration house officer in the unit in which they will be employed following graduation. Students are resident for the duration of this shadowing attachment and must perform a series of tasks routinely undertaken by a preregistration house officer. These tasks (for example, signing death certificates, coping with medical and surgical emergencies) are carried out under the supervision of a preregistration house officer or other junior medical staff. Most of these tasks are listed in a log diary (also known as the Student Doctor Log for Preregistration House Officer Workshadowing) which must be completed by the student on execution of each of the prescribed tasks. A brief description of the work undertaken to complete the task must be entered in the appropriate section of the diary, signed by the student and countersigned by the supervising member of staff. The diary must be completed to the satisfaction of the Medical Education Unit (MEU), which has responsibility for monitoring this component of the course. We understand that the diary is returned to the student by the MEU to keep as a personal and permanent record of achievement.

94. The feedback we received from preregistration house officers and junior medical staff suggested that they found the 'shadowing attachment' in year five to be invaluable preparation for their work as pre-registration house officers.

Other issues

Student support

95. The students whom we met spoke positively about the systems put in place to ensure they were well supported academically and personally. They particularly liked and took full advantage of the 'open door' policy operated by the Faculty, whereby students have direct access to academic, administrative and pastoral staff. This policy includes the Dean who will see any student on request.

96. New medical students have the benefit of two induction programmes on arrival at Queen's. The first is organised by the University during the week prior to the beginning of the first semester and takes in all new students to Queen's. The second is run by the Faculty over the first three days of the first semester and includes a formal welcome from the Dean, a supervised visit to one of the major teaching hospitals in Belfast and the completion of a first aid course. During this programme the 'parenting' scheme is introduced in which second year students befriend and look after new first year students. This scheme appeared to work successfully. The scheme was established at the instigation of the Belfast Medical Students Association in 1997, and is funded by the Faculty.

97. Each student is assigned to a medically qualified member of the academic staff who acts as a personal tutor, providing support, of a pastoral rather than an academic nature, throughout the course. We were told that this system had been successful in identifying and resolving many personal and academic difficulties. In cases where this has not proved possible, the Dean will invariably become involved, usually interviewing the student personally. The Faculty Office maintains and monitors the records of students at risk.

98. A range of measures is deployed to provide students with academic support. So that there is no sudden exposure to clinical work, this is introduced gradually to new students, primarily through the Early Medical Contact Programme in the first semester and the Introductory Clinical Skills Course in the second semester. The study guides contain detailed information about each aspect of the course whilst the Medical Education unit provides students with a focal point of contact for advice about the new curriculum. A consultant has been appointed in each hospital to act as a coordinator for each part of the course whom students can approach for information and advice.

99. We were told that students working in the community and in peripheral hospitals have established strong links with local clinicians who can provide support if this is required.

100. These measures allow the poorly performing students to be identified quickly and immediate

support to be given. We were told that students failing examinations in any part of the course are given individual attention. We were left with the overall impression that in the rare event of students requiring additional support, they knew where to look for, and were confident of finding this.

Feedback to students

101. After our visit in 1995 we passed on to the Faculty the students' concern that they did not receive sufficient guidance on how they were progressing throughout the course. In our view and, more importantly, that of the students, the Faculty has done much to allay this concern.

102. In July 1998 the Faculty published guidance setting out the standards to be achieved in the provision of feedback both for staff to students and for students to staff throughout the entire course. Its key aims are that feedback should:

- be regular, frequent and prompt
- accompany the return of students' assessed work
- be specifically related to defined course objectives and assessment criteria.

103. A copy of the Faculty's Guidance on Feedback in Education and Training is attached at Annex H.

104. The principles set out in this document appeared to be being observed. Students considered that generally the quality and immediacy of feedback had improved substantially. They commented in particular on the rapid feedback they received after the OSCE in general practice and the helpful progress reports they received half-way through some of the long clinical attachments, for example in obstetrics and gynaecology where their performance is formatively assessed at the mid-point and summatively assessed at the end of the eight week attachment. This contrasted very favourably with the tardiness of the feedback during some of the clinical attachments in the old, pre-1996 course. We learned that staff, too, are encouraged to take time out and evaluate collectively the quality of their teaching. This happens at the mid-point of phase one when module co-ordinators draw all the tutors together for a meeting to comment on how the course is proceeding and to identify and resolve any problems. We thought this was an excellent initiative.

105. Students also considered that they were kept well abreast of curricular developments and able to influence these if necessary. Using money provided from the Supplement for Undergraduate Medical and Dental Education (SUMDE) the Faculty is able to keep students and staff informed of the progress of the new curriculum by regularly printing and distributing a newsletter. Each section of the course is evaluated by student questionnaires, completed anonymously at the end of every module. This information is made available to the teaching and student body. Students are also well represented on the focus groups, which meet annually to address specific issues, and on the Phase Quality Assurance Committees (PQAC) which meet at least once a term to discuss problems related to the delivery or quality of the course. The minutes of PQAC meetings are posted on noticeboards and are available on the student website so students can see the outcome of issues which they have raised.

Quality control

106. The quality management structure of the curriculum is described in the diagram at Annex B.

107. The Teaching and Learning Committee (TLC) includes staff and students in its membership and has overall responsibility for monitoring the quality of teaching and learning in the Faculty. Overall responsibility for the curriculum is vested in the Undergraduate Medical Education Committee (UMEC), under the chairmanship of the Dean of Faculty Both the TLC and UMEC report to the College of Medicine and Health Science Board and are ultimately answerable to the central university structures.

108. External examiners play a key role in the quality assurance process, formally monitoring and reporting on methods and standards of assessment. Their reports are considered by the Phase Teaching

Committees and by the appropriate Examination Board, a statutory body that also reviews examination regulations and scrutinises results. Action on any recommendations or comments is reported to the Academic Council.

109. We understand that peer review of courses and modules has now been instituted and the Faculty hope in the future to develop further peer review of individual teaching.

110. Although Northern Ireland employers do not produce formal reports on the quality of graduates we were told that informal comments made by clinicians to academic colleagues indicate that they are very satisfied with the medical graduates of Queen's University. This confirmed our own experience when we spoke to employers.

Areas of good practice

111. *Supervisory structures:* We were satisfied that the Faculty had robust mechanisms in place to oversee the course and to monitor the quality of student teaching. We believe that the effectiveness of its supervisory structures has been a key factor in the Faculty's rapid and successful implementation of the new curriculum.

112. *Perioperative and emergency medicine:* We thought that this attachment was an innovative way of introducing students to a variety of patient conditions on the accident and emergency wards.

113. *Clinical Skills Education Centre:* This is an excellent, well-maintained resource which is used extensively for basic clinical skills and communication skills training.

114. *Liaison with peripheral hospitals:* We were impressed by the use which the Faculty makes of all hospitals in the province to provide clinical teaching.

115. *Attitudes:* We believe that the Faculty has made a useful start in tackling the very difficult task of assessing and influencing attitudes. We were particularly struck by the appreciation by students of the importance of having good role models as teachers and clinicians.

116. *Communication skills:* We commend the care taken to integrate the teaching of communication skills throughout the curriculum. It is perceived by students as being essential to their professional development.

117. *Study guides:* These have proved to be invaluable resources for students. Professionally designed, they describe the aims, objectives and assessment criteria for each component of the course.

118. *Assessment:* The Faculty are to be commended for devising a scheme of assessment which reflects the integrated curriculum and matches the knowledge, skills and attitudinal objectives of the course.

119. *Student support:* We congratulate the Faculty on the steps it has taken to provide academic and personal support for its students.

120. *Feedback to students:* We were pleased to note a substantial improvement in the quality and immediacy of feedback to students since our last visit in 1995. In particular we would compliment the Faculty on the provision of individual feedback on student performance midway through some of the long clinical attachments. We know that this is greatly valued by students.

Areas for further consideration

121. *Special Study Modules:* Whilst we were pleased to note the high profile accorded to SSMs in the new curriculum, we did discover that it was theoretically possible for students to complete the SSM programme by confining their study to one particular subject area. We would therefore invite the Faculty to review this matter so that students are required to study in breadth as well as depth.

122. On the matter of students complaining that they had not received their first choice of SSM in consecutive semesters, we have been assured that this difficulty has now been resolved. Students are now weighted accordingly to their choice of SSM in the Faculty's computer database.

123. *Intercalated degrees:* We were disappointed to learn that there had been a recent decrease in the number of students undertaking intercalated degrees, and would encourage the Faculty to promote this option more vigorously now that the new curriculum has been fully implemented.

124. *Computer facilities:* Although the student perception is that the number of personal computers is sufficient, there were some complaints about the speed and reliability of the system. The Faculty might wish to explore ways of improving the efficiency of the system.

125. *Changing patterns of healthcare:* The efforts which the Faculty has made to ensure that students gain experience in general practice and of community health services are commendable. We would, however, suggest that it gives some consideration to using hospital-based day case procedures to enhance the learning experience of its students. We believe that these procedures have particular value in enabling students to understand the concept of "patient care pathways".

126. *Public health medicine:* We consider that public health teaching should enjoy a higher profile in the curriculum and should be delivered in a more integrated way throughout the course. We understand that the Faculty is committed to raising the profile of this important discipline.

127. *Multicultural medicine:* We understand that the Faculty is exploring ways of increasing the preparation of its students for medical practice in a multicultural society. At present this aspect of the curriculum is under-represented for understandable reasons.

Conclusion

128. It soon became apparent to us that much had been achieved in the intervening three years since our last visit, culminating in the successful implementation of an integrated, systems-based, curriculum which all students are now following.

129. This is no mean achievement and we were therefore rather surprised that the Faculty did not seek to publicise the full extent of their success in the documentation sent to us prior to the visit. We shall display no such reticence. We congratulate the Faculty on all the hard work, commitment and imagination invested in developing and introducing so rapidly a new curriculum, based around the recommendations of *Tomorrow's Doctors*. In successfully managing this enormous change the Faculty is also to be commended for actively seeking and taking account of the views and comments of its students. We look forward to hearing about further progress in a year's time.

Part 2 : General Clinical Training

Background information

130. Prior to the visit we were provided with helpful background information about general clinical training within the province. This included a summary, reproduced at Annex I, showing the extent to which the recommendations in *The New Doctor* have been implemented.

Form of the visit relating to general clinical training

131. The day started with a meeting of the Pre-Registration Committee (PRC) which is the body responsible for overseeing all matters concerning the pre-registration year with the University. This was followed by an overview of general clinical training provided by the Dean and the Postgraduate Dean.

We also had discussions with several NHS trust chief executives and medical directors. After lunch we talked with a group of educational supervisors from a variety of hospitals within the province, and met with PRHOs and SHOs from a number of locations and specialties. We finished by feeding back our general impressions of the day to the Pre-Registration Committee.

132. We were joined for some of these meetings by colleagues from the QAA team.

Organisation and management of the PRHO year

133. There are currently 11 NHS trusts involved in the training of PRHOs within the deanery.

Supervisory structures

134. We were told that the Northern Ireland Council for Postgraduate Medical and Dental Education (NICPMDE), whose brief is to provide advice to the Department of Health and Social Services on issues relating to postgraduate medical and dental education, is responsible for the overall management of the pre-registration year within the province. The Pre-Registration Committee (PRC), supported by the Dean and the Postgraduate Dean, takes responsibility for general clinical training on behalf of the University.

135. The main functions of the PRC are to:

- oversee all University-related matters concerning the PRHO year
- inspect and approve all PRHO posts in the province
- approve non-Northern Ireland posts offered to Queen's University, Belfast graduates
- address and resolve all education and training problems concerning PRHOs
- ensure that hospitals observe the GMC recommendations on general clinical training and the DHSS New Deal regarding junior doctors' ho

136. Meeting generally at three monthly intervals, the PRC reports to the Faculty of Medicine, the Department of Health and Social Services and NICPMDE.

137. We were disappointed to learn that there is no PRHO on the membership of the PRC.

138. We were interested to learn that the Committee had co-opted two retired honorary professors to its membership. They make frequent informal visits as a team to hospitals discussing current problems and possible solutions with PRHOs and consultants, and reporting back regularly to the PRC. We were told that this informal approach had engendered more positive feedback from PRHOs than the more formal visits mounted by the PRC.

The approval of posts

139. The PRC organises visits to every hospital involved in the training of PRHOs on a five year rolling programme. The criteria for approval of individual posts are based on those set out in *The New Doctor*.

140. The opinions of PRHOs are sought by the PRC at each formal inspection visit and during the more frequent, informal visits made by the two co-opted members of the Committee. Until recently a confidential questionnaire was sent annually to all PRHOs seeking their detailed and frank views on the quality of their training but this practice had now ceased due to a low response rate (average 30% return) and the lack of resources necessary to follow up the comments made. We understand that work is currently in progress to develop a new questionnaire. The deanery hopes to improve the response rate by inviting PRHOs to return this questionnaire before completion of their training is officially certified.

Communicating the aims and objectives of the PRHO year

141. A copy of *The New Doctor* is given to all PRHOs at the start of their general clinical training so that

they are aware of the aims and objectives of the PRHO year.

142. There is an educational supervisor appointed to each hospital engaged in the training of PRHOs. The Faculty sees the educational supervisor as providing a key channel of communication between the PRC, PRHOs and NHS trusts. Regular meetings of educational supervisors are organised at which education and training for PRHOs are discussed. Whilst we commend this initiative, we were disappointed to learn that some educational supervisors did not communicate all relevant information to PRHOs and trusts as expected.

143. Sessions with the supervising consultant, designed to provide feedback on PRHO performance are scheduled to take place at the end of each attachment, but practice appears to vary from post to post. Some hospitals have designed a feedback form giving both the consultant's and the PRHO's views on the trainee's performance in post. However, most PRHOs receive little or no feedback on completion of an attachment. The Faculty is keen to address this problem but is awaiting the issue of a national PRHO assessment form, currently being developed by the Conference of Postgraduate Medical Deans. We would wish to see trainees receiving structured feedback on their performance early on as well as at the end of their attachments, so satisfactory progress can be confirmed. Regular meetings with educational supervisors also allow any deficiencies to be quickly identified and addressed.

The selection of PRHOs

144. The Faculty operates a centralised PRHO matching scheme to facilitate the appointment of PRHOs but we understand that responsibility for this will soon be assumed by the NICPMDE. The matching scheme comprises a three-stage exercise, whereby candidates apply to three hospitals in Northern Ireland in order of preference. If unsuccessful at the first stage of interviews, candidates proceed to their second choice provided there are still posts available at that hospital. There is flexibility built into the scheme so that candidates can amend their choice of hospital at this point. The process continues until all PRHOs are appointed or all posts are filled. Graduates from other medical schools than Queen's have an equal opportunity of appointment to a PRHO post in Northern Ireland under current employment and equal opportunities legislation.

145. In the event of a final year student being unable to secure a PRHO post locally, we were told that the Faculty would contact other deaneries throughout the UK to assist the student in finding a post. If this proved unsuccessful an approach could be made to the DHSS to support the creation of a supernumerary post. PRHOs intending to complete their general clinical training outside the UK must approach the deanery to obtain prior approval of the proposed training programme.

Monitoring the quality of PRHO posts

146. Within the deanery two types of visit are undertaken to assess the quality of general clinical training:

- a. Formal inspections mounted by the PRC.
- b. Informal visits carried out by the two co-opted members of the PRC.

147. Each hospital involved in the training of PRHOs receives at least one inspection visit from the PRC every five years, and more frequently if the need arises. Prior to each visit the hospital receives notification of the key areas which the PRC will be specifically addressing together with a synopsis of the recommendations in *The New Doctor*.

148. In the course of the visit the PRC team meets with PRHOs in post, supervising consultants, the educational supervisor for the hospital, and the Director of Clinical Services before having a final discussion session with the educational supervisor, the Director of Clinical Services and the Chief Executive of the Trust. This session allows the PRC to provide feedback on its findings and to explore with the Trust solutions to problems which have been identified.

149. After each visit the PRC sends a report to the hospital formally conveying its conclusions and recommendations. The hospital is given an agreed timescale to respond to the recommendations and is required to report back to the PRC on the action which it has taken.

150. In addition to the formal inspection programmes, the PRC makes excellent use of the skills and experience of two retired professors of medicine and surgery whom it has co-opted to the Committee. They make frequent visits to hospitals, particularly if concerns have been expressed to the PRC by educational supervisors or PRHOs. We commend this initiative, and offer it as a model for consideration by other medical schools.

151. It seemed to us that effective systems had been established to ensure that all PRHO posts conform to an appropriate standard. We were told that approval had been withdrawn from five posts in the last three years and that other posts, deemed to be too specialised for general clinical training, had been reallocated elsewhere within trusts.

Components of a high quality PRHO post

Induction

152. Each hospital administers its own formal induction programme following a format prescribed by the University. These programmes usually take place on the first Tuesday in August and are generally regarded as helpful by PRHOs.

153. We have already referred in paragraphs 93 and 94 of our report to the four week attachment when final year students shadow the PRHO in the unit where they will be employed following graduation. The Faculty considers that this initiative has been successful in meeting its objective of preparing final year students for the demands of the pre-registration year. Having spoken to PRHOs and educational supervisors, we would strongly support this view.

Educational opportunities

154. The Faculty believes that it has successfully raised the educational profile of PRHOs as far as trusts are concerned so that clinical directors now perceive PRHOs as trainees rather than as merely providing a service. All hospitals involved in PRHO training run formal educational programmes. These are usually arranged by the educational supervisor though it is not uncommon for PRHOs to choose topics for the programme and to lead educational sessions themselves. These programmes may be delivered in a variety of ways (e.g. formal teaching sessions, ward rounds, audit meetings) and their educational content is subject to regular review by the PRC.

155. We were told in our discussions with PRHOs that the aim of the deanery is to provide one hour's formal learning and two hours experiential learning per week for all PRHOs, but in practice this was variable. We were, nevertheless, pleased to learn that one hospital dedicated four hours per week to assisting PRHOs in the development of their clinical skills.

156. The majority of PRHOs were appreciative of these educational opportunities but many were unable to take advantage of these due to pressure of work. The PRC has proposed various strategies in an attempt to improve attendance at educational sessions, but these have met with limited success. Hospitals have been encouraged to identify bleep-free time and some have instituted an arrangement whereby SHOs hold bleeps for PRHOs. We were told that in other hospitals, though they had been granted time off to attend educational sessions, PRHOs were reluctant to leave the ward if there was no medical cover available. Trusts have also been asked to schedule these sessions at lunchtime - with the inducement of lunch included.

157. Some hospitals keep a register of PRHO attendance at educational sessions, which is regularly

reviewed. If there is evidence of a particularly poor record of attendance, the reasons for this will be discussed at a one-to-one session between the educational supervisor and the individual in question.

158. One of the main issues addressed during PRC visits is whether PRHOs are still carrying out repetitive and menial tasks of little or no educational value (e.g. routinely taking bloods, finding beds, or portering specimens or drugs). In our discussions with the Chief Executives of Trusts there was a general acknowledgement of the difficulty of recruiting a sufficient number of skilled nurses to carry out such duties. Daisy Hill Hospital had produced an innovative solution to this problem by appointing six healthcare workers to assist nurses with their duties. This, in turn, freed up time to allow nurses to relieve PRHOs of some of the tasks assigned to them. Funding had been found to allow all six healthcare workers to undertake thirteen weeks of professional training to enable them to assist the nursing staff in this way. We commend this imaginative use of resources.

159. We thought that the PRC and the deanery had worked hard since our last visit to improve the educational experience of the PRHO year. The PRHOs appreciated the efforts which had been made in this respect but many still considered that they were routinely required to carry out inappropriate tasks. They particularly welcomed the introduction of a phlebotomy service, (though this was not available at weekends) and the appointment of bed managers and nurse-practitioners. However, some areas of difficulty were still evident. Although access to IT facilities was generally good we heard that at one hospital PRHOs could not access patients' records at the weekend as the network was shut down over this period. PRHOs also related to us the problems which they still encountered at many hospitals in obtaining the results of radiological investigations.

Educational supervision

160. Under the terms of a formal contract drawn up between the Trust and the Northern Ireland Council for Postgraduate Medical and Dental Education (NICPMDE) an educational supervisor is employed at each hospital engaged in PRHO training. The appointment of each educational supervisor is recognised by the PRC.

161. Educational supervisors are encouraged to attend training courses organised by various postgraduate bodies including the National Association of Clinical Tutors. We learned that NICPMDE is currently running a 'Teaching the Teacher' training programme. This comprises a two day structured workshop focusing on the acquisition of basic teaching, assessment and appraisal skills. The first programme is specifically aimed at educational supervisors.

162. Should a problem with an educational supervisor be reported by a PRHO or another member of staff, the PRC will intervene, interviewing those concerned in an attempt to resolve the difficulty. In general PRHOs appeared reasonably satisfied with their educational supervisors though some lapses in communication were apparent. We were very disappointed to learn that in the relatively small group of PRHOs with whom we spoke, two had not met their educational supervisor and one did not know their educational supervisor's name.

Clinical training and supervision

163. The PRC uses its visits programme to ensure that core generic clinical training, as defined in *The New Doctor*, is provided. We were told that if a clinical supervisor is not performing satisfactorily, the PRC issues a preliminary warning to the trust. If this does not result in an improvement in performance, recognition is withdrawn from posts under the clinical supervisor's supervision.

164. PRHOs were positive about the clinical supervision they received. Those whom we met had never been placed in a position where they were unable to seek direct support or guidance from a senior colleague.

Monitoring the progress of PRHOs

165. We were told that PRHO performance is continuously monitored, and if any deficiencies are noted these will be discussed with the PRHO by the educational supervisor and remedial action agreed. Depending on the nature of the deficiency this may involve referral to an occupational health doctor for counselling or, in the case of a problem with interpersonal skills, specific retraining will be arranged. The term of service for any PRHO undertaking a lengthy period of retraining is likely to be extended to take account of this period.

166. If more serious problems are identified, such as unsatisfactory clinical performance, the educational supervisor and/or the clinical tutor will notify the Dean or Postgraduate Dean. The PRHO in question will be interviewed by the Dean who generally consults the PRC for advice and guidance. Disciplinary matters are usually considered first under the internal procedures of individual hospitals before they are reported to the PRC.

167. Each hospital is responsible for monitoring the sickness record of every PRHO it employs. As a general rule, the matter is referred to the PRC for consideration in the event of a PRHO being absent from post for more than a month due to ill health. Should absence continue for a period in excess of six weeks, it is recommended that the term of pre-registration training be extended.

Professional development and personal well-being

Careers advice

168. Each December a Pre-Registration Careers Symposium is organised by the NICPMDE where PRHOs meet specialty advisers across the various disciplines. These symposia are perceived to be useful by PRHOs and are generally well supported, with a 75% attendance rate reported last year.

169. The PRC encourages clinical tutors, educational supervisors and supervising consultants to provide personal and careers advice on request. These sources are used variably by PRHOs with some preferring to seek informal careers advice from other trainees and junior doctors.

170. The NICPMDE also produces an annual careers booklet. At the time of our visit the 1998/1999 version had just been printed and we can confirm that it is an excellent guide, offering detailed careers information to PRHOs. Unfortunately it had not yet been circulated to any of the PRHOs with whom we spoke. We are sure that steps will soon be taken to remedy this.

Support for PRHOs

171. The PRHOs see the induction programme as a useful orientation exercise, when they meet their educational supervisor and clinical tutor and are informed of the various support facilities available to them. Educational supervisors are expected to offer both pastoral and careers advice but we learned that the experience of PRHOs was variable. Often PRHOs will approach the Faculty Office or NICPMDE directly for advice and information.

172. We were told that support services vary between different Trusts but the larger hospitals all employ an occupational health doctor to provide counselling and support for PRHOs.

173. In terms of general support for PRHOs we noted that at some hospitals regular monthly meetings took place involving nurses, junior doctors and consultants. We commend this initiative which facilitates discussion of various work issues in an open and informal manner.

Accommodation, catering and personal safety

174. The standard of accommodation is monitored on the PRC inspection visits and by means of confidential questionnaires completed by PRHOs. Any unsatisfactory comments or findings are taken up with the Chief Executive and Medical Director of the Trust. Our attention was drawn to current issues

relating to unsatisfactory accommodation, on-call facilities and personal safety which, we were assured by the deanery, are being actively addressed. Catering is considered to be a problem in hospitals throughout Northern Ireland, and the serving of hot food after 6pm is acknowledged to be a rarity. We were assured that steps have been taken to provide alternative solutions to catering problems where possible, and microwave ovens and vending machines have been installed in many hospitals.

175. Personal safety, rather than accommodation or catering issues, appeared to give PRHOs more grounds for concern. Although action taken by the PRC meant that Belfast City Hospital now provides a safer working environment for PRHOs, this was not perceived to be the case for the Royal Victoria Infirmary.

176. Dealing with aggressive, intoxicated and/or psychiatrically disturbed patients in casualty was highlighted as a problem affecting many PRHOs. We were told that an excellent protocol for coping with and caring for aggressive, intoxicated and disturbed patients is in use at the Mater Hospital and we suggest that this could be implemented in all Northern Ireland hospitals.

Contractual matters

177. The hours worked by all junior medical staff, and especially PRHOs, are monitored by the Department of Health Task Force. The leader of the Task Force is invited to PRC meetings in order to exchange information, whilst local implementation groups have been established within each trust to ensure that each post conforms with the requirements of The New Deal.

178. We were informed that NICPMDE intends to hold a workshop early in 1999 with the aim of raising awareness of and highlighting specific issues surrounding The New Deal for consideration by local implementation groups.

Plans for further development

179. The NICPMDE is currently bidding for four additional house officer posts beginning in August 1999 and a further four in August 2000. We learned that the bid to fund two additional posts for August 1998 was unsuccessful, but the Royal Group of Hospitals Trust found funding for these posts from its own reserves.

180. The deanery is intent on increasing the complement of PRHO posts throughout the province in the next few years by at least ten posts to take account of recent increases in the undergraduate intake and welcome decreases in the numbers of students leaving the course. The deanery anticipates that over the next four years the number of graduates will exceed the number of PRHO posts available in Northern Ireland.

181. The deanery regrets that there are no PRHO posts in general practice in Northern Ireland, as experience of primary care would enhance the educational content of the PRHO year. PRHO rotations into general practice would also relieve some of the resource pressures on trusts.

182. We understand that there are sufficient numbers of GP trainers in the province to accommodate any reasonable increase in the amount of teaching which this initiative would require. We hope that resource or legislative issues do not prove a long-term barrier to the provision of PRHO training in general practice in Northern Ireland.

Areas of good practice

183. *Formal and informal monitoring of posts:* It seemed to us that effective formal systems had been established to ensure that all PRHO posts conform to an appropriate standard.

184. In addition to the formal inspection programmes, the PRC makes good use of the skills and experience of two retired professors of medicine and surgery whom it has co-opted to the Committee.

They make frequent informal visits to hospitals, particularly if concerns have been expressed to the PRC by educational supervisors or PRHOs. We commend this initiative, and offer it as a model for consideration by other medical schools.

185. *Preparation for the PRHO year:* The feedback we received from pre-registration house officers and junior medical staff suggested that they found the 'shadowing attachment' in year five to be invaluable preparation for their work as pre-registration house officers.

186. *Support for PRHOs:* In terms of general support for PRHOs we noted that at some hospitals regular monthly meetings took place involving nurses, junior doctors and consultants. We commend this initiative which facilitated discussion of various work issues in an open and informal manner.

187. *Helping to relieve PRHOs of inappropriate duties:* In our discussions with the Chief Executives of Trusts there was a general acknowledgment of the difficulty of recruiting a sufficient number of skilled nurses. Daisy Hill Hospital had produced an innovative solution to this problem by appointing six healthcare workers to assist nurses with their duties so that, in turn, they had more time to relieve PRHOs of some of the tasks assigned to them. We commend this imaginative use of resources.

188. *Clinical supervision:* PRHOs were positive about the clinical supervision they received and knew who to contact if they needed more clinical support or advice.

Areas for further consideration

189. *Educational sessions:* Although all hospitals now arrange formal educational programmes, PRHO attendance has been variable, largely, we were told, due to pressure of work and a reluctance to leave the ward without medical cover. Trusts may wish to consider how this situation could be alleviated so that trainees are able to attend scheduled educational sessions.

190. *Inappropriate duties:* Although it was evident that the PRC and the deanery had worked hard since our last visit to improve the educational experience of the PRHO year, many PRHOs still considered that they were routinely required to carry out inappropriate tasks. The PRC will wish to continue to explore solutions to this problem with PRHOs and trust managers.

191. *Educational supervisors:* The Faculty sees the educational supervisor as providing a key communication link between the PRC, PRHOs and NHS trusts, but we were told that some educational supervisors performed inconsistently in this role. We were also disappointed to learn that in the relatively small group of PRHOs with whom we spoke, two had not met their educational supervisor and one did not know their educational supervisor's name. We hope that consideration will be given to ways of improving the consistency of educational supervisors, particularly in the area of communication.

192. *Feedback to PRHOs:* Feedback is variable and we learned with some disappointment that most PRHOs receive little or no feedback on completion of an attachment. We would wish to see trainees receiving structured feedback on their performance early on as well as at the end of their attachments so satisfactory progress can be confirmed and any deficiencies can be identified and resolved. The Faculty is keen to address this problem and may wish to consider short-term initiatives to improve the quality of feedback whilst it awaits the issue of a national PRHO assessment form.

193. *Personal safety:* Whilst we congratulate the PRC and trusts on the steps taken since our last visit to improve personal safety, this remains a live issue for some trainees, particularly when they are called out at night. Further consideration may need to be given to providing beds within all hospitals for staff on call.

194. Dealing with aggressive, intoxicated and/or psychiatrically disturbed patients in casualty was highlighted as a problem affecting many PRHOs. We were told that an excellent protocol for coping with and caring for aggressive, intoxicated and disturbed patients is in use at the Mater Hospital and we

suggest that this could be implemented in all Northern Ireland hospitals.

Conclusion

195. We thought that much had been done since our last visit to improve the quality of life for PRHOs and were especially pleased to note the attention paid to the recommendations in *The New Doctor* in effecting these changes. The deanery is keen to press ahead with other initiatives and we look forward to hearing about these in the future.