University of Tasmania

SCHOOL OF MEDICINE

YEAR 4

CAM431/432 (Launceston Clinical School)
CAM433/434 (Rural Clinical School, Burnie)
CAM435/436 (Hobart Clinical School)

2012 HANDBOOK

YEAR 4 HANDBOOK 2012

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1. INTRODUCTION

The purpose of this handbook is to provide comprehensive information about aspects of Year 4 of the MBBS course. It contains details students will need to know, including

- the Unit Outline for Year 4 of the MBBS course which outlines the essential components of the Unit;
- information on clinical attachments, case based-learning (CBL) and learning resources;
- assessment procedures; and
- administrative requirements.

The Unit Outline can be found in Appendix 1 and should be read by all students. As there are some individual differences between the three Clinical Schools where Years 4 and 5 are taught, students need to seek specific information for their own Clinical School in the respective Guidelines.

1.1 Changing Philosophy of Medical Education

Some decades ago, almost all medical courses taught segregated subjects: pre-clinical sciences presented in lecture format and examined by multiple choice questions which in general tested recall of memorised facts and therefore promoted superficial learning, followed later by clinical sciences, taught in individual, predominantly hospital-based specialty blocks by lectures and by bedside teaching in hospital wards. Top graduates tended to be those who memorised the most facts.

The content of medical education is now well beyond memorising, and this is reflected in the changes in teaching and learning that have occurred in other disciplines across the University. These changes include:

- recognition that integration improves learning. Examples of this are the integration occurring between pre-clinical studies and clinical experience, the integration between hospital specialties; and between hospital medicine, the speciality of General Practice and community delivered medicine.

- introduction of flexible teaching and learning approaches encouraging
  - learner-centred education
  - good teaching and learning practices for all students
  - less time and place dependence than more traditional forms of teaching and
  - increased learners' responsibility for their own learning.

Self-directed learning and small group learning have been introduced as the main formats for teaching and learning, supported by lectures as appropriate.

Assessment measures focus more on assessing performance, communication skills, clinical reasoning, and personal and team skills. In addition, more reliable methods of assessing clinical skills such as Objective Structured Clinical Examinations (OSCE) and the mini-clinical evaluation exercise (mini-CEX) have replaced the traditional short cases and long case exams. OSCEs are also able to assess a broader range of clinical skills, including explaining diagnoses and treatment and handling of ethical issues. These assessments have at least an equal place with knowledge-based assessment measures such as multiple choice questions. To guide learning and to assess learning objectives not readily tested by other methods, other assessment tools, collated in a portfolio, have been introduced.

There is also more emphasis on formative assessment, i.e. feedback is provided to students to help them identify strengths and weaknesses and to direct further learning, and is aimed at promoting learning rather than testing gaps in knowledge.

1.2 Outcomes of Medical Graduates

The overall objectives for medical education are to equip students to function with excellence after graduation, to provide them with the knowledge and skills required primarily for their intern and resident years and the foundation for later entry to vocational training programs. Medical schools are increasingly recognising that there are a variety of ways in which students can gain the appropriate experiences required to achieve these objectives.

The TSoM has defined the attributes that medical students should exhibit on graduation, equipping them for subsequent training and future roles in the Australian health system. These attributes are referred to as the Medical Graduate Profile (MGP) and appear in the Unit Outline in this Handbook (see Appendix 1).

The MGP defines the educational outcomes, which will be used to align teaching, learning and assessment. This profile is divided into five ‘themes’ which provide a framework for undergraduate learning, curriculum organization and assessment at the TSoM. The themes and their outcomes are:

1. **Human Health and Disease**: outcomes relating to understanding normal and abnormal human structure and function and the clinical application of this
2. **Communication and Collaboration**: outcomes relating to communication skills, team working and leadership skills
3. **Community Health and Disease**: outcomes related to the Australian health care system, public health, community based practice; preventative health care, environmental health and health delivery to populations of highest need e.g. Aboriginal, rural, refugee and economically impoverished populations.
4. **Personal and Professional Development**: outcomes related to ethics, lifelong learning, and high quality, safe health care delivery
5. **Integration**: outcomes that ensure students are able to synthesize material, think critically and creatively, solve problems, can appraise the evidence they base their future clinical practice on, and are knowledgeable about research methodologies.

1.3 Aim of Year 4

The specific aim of Year 4 is to provide students with experience of a range of clinical specialties, including the specialty of General Practice, and their scopes of practice, together with the further building of clinical skills and the integration of theoretical knowledge and clinical practice.

1.4 Program Delivery and Structure

The Year 4 program is delivered at three campuses: the Hobart Clinical School (HCS), Launceston Clinical School (LCS) and the Rural Clinical School (RCS) in Burnie. All students are expected to attend an Orientation Day at their individual clinical schools. The Orientation schedule will be emailed to all students in January.

Students are divided into small groups and attached to different clinical specialties; these are listed in Section 2.1. These attachments will vary between Clinical Schools, and students must consult their specific Clinical School Handbook or MyLO website for details and schedules of attachments.

All students will participate in integrated case-based learning sessions. These sessions will cover the same core set of topics at each Clinical School, but may also include discretionary topics.

2. KEY COURSE COMPONENTS

The Year 4 course has five main components: clinical attachments, development of a portfolio containing evidence of attainment of learning outcomes case-based learning sessions, a range of tutorial and lecture sessions, and a 4-6 week elective after the final examination and results declaration in November and before the start of first semester of the year 5.

The major focus of Years 4 and 5 is to maximise effective clinical encounters with patients, with exposure to as many patients as possible, and, utilising the theme structure, to develop the full range of skills relating to the MGP. While emphasis is on common conditions, exposure to unusual conditions can assist in recognition of similar presentations many years later. Reading based on patient exposure reinforces understanding and memory. Patients encountered should also be followed over a period of time to understand the roles of other health professionals in extended care, the role of community health care and the progress of illness over time.

2.1 Clinical Attachments

Patients will be seen in discipline-based attachments. This may include rostered after hours shifts or “on call” depending on the clinical discipline and the requirements of individual clinical schools. The schedule for these attachments is in the Handbooks or on the MyLO websites for the individual Clinical Schools.

Students are expected to use the Student Placement Management System (SPMS) to find details of their clinical and community placements. The SPMS is a management and communication tool designed to streamline the process of managing workplace learning placements.

Staff will brief students about using the system to check on their placements and to access a variety of other information.

Generally the attachments for Year 4 will include clinical exposure to:

- Medical specialties
- Surgical specialties
- Paediatrics
- Obstetrics and Gynaecology
- Psychiatry
- General Practice
- Emergency Medicine (at the RCS).

The Learning Outcomes for the clinical attachment disciplines for Years 4 and 5 can be found in the document *"Learning Objectives for the Year 4 & 5 Clinical Attachments 2012"*. All students should be familiar with these learning objectives and use them as a focus for their attachments and to assist clinical teachers to know the knowledge and experience students are expected to obtain during their attachments. The learning objectives for the various clinical attachments together with the MGP will inform the development of questions for the MCQ/EMQ exam and stations for the OSCE. It is important to recognise that opportunities to achieve these learning objectives are not restricted to attachments to the specific specialty listed above the objectives but will occur in many other clinical contexts.

At the beginning of the attachment students should decide with their clinical supervisor (registrar or specialist) on their personal learning objectives for the attachment. These should reflect the objectives listed in the learning objectives document, but will take account of previous experience, interests and reflection on the student's strengths and weaknesses, and the opportunities provided by the attachment. It is recommended that students contact a representative of the unit or General Practice to which they are to be attached a week prior to commencement. This contact will ensure students are aware of the unit programs or General Practice routines, and therefore make full use of the learning opportunities, so that a planned and efficient deployment of students to various activities offered by the unit or General Practice is ensured. Check your school's preferred process for contact.

Students should ensure the completion of a clinical attachment assessment by the discipline coordinator or their delegate (senior registrar at least) based on performance during the attachment. This includes performance in written and clinical assessment tasks set by the discipline concerned (further details of these requirements may be found in the discipline specific work books provided for most attachments.) The assessment form can be found in Appendix 2.1. You may also be required to get short attachment assessments completed by your placement supervisor. The assessment form for short attachments can be found in Appendix 2.2. ***It is each student's responsibility to ensure that the assessment form is completed and lodged with the Year Coordinator within one week of completion of the clinical attachment.***

Roles and responsibilities

All UTAS students undertaking Professional experience placements are required to comply with the policy and procedures in the Safety in Practice kit. A link to this kit can be found on the Faculty of Health Science homepage under Professional Experience Placements
http://fcms.its.utas.edu.au/healthsci/healthsci/files/Safety%20in%20Practice%20Kit.pdf
On attachments, students must identify themselves to patients and staff as a medical student who is working as part of the medical team. Students should at all times wear their Hospital University identity card (not as a lanyard) and carry student identity documentation. In hospital practice, under the direction and supervision of the intern, resident, registrar or specialist, students will be expected to admit patients and may have the opportunity to perform some procedures. Identification should also be worn when on General Practice and community placement.

Anything written in the medical record or on a form is to be signed by the student, defining medical student status, and countersigned by a doctor. ***Students should not fill out drug charts, prescriptions or death certificates because of the medico-legal implications*** but are encouraged to fill out mock forms for actual patients to get experience. These must be de-identified, clearly marked "practice forms", and after being assessed as adequate by your supervisor, placed in your portfolio. Under supervision, students can also be involved in patient communication. Sensitive communication such as breaking bad news, dealing with distressed patients and relatives or communicating about adverse events is left to qualified doctors, but where possible observed as these communication skills are vital to all students' future careers. Students may observe sensitive communication provided the patient gives consent for the student to be there.

Guidelines for students on clinical placement with the Department of Health and Human Services can be found on
http://fcms.its.utas.edu.au/files/policies/dhhsclinplace_06(1).pdf and are set out below in Section 5.2.

2.1.1 Medical Attachment

The Year 4 attachment is designed to build on the student's previous knowledge and give further experience of common problems managed by medical specialties through tutorials, attachment to medical units, outpatient clinics and for some students, consultant specialist private rooms and private hospitals. It will provide an opportunity to consolidate basic and clinical knowledge, and refine verbal and written communication skills. Under supervision students may have the opportunity to begin to acquire competency in essential practical skills. **It is recognised that the extent of experience in any specialty area will be limited; however, students will encounter many of the conditions in other clinical contexts.** Students should already have some familiarity with many of the presentations and diseases listed in the *"Learning Outcomes for the Year 4&5 Clinical Attachments 2012"* from teaching and clinical attachments in earlier years of the course. These objectives and the student's experience during this attachment will help them gain an overview of the scope of various medical sub-specialties. Where such opportunities do not arise, the list should guide future reading. In addition, the selective term in Year 5 may be used to acquire experience in those sub-specialties not available at the clinical school attended, assuming a selective term is available at your school.

2.1.2 Surgical Attachment

This attachment will cover a selection of surgical experiences and sub-specialties which will vary between Clinical Schools depending on which sub-specialist services are available at the local public or private hospitals. Information on the sub-specialties and timetables will be found in your Clinical School Handbook or on MyLO for each Clinical School. By the end of this attachment students should have acquired a broad knowledge of several sub-specialties, including presentation, diagnosis and management of common conditions and the use of diagnostic tests. The sub-specialties may include general, orthopaedics, ophthalmology, urology, otorhinolaryngology, neurosurgery, plastic surgery, colorectal surgery, breast and endocrine surgery, and paediatric surgery.

2.1.3 Paediatric Attachment

The Year 4 Paediatric attachment aims to provide students with the basics of Paediatric Medicine. The attachment will prepare students, through clinical practice, case-based learning, tutorials and practice to attain the skills and attributes required to care for paediatric patients and their families. The attachment will also provide a sound knowledge of common and important paediatric presentations. In comparison with adult medicine, paediatric inpatients are less common with much shorter lengths of hospital stay. Much teaching and learning in paediatrics occurs in the outpatient setting and students should ensure they utilise these opportunities as much as possible. Many learning outcomes in paediatrics will also be achieved in your General Practice attachment, especially if you are in the practice later in the day or after hours.

At the beginning of this attachment students should familiarise themselves with the attachment guidelines and/or the unit's protocols. With their clinical supervisor, they should decide on a set of achievable learning outcomes that reflect the objectives indicated in the document *"Learning Outcomes for the Year 4&5 Clinical Attachments 2012"*.

2.1.4 Obstetric and Gynaecology Attachment

The Year 4 attachment aims to provide students with the basics of Obstetric and Gynaecological Medicine. The attachment will prepare them, through clinical practice, case-based learning, tutorials and practice to attain the skills and attributes required to care for these patients. The attachment will also provide a sound knowledge of common and important obstetric and gynaecological presentations.

At the beginning of this attachment students should familiarise themselves with the attachment guidelines and/or the unit's protocols. With their clinical supervisor they should decide on a set of achievable learning outcomes that reflect the outcomes listed in the document *"Learning Outcomes for the Year 4&5 Clinical Attachments 2012"*.

2.1.5 Psychiatry Attachment

The Year 4 Psychiatry attachment aims to provide students with experience in the community, in outpatients and on the ward, seeing patients who suffer from a mental illness, whether mild, moderate or severe. Given the interaction between physical and mental illness, this discipline will overlap with all the other attachments and so learning should take place throughout the year, not just during the psychiatry attachment. By the end of the year the student will have learnt about awareness of, and diagnosis in mental illness, management with both pharmacological agents and psychotherapeutic techniques, the vital part played by all team members and the necessity of a multidisciplinary approach in caring for these patients and their families. Experience seeing patients will be supplemented by case-based learning sessions and tutorials throughout the year.

2.1.6 General Practice Attachment

The General Practice learning objectives provide general skills that students should achieve by the end of their final year. Generally students are expected to achieve learning outcomes associated with more complex presentations by the end of Year 5 compared to the end of Year 4. A major difference between General Practice and other specialities is the emphasis on patient centred as opposed to disease centred medicine across all patient age groups thus students will note that disease based learning outcomes may not be unique to General Practice and that students may encounter presentations that overlap with all other disciplines. The General Practice curriculum will be relevant to other teaching opportunities as well such as case-based learning sessions, seminars and tutorials.

The learning outcomes should be the focus of a General Practice/community attachment. They are considered to be those required to practise safely as an intern. Students should discuss the learning opportunities a placement with a General Practice is likely to provide with their General Practitioner supervisor at the beginning of each placement and note these in their clinical attachment form.

2.2 Portfolio

Portfolio-based learning underpins assessment for the Year 4 and 5 programs. It allows students to track, and staff to assess, learning. The portfolio is a means of documenting skills, experiences and achievements during the last two years of the medical course. It also acts as a guide to student learning.

Students commence collecting their Clinical School portfolio in Year 4. Generally it should be compiled in an A4 ring binder, which will be provided at the beginning of the year. However, note that the Launceston Clinical School will be using an electronic portfolio in 2012 for aspects of the General Practice rotation. Launceston based students will be instructed on this.

Sample forms to document/assess each portfolio component are included in Appendix 2 of this document and are also located on your school's MyLO website. These forms are guides only and may vary in detail from school to school or in paper based versus electronic format.

The following information refers to each component of the Year 4 portfolio:

1) **Introduction describing you and your achievements.** Your claims are to be evidenced by the contents of your portfolio or other evidence you introduce. You will need to link your evidence to your claims using text. The ability to accurately reflect on your professional attributes is a core skill you will need as a clinician over the life-time of your professional practice. The ability will be used as you apply for employment in the future. This component of your portfolio offers an opportunity to learn and improve upon this skill.

2) **Clinical Attachment Assessment:** an assessment for each clinical attachment 2 weeks or longer signed off by the discipline coordinator or delegate based on performance during the attachment including performance in any assessment tasks set by the discipline concerned during the attachment.

   Attachment workbooks should provide evidence of more than 15 logged patients per week, using short, disease-orientated descriptors. At least 4 of these patient encounters are to be used to write detailed reports. It is assumed you will have either clerked or had a deeper learning involvement with these 4 patients. Detailed reports should convey a clinically organised appreciation of relevant positive and negative features of the patient presentation and learning points supported by high quality references. If your rotation offers fewer than 15 patient contacts per week speak to your rotation co-ordinator about this.

   It is each student's responsibility to ensure that this form is submitted to the clinical attachment assessor **and returned to the Year unit coordinator's office within 1 week of completion of the clinical attachment.**

   Where there is a borderline or an unsatisfactory clinical attachment report, a meeting will be held between the student, the discipline coordinator and the Unit Coordinator at which a decision as to remediation requirements and processes will be made. Where a student has two unsatisfactory clinical attachment reports within a year remaining after appropriate remediation, this will be considered as a fail and the student will not be eligible to pass the unit.

3) **A Log of Skills** in which student's record information about procedures seen and/or performed during the hospital and community placements. Each procedure must also note an identifying code for the patient involved such as a hospital UR number, or initials and date of birth, to aid possible random audit of claims made. Students are to be supervised in performing skills in the patient care setting and are expected to seek feedback on how to improve their performance from their supervising clinicians. However a signature from the supervising clinician to evidence assessment of student competence in performing a skill will only be required for the following 6 key competencies.

   Six key competencies must be assessed by a registered clinician as being performed competently by the student. By the end of 4th year these 6 competencies should at least have been signed off as performed in simulation teaching. By the end of 5th year venepuncture and intravenous cannulation should be assessed in patient care scenarios as being performed competently. The 6 are:

   - **CPR**
   - **Airway management**
   - **Venepuncture**
   - **Male urinary catheterisation**
   - **Female urinary catheterisation**
   - **Cannulation**

4) **Two reflective pieces**, to be submitted on dates specified by the individual Clinical Schools, written in a prescribed format of 1,000 to 1,500 words each (with a word count included) that reflect the learning outcomes of the themes Personal and Professional Development and Communication and Collaboration. Your clinical school may specify discussion areas for a reflective piece.

5) **Mini clinical examination exercise (mini-CEX)**

   In each of years 4 & 5, a minimum of 10 mini-CEX, in at least 4 disciplines, is to be submitted in your portfolio. A mix of complexity and domain focus for the compiled mini-CEX is also expected.

6) **Evidence of ongoing participation in CBL learning tasks.** The requirements for this portfolio component may vary among the Clinical Schools. Students should consult their Clinical School handbook or MyLO website for requirements.

The above 6 tasks constitute the summative assessment component of the portfolio. The summative portfolio is an integral component of the final assessment. All elements of the portfolio must be passed satisfactorily before a student progresses. Late submission of portfolio requirements will lead to a supplementary pass as your academic achievement for the year. This will impact on your overall eligibility to be recognised on the Dean's honour roll, and will appear on your academic transcript. Non submission of portfolio pieces will lead to failure for the year.

Specific additional portfolio requirements may vary between Clinical Schools and students are advised to consult the Year 4 handbook or MyLO website for the Clinical School they are attending for details. It is expected that additional formative elements will be included in the portfolio e.g. case reports, evidence of ward presentations, etc.

2.2.1 Log of skills

Airway management, male and female catheterisation, venepuncture, IV cannulation, and CPR will need to be signed off as having demonstrated competency by a clinical school appointed nominee

A record of all completed skills should be maintained. Some clinical schools will provide Log of Skills booklets for students; some discipline workbooks may contain an abridged log of skills most relevant to that discipline. A summary sheet of your log of skills should be placed in your portfolio. See Appendix 2.3.7.

Students may not be able to complete four of each of the procedures; however, they are expected to **perform or observe at least 40% of the listed skills at least once by the end of Year 4.** Please note that skills practiced in simulated educational sessions will usually precede performing these skills on consented patients. Cardio Pulmonary Resuscitation and use of an automatic or semi-automatic defibrillator are examples of skills that should be demonstrated using simulation alone. If some skills are difficult to complete please discuss this with your Associate Head of School.

- *See unit outline appendix for the detailed list of skills requiring evidence of competency by the end of your 5th year.*

When there is a death on the unit to which a student is attached, a copy of the blank death certificate form containing no patient identifying information should be filled out independently from the medical staff and then compared and discussed. This should be clearly marked "PRACTICE" and placed in your portfolio. Similarly for the drug chart.

Compile all forms containing your evidence and complete a summarising cover sheet for inclusion into your portfolio by the end of the year.

2.2.2 Reflective pieces

The reflective pieces provide an opportunity for students to record their personal assessment of the activities undertaken. They are more related to thinking about process, behaviour and attitudes rather than medical content, how you value and learn from encounters with patients and professionals, and how this affects your professional growth. The assessment marking sheet for reflective pieces can be found in Appendix 2.4 of this Handbook.

Reflection is a tool to assist in gaining insight into educational or other values of what students are doing. Through it students can assess:

- the quality of the activity
- the degree of learning that took place
- whether it led to a change in thinking or emphasis, or led to further study in that area

- what influence it had on how the student will approach medicine in the future.

Reflective learning aims to go beyond the superficial learning of memorizing facts; it aims to foster deep learning, where what you learn is put into context and can be applied in practice.

The **deep learn**ing cycl**e** has four stages: doing, reflecting, connecting and deciding.

- **Doing** is action.
- **Reflecting** is about observing your own thinking and actions. A sort of mental post-mortem about something you did, or said or heard or saw.
- **Connecting** is about creating new ideas or possibilities for how it might be done or said next time. Books, internet searches or other people might help here.
- **Deciding** is where you choose which idea or possibility you will adopt and why. Next time, supported by the above stages, you will hopefully do things differently. This is a new, effective, appropriate behaviour informed by the stage of reflection.

All of these stages are fundamental to learning. If you just 'decide and do' then how do you know that what you did was effective? Conversely if you just sit and reflect but never connect and do then how do you get better? How do you know the results of your reflecting?

Handy hints for keeping a reflective journal or diary

- Carry a note book with you and make a few brief notes as things crop up. Use the 'doing–reflecting–connecting–deciding' cycle to guide you. If using an electronic portfolio, these may be noted at the day's end.
- Reflection is about being honest – with yourself and what is around you. Keeping confidentiality in mind, make sure your notes cannot identify other professionals or patients.
- Use the doing-reflecting-connecting-deciding framework to structure your writing. In the following example it was natural to start with "doing" as it was reflecting on an experience.
- Do not try to write what you think may be 'expected' by anyone else.

It may help to ask yourself questions such as:

- What educational outcomes/objectives did this experience/activity meet?
- Did the experience/activity specifically relate to the learning outcomes outlined in the Medical Graduate Profile? If so, in what way?
- Did this meet <u>my</u> learning objectives? If so, how significantly?
- How can I implement things I learned?
- What learning strategies did I use during this activity? What other strategies may have been more beneficial?
- Do I need to approach patients/colleagues differently because of something I learned during this activity?
- What are the ethical or professional issues that concern me or have not been satisfactorily addressed?

Learning outcomes to be assessed by the reflective pieces

The learning outcomes from the MGP in the themes of Communication and Collaboration and Personal and Professional Development will be assessed using the reflective pieces. Examples are provided here of how you can use the objectives of the Medical Graduate Profile (listed here in italics) to structure the reflective pieces.

Communication and Collaboration - *Students will be able to demonstrate appropriate and effective communication skills in a variety of settings*

- *Demonstrates appropriate communication skills in consultations/interviews with patients, families and their carers.*

  Think of a situation you have witnessed when there was a breakdown in communication between a doctor and a patient or other health professional. Think from the perspective of the person that you choose. Describe each situation, what went wrong and why. Then consider how you would do it differently in the future if you were in the position of that doctor. *Write one or two separate pieces.*

- *Demonstrates the ability to work collaboratively with colleagues in the healthcare teams*

  Select an experience in which you were part of a health care team. Choose a team that functioned very well, or alternatively one in which there were problems. Describe the situation. What made this team function well/poorly? How could you improve the team functioning? If you were a doctor on the team, what (if anything) would you do differently?

Personal and Professional Development - *Students will demonstrate a commitment to compassionate, professional and ethical behaviour and they will understand the legal responsibilities of a medical practitioner.*

- *Demonstrates a commitment to compassionate, professional and ethical behaviour*

  Think of a case that you have seen involving an ethical dilemma (e.g. abortion, "not for resuscitation" order, enrolling a patient in a clinical trial). Describe the situation and present both sides of the issue. Reflect on the situation. How well was it handled? Would you do anything differently if you were the doctor?

  It is not always in the interests of patients or their families to do everything that is technically possible to make a precise diagnosis or to attempt to modify the course of an illness. Describe a patient you encountered for whom this was true. Why was this the case for this patient? What communication issues arose in terms of deciding how to manage the patient? Who was involved in the decision? Reflect on the appropriateness both of the process and the outcome.

- *Demonstrates a commitment to compassionate, professional and ethical behaviour*

  Look for a situation in which a doctor's own interests were potentially in conflict with that of the community, the patient, or indeed his or her profession. Or find an example where a doctor has made a positive impact on the community, for example through charity or similar work. Discuss these with the doctor. Describe the situation and reflect on the doctor's attitudes and behaviours. What impact does this positive role modelling have on you? How would you translate this into your own set of attitudes and behaviours? What will you do differently in the future?

- *Understands the need for respect of the interests, dignity of every human being*

  Describe an encounter with a patient that you found particularly challenging in terms of your attitude to the patient. The important thing is to be open and honest. Perhaps the patient has a disability and you find this difficult to deal with, or the patient may have a drug or alcohol problem and become abusive; the patient may be malingering; or may be unkempt. Describe the encounter and why you found it challenging. What attitudes did you have towards this patient? If you had been the doctor would this have impacted negatively on the patient's care?

- *Understands the principles of quality improvement, risk management and patient safety.*

  Think of a situation in which there was an adverse outcome or error made. Think about contributing factors from a systems perspective rather than just levelling blame at a single doctor. Reflect on the incidents and look for future solutions to prevent them happening again.

You may choose to write your reflective piece in a format different from the example overleaf, however, should you wish to do this, it is advisable to discuss your idea with your Unit Coordinator prior to commencing the reflective work. There must be evidence in the writing that the student understands and has engaged deeply with the issue, has demonstrated some insight about his or her own attitudes and behaviour, and learned something. Please use the published literature in your reflection as evidenced by referencing. Assessment criteria are included in Appendix 2.4.

Example of a reflective piece

This short piece is included as an example to guide you. It is quite brief as it is for illustrative purposes. In this piece it would have been appropriate to "research" and discuss further any impacts that a doctor consulting with another doctor may have on the consultation. Student submissions are expected to contain more depth and contain a minimum of 1000 words and a maximum of 1,500 words in each piece.

This piece addresses the following objective: *Demonstrates appropriate communication skills in consultations/interviews with patients, their families and their carers.*

Doing:

This experience for me came from the perspective of my being a patient/parent, rather than a clinician. My son was due to go to Melbourne for surgery. We had some concerns and questions about what was proposed and had communicated these to an extremely helpful paediatric registrar at a clinic appointment in the RHH. He promised to follow this up with the paediatrician in Melbourne (which he did).

I was telephoned two days later on my mobile early one evening by the paediatrician from Melbourne who sounded pretty hassled. He proceeded to talk at me for nearly half an hour during which time I barely got out a couple of questions and a few monosyllables.

Reflecting:

It was long frustrating conversation in which I hadn't felt heard at all. He had no idea what my concerns were and didn't try and find out. Instead he seemed to just assume and started talking. I did get my questions answered (simply because he talked for so long and covered everything and a lot more besides!) and we did have an appropriate decision made at the end of it, but it struck me as rather paradoxical that this clinician was terribly busy, yet we could have had the same outcome in probably a third of the time. Not to mention it being a waste of my time as well! Most of what he was telling me I knew already and wasn't what I was concerned about!

I wondered if the fact that I was a doctor too (albeit one with almost no experience in this specialised area of paediatrics) influenced his behaviour. I wondered if my questions had been mistakenly interpreted as threatening or challenging his expertise, and that his approach had been a defensive one.

There had to be a better way of handling such a conversation.

Connecting:

In order to review a theoretical framework and guide for communicating with patients in this sort of situation, I visited the skills cascade website (www.skillscascade.com) which deals with communication and consultation skills for doctors. It provided me with a few key messages that reinforced my own consulting behaviour.

The first, and most important, message was to identify at the beginning of the consultation the patient's agenda. Find out what their ideas, concerns and expectations are. Let the patient do most of the talking for the first few minutes. Listen attentively. Then summarise for the patient your understanding of their issues.

Second, periodically check understanding and make sure the consultation is "on track". At the end summarise the main points and check with the patient that they have the same understanding as you.
Third, if you begin to feel out of your depth, uncomfortable, challenged etc, then stop talking and start asking more questions. If you feel uncomfortable it is because the patient is uncomfortable. You need to find out why.

Deciding:

All these points seemed relevant to the case. When handling a similar situation in the future I would acknowledge that the patient had some questions and concerns

- *Use open ended questions to ascertain the patient's agenda*
- *Summarise my understanding of the patient's agenda and check that it matches their perspective.*
- *Discuss the issues and answer the questions as best I could*
- *Check that the patient understands what I am saying and is happy with the answers and suggestions I am making.*
- *Summarise the outcomes of the consultation for the patient.*

2.2.3 Clinical attachments

At the beginning of each clinical attachment students will need to decide on personal goals for learning in that attachment and fill those out on the student section of the clinical attachment assessment form (see Appendix 2.1 for assessment forms). Students may wish to seek the guidance of the discipline coordinator or clinical supervisor. At the end of the attachment, students should reflect on their progress in meeting their goals. Students should ask their supervisor to fill in their section of the form and arrange to meet their supervisor in the last week for feedback about their performance during the attachment.

2.2.4 Mini clinical evaluation exercise (mini-CEX)

The mini-CEX offers opportunities to assess clinical encounters on a regular basis. The mini-CEX focuses on the core skills that senior medical students need to be able to demonstrate in patient encounters. It is an evaluation that can be readily incorporated into any interaction between medical student and patient.

The mini-CEX is a 15–20 minute observation or snapshot of the interaction. Particular assessments may focus on a limited range of competencies from a list that includes history taking, physical examination, and clinical judgement in relation to choosing investigations, interpersonal qualities/professionalism, counselling skills, organisation and overall clinical competence.

Based on multiple encounters over time in different settings assessed by different clinicians this method provides a valid, reliable measure of performance. It is an assessment tool that will be used in your junior doctor years as well.

Following are guidelines for the mini-CEX examination process and the form to record the mini-CEX can be found in Appendix 2.5:

Descriptors of competencies demonstrated during the mini-CEX

- **Medical Interviewing Skills:** Facilitates patient's telling of story; effectively uses questions/directions to obtain accurate, adequate information needed; responds appropriately to affect, non-verbal cues.
- **Physical Examination Skills:** Follows efficient, logical sequence, balances screening/diagnostic steps for problems, informs patient; sensitive to patient's comfort, modesty.
- **Interpersonal Qualities/Professionalism:** Shows respect, compassion, empathy, establishes trust, attends to patient's needs for comfort, modesty, confidentiality, information.
- **Clinical Judgment:** Selectively orders/performs appropriate diagnostic studies, considers risks, benefits.
- **Counselling Skills:** Explains rationale for test/treatment, obtains patient's consent, educates/counsels regarding management.
- **Organisation/Efficiency:** Prioritises; is timely; succinct; correct documentation related to transitions in care.
- **Overall Clinical Competence:** Demonstrates judgment, synthesis, caring,

effectiveness and efficiency.

Guidelines to assist in developing these clinical skills can be found in "Clinical Examination a Systematic Guide to Physical Diagnosis" by Talley & O'Connor.

This guide will never replace the most valuable resource for student learning - the patient - who will provide the best opportunity for students to develop their clinical skills and should be treated with great respect. The ultimate aim of any medical consultation is to provide an acceptable solution to the problem brought to the doctor by a patient, but any guidelines should be tailored to suit the individual and situation.

2.3 Integrated case-based learning (CBL)

The case-based learning program is the thread that links all the activities in Years 4 and 5. Case-based learning is a useful approach as it ensures that learning is placed in the clinical context in which it will later be used. It is also useful as it often demonstrates how effective care of the patient requires input from more than one discipline, and indeed often from more than one profession.

CBL sessions will be conducted during term time. These sessions are structured such that a new case is introduced each week. The format of CBL will be slightly different at each Clinical School and students are advised to consult the Guidelines for the Clinical School they are attending. The requirement regarding participation in CBL tasks throughout the year will vary from school to school. A sample assessment form can be found in Appendix 2.6 and, if used, these forms should be included in the portfolio.

Suggestions for students to show evidence of participation and competency in CBL sessions include:

- providing the learning group with references that are current, representative of key research work in the area and appropriately documented according to TSoM referencing guide
- using electronic tools such as PowerPoint software to present key information in a logical and clear manner
- using question and answer teaching approaches to elicit participation from the group and assist in the process of student self-directed learning
- sharing research and presentation tasks amongst the team for team based delivery
- providing a useful summary in written and/or oral form at the end of the presentation which reflects a clear understanding of the topic.

All Clinical Schools will cover the same core case topics during 2012. The following is a list of these topics, together with areas that will be covered within the presentation of the case, or which students will be expected to learn about. Discretionary cases may also be presented by each clinical school.

2.3.1 CBL Core Topics

(Note: These cases will not necessarily be delivered in this order in your Clinical School. Not all principle diagnoses listed will necessarily be covered in CBLs but students should use the Major Subsets and Principle Diagnoses as a guide to learning. Some topics, or aspects of topics, may be covered as part of lecture or tutorial series as well. Check your School's program.)

Major Symptom Complex	Major Subsets	Principle Diagnoses
Dyspnoea	Respiratory (child and adult) Cardiac	COPD Asthma Occupational lung disease Neoplasia Infection Ischaemic Heart Disease Acute Pulmonary Oedema
Chest Pain	Cardiac	Ischaemic heart disease – ▪ acute coronary syndrome ▪ chronic, stable angina & others e.g. pericarditis
Chest Pain	Pulmonary Embolus	DVT/PE Hypercoagulability states Anti coagulant therapy
Diabetes Type 1	Acute management issues	Coma Abdominal pain Weight loss Polyuria
Diabetes Type 2 + Obesity	Vascular pathology Adult obesity	Peripheral vascular disease Retinal disease Renal disease Cardiac disease Metabolic syndrome Preventative strategies Morbidity
Gastrointestinal bleeding	Upper tract bleeding Lower Tract Bleeding	Peptic ulcer Angiodysplasia Varices Colitis Bowel cancer Diverticular disease Local anal conditions
Pregnancy	Abnormal Normal Unwanted	Preventative care Screenings/ethical issues Antenatal and postnatal care Termination/contraception
Fatigue	Chronic fatiguing illnesses	Multifaceted Dealing with uncertainty in diagnosis Psychological causes Infective/inflammatory Neoplastic

Major Symptom Complex	Major Subsets	Principle Diagnoses
Stroke	Cerebral Haemorrhage Cerebral Thrombosis	SAH SDH TIA Stroke prevention
Diarrhoea and Vomiting	Adolescent Paediatrics	Coeliac disease Inflammatory bowel disease Infection
Headache	Vascular Other	Tension Migraine Neoplasia Infection
Back Pain	Acute Chronic	Mechanical Disc Neurogenic Red & yellow flag disorders Issues of chronic pain management
Major Trauma	Will be dealt with through the Trauma Courses	
Visual disturbance	Sudden loss of or deterioration in vision The painful red eye	Diplopia Cataract Glaucoma Eye trauma Infection Vascular accidents
Abdominal pain	1. Child 2. O&G 3. Adult	Intussusception Volvulus Congenital abnormalities Migraine Pregnancy Ruptured ovarian cysts Chronic pelvic inflammatory disease Obstructed viscus Ischaemic Lithiasis Sepsis/inflammatory Neurogenic Abdominal wall pain
Rheumatological and Autoimmune disease	Iconic disease e.g. rheumatoid arthritis (joint disease)	Rheumatoid arthritis Osteoarthritis Gout Haemochromatosis Infection
Thyroid disease	Hyper Hypo Mass(es)	Autoimmune Neoplastic Iatrogenic

Major Symptom Complex	Major Subsets	Principle Diagnoses
Neoplasia	1. Breast 2. Prostate	Screening Genetic Broad overview of treatment strategies Screening Genetics Broad overview of treatment strategies
Disability	Intellectual Physical	Acquired brain injury Spinal cord injury Congenital
Injury	Non-accidental Accidental	Suicide Adolescent risk-taking Behaviour Injuries and workers' compensation Intimate partner violence
Sexual dysfunction	Men's health	Sexual dysfunction Prostate cancer
Mood disorders	Anxiety Depression	Mild, moderate & severe Co-morbidities
Psychosis versus delirium		Schizophrenia Epidemiology Age related features
Febrile illness	Acute febrile illness PUO	Paediatrics PUO to be discussed
Urinary symptoms	Women Men	UTIs STIs Urgency Frequency Dysuria Incontinence
Mid life	Men's health Women's health	General mid-life issues Screening for disease Whole patient care
Vaginal bleeding	Amenorrhoea Polymenorrhoea	Dysfunctional Neoplastic Fibroid related
Preventative health care	Child Adult	Evidence based screening Immunisation Primary, secondary and tertiary prevention
Sepsis		Sepsis in an adult PUO Septic shock Ward care versus ICU care

Major Symptom Complex	Major Subsets	Principle Diagnoses
Aboriginal health		Preventative health issues Rheumatic heart disease Stolen generation issues
Refugee health		Screening issues on settlement into Australia Long term health issues

2.4 Electives

While students can choose the destination and theme of their elective, the Associate Head of School in your clinical school may direct you to choose an elective that meets your specific learning needs.

It is essential that all students submit the registration form and Safe in Practice form relevant to the elective by the last day of semester 1. Immunisation and health forms must be submitted by 1 September 2012.

'Pre-departure' training will be provided to all students although is especially directed as students travelling overseas or to remote Australian communities. 'During elective' and 'post return' education and support will be provided by the School. The emergency contact during electives will be Dr Nick Cooling (nick.cooling@utas.edu.au Mob 0427285079), with additional assistance provided by International SOS. These emergency contact details will be provided on a wallet size card prior to your departure.

All elective proposals and associated documentation will be approved by the Director of Electives & Internationalisation, Dr Nick Cooling.

The Elective Booklet contains important information on how to plan and execute a successful elective. It is available via the School of Medicine Internationalisation and Elective (SMILE) Program section of the School of Medicine website. http://www.utas.edu.au/medicine/

On completion of the elective students are required to submit a:

a) Brief log book of experiences (lodged via MyLO)
b) Supervisors report (see School of Medicine website)

In early 5th year deliver a brief presentation to your peers & teachers , highlighting their learning experience, at their local clinical school. Each clinical school will advise you on the schedule and specify the requirements for this electives presentation. Keep this in mind when you undertake your elective and prepare your final year portfolio.

3. RECOMMENDED RESOURCES

look to your MyLO sites as these resources may change throughout the year

3.1 Electronic resources

PubMed (Medline) via UTAS network

Cochrane Library via UTAS network

BMJ Clinical Evidence via UTAS Library database

Australian Medicines Handbook via UTAS network

Up-to-Date via the UTAS network www.uptodate.com

Meta search engines that will find clinically relevant, evidence based material:

"Trip Database" http://www.tripdatabase.com and via UTAS network

Merck Manual On-line http://www.merck.com/ and via the UTAS network

Therapeutics teaching will include the web-based resources of the National Prescribing Curriculum: http://nps.unisa.edu.au/NPSStart/index.htm (students will need to obtain an access code for this site from administrative staff at their clinical school); www.nps.org.au and click on Health Professionals

NHMRC Clinical Practice Guidelines:

http://www.nhmrc.gov.au/guidelines/index.htm

Radiology specific: www.chestx-ray.com,

Skills Cascade the Calgary-Cambridge approach to teaching consultation and communication skills http://www.skillscascade.com

Anaesthetics specific:

Guidelines for Management http://www.anzca.edu.au/resources/endorsed/

Google and Google Scholar

Australian Resuscitation Council: http://www.resus.org.au/

Rural Adult Emergency Guidelines (NSW):

http://www.health.nsw.gov.au/policies/gl/2010/pdf/GL2010_003.pdf

Guidelines for Management of Acute Coronary Syndromes:

http://www.heartfoundation.org.au/SiteCollectionDocuments/mja-issue.pdf

Asthma Management Handbook:

http://www.nationalasthma.org.au/uploads/handbook/370-amh2006_web_5.pdf

Clinical Guidelines for Stroke Management:

http://www.strokefoundation.com.au/clinical-guidelines

Allergy and Anaphylaxis Guidelines: http://www.allergy.org.au/

Emergency Management of Cardiac Arrhythmias:

http://www.racgp.org.au/afp/200707/200707grantham.pdf

3.2 Required or recommended texts

Students should have one textbook readily available for each discipline and access the most recent editions of the discipline-specific texts below. Unless specified, texts are recommended but not required.

Note: Copies of all titles are usually held in the library of the Clinical School/hospital and usually in the Reserve Section. As well as latest editions of books many are also available as earlier editions. Some titles are also held as e-textbooks or on CD-ROM. Other discipline specific titles are also provided through the Reserve Section.

ANAESTHETICS

Gwinnutt CL. (2008) *Lecture notes in clinical anaesthesia.* 3 ed Blackwell
Nathanson M, Mahajan R. (2007) *Anaesthesia.* Churchill Livingstone
Allman K & Wilson I. (2006) *Oxford Handbook of Anaesthesia.* 2 ed Oxford University Press

SURGERY

Refer to the free print-out on the basic level of anatomical knowledge required for successful completion of the course, available from Discipline of Surgery Secretary
Burkitt, Quick. (2007) *Essential Surgery: problems, diagnosis and management* 4 ed. Churchill Livingstone
Cuschieri A. (2003) *Clinical Surgery,* 2 ed. Blackwell
Smith JA et al *Hunt and Marshall's Clinical Problems in Surgery*,. 2nd ed 2010, Churchill Livingstone

Ear, Nose and Throat

Bull PD. (2007) *Lecture notes on diseases of the ear, nose and throat*. 10th ed. Blackwell
Lucente F. et al. (2005) Essentials of Otolargyngology, 5th ed,. Lippincott, Williams & Wilkins
Pasha R (2006) Otolaryngology, Head and Neck Surgery: clinical reference guide, 2nd ed Plural Publishing
Lee KJ. (2008) *Essential Otorargyngology Head and Neck Surgery*, 9 ed. McGraw-Hill Medical Publishing
Useful website http://www.martindalecenter.com/MedicalAudio_2_C.html#ENT-COUR

Ophthalmology

Batterbury & Bowling. (2009) *Ophthalmology: An illustrated colour text,* 3 ed. Elsevier, Churchill & Livingstone.

Kanski J. (2011) *Clinical Ophthalmology; A systematic approach* , 7 ed. Butterworth Heinemann & Elsevier

Riordan-Eva, P et al. (2004) *Vaughan & Ashbury's General Ophthalmology,* 16th ed. Lange Medical books

Orthopaedics

Apley AG, Solomon L, Warwick DJ (2010) *Apley's System of Orthopaedics and Fractures,* 9 ed, Hodder Education

Dandy DJ. (2003) *Essential Orthopaedics and Trauma,* 4 ed. Churchill Livingstone

Hamblin D & Simpson A (2010) *Adam's Outline of Orthopaedics,* 14 ed. Churchill Livingstone McRae R. (2008) *Practical Fracture Treatment*, 5 ed. Churchill Livingstone

McRae R. (2006) *Pocketbook of orthopaedics and fractures,* 2 ed.

Plastic Surgery

McGregor A & I. (2000) *Fundamental Techniques of Plastic Surgery and their surgical applications,* 10 ed. Churchill Livingstone

Surgery and Surgical Specialties

Browse Norman (2005) *Symptoms and Signs of Surgical Disease,* 4 ed. Edward Arnold

Bailey and Love (2008) *Short Practice of Surgery,* 25th ed. HK Lewis & Co, Chapman Hall

Urology

Dawson and Whitfield (2006) *ABC of Urology,* BMJ Publication.

EMERGENCY MEDICINE

Cameron et al (2009) *Textbook of Adult Emergency Medicine.* 9 ed Churchill Livingsone

Brown and Cardogan (2010) *Emergency and Acute Medicine: Diagnosis and Management.* 6 ed Hodder Education

GENERAL PRACTICE

Required texts

Murtagh J. (2011) *General Practice*, 5th edition. McGraw Hill

Silverman J, Kurtz S, Draper J. (2005) *Skills for communicating with patients*, 2nd edition. Radcliffe Publishing

Recommended reading

Britt H, et al (2011) *General Practice Activity in Australia 2010-2011*. General Practice Series No 29. Sydney University Press . Accessed 28th Nov 2011 at http://ses.library.usyd.edu.au/bitstream/2123/7772/4/9781920899868_CDROM.pdf

Murtagh J. (2008) *Patient Education*, 5th edition. McGraw Hill

Murtagh J. (2008) *Practice Tips*, 5th edition. McGraw Hill

Murtagh J. (2011) *General Practice Companion Handbook*, 5th edition. McGraw Hill

RACGP. (2009) *Guidelines for Preventive Activities in General Practice (The Red Book)*, 7th edition. Available online at http://www.racgp.org.au/guidelines/redbook

RACGP (2004) *SNAP: Smoking, Nutrition, Alcohol and Physical Activity. A population health guide to behavioural risk factors in general practice*. Available online - http://www.racgp.org.au/guidelines/snap

RACGP (2006) *Putting Prevention Into Practice (The Green Book).* Available online at - http://www.racgp.org.au/guidelines/greenbook

RACGP (2006) *Keeping the Doctor Alive. A self care guidebook for medical practitioners.*

INTEGRATION across DISCIPLINES

Required

The *"Therapeutic Guidelines"* series

Analgesic (2007)
Antibiotic (2010)
Cardiovascular (2008)
Endocrinology (2009)
Gastrointestinal (2011)

Neurology (2011)
Respiratory (2009)
Rheumatological (2010))
Psychotropic (2008)
Emergency Medicine (2008)
Dermatological (2009)
Palliative Care (2010)
Oral and Dental (2007)

Australian Medicines Handbook (2011)

Talley N and O'Connor S. (2006) *Clinical Examination: a systematic guide to physical diagnosis*. 5ed. Churchill Livingstone

Recommended:

Burgess R (ed) (2011) *New Principles of Best Practice in Clinical Audit*. 2 ed. Radcliffe Publishing

Carson B etal (2007) *Social determinants of Indigenous Health*. Allen and Unwin

Duckett S & Willcox S. (2011) *, The Australian Health Care System*. 4 ed Oxford University Press

Hassed C. (2008) *The Essence of Health: The Seven Pillars of Wellbeing*, Ebury Press.

Haynes R.B et al (2006) *Clinical Epidemiology: How to Do Clinical Practice Research*. 3 ed. Lippincott Williams & Wilkins

McGee S R (2012) *Evidence-based physical diagnosis.* 3ed. Saunders

Malanga, GA, Nadler SF. (2006) *Musculoskeletal Physical Examination: an evidence-based approach*. Elsevier

Marmot M & Wilkinson R. (2006) *Social Determinants of Health*.2 ed. Oxford University Press

Stewart M, Belle Brown J, Weston W, McWhinney I, McWilliam C and Freeman T. (2003) *Patient-Centred Medicine – Transforming the Clinical Method*, 2nd edition. Radcliffe Medical

Straus S et al (2011) *Evidence-based medicine: How to practice and teach it* 4 ed. Churchill-Livingstone.

Thomson N, (ed) (2003) *The Health of Indigenous Australians*. Oxford University Press

Wilkinson R & Pickett K (2010) *The Spirit Level: Why Equality is better for Everyone.* Penguin Books

Yung A, et al (2005) *Infectious Diseases; A clinical approach*. 2 ed IP Communications

GERIATRIC MEDICINE

Delirium

Young J, Inouye SK *Delirium in older people* BMJ 2007 Apr 21; 334 (7598):842-6

Inouye SK *Delirium in older persons* NEJM 354(11):1157-65

Cognitive Assessment

Thomas H Bak and Eneida Mioshi *A cognitive bedside assessment beyond the MMSE: the Addenbrooke's Cognitive Examination* Practical Neurology, Aug 2007; 7: 245 - 249.

Woodford HJ, George J. *Cognitive assessment in the elderly: a review of clinical methods* QJM. 2007 Aug;100 (8):469-84

Holsinger T, Deveau J, Boustani M, Williams JW. *Does this patient have dementia?* JAMA 2007 297 (21):2391-404

Strub RL, Black FW (2000) *The Mental Status Examination in Neurology* 4th ed. FA Davis Company

Hodges JR (2007) *Cognitive Assessment for Clinicians* 2 ed. Oxford University Press

Capacity Assessment

Darzins P, Molloy DW, Strang D (Editors) *Who Can Decide? : The six step capacity assessment process* (Available from Alzheimer's Australia SA) http://new.alzheimersonline.org/index.php?option=com_content&task=view&id=397&Itemid=108

Assessment of Mental Capacity: Guidance for Doctors and Lawyers (2004) 2 ed British Medical Association and The Law Society. BMJ Books

MEDICINE

Colledge et al (Ed)(2010) *Davidson's Principles and Practice of Medicine* 21st ed. Churchill Livingstone / Elsevier

Medical Research Council, UK. (2000) *Aids to the Examination of the Peripheral Nervous System*. 4 ed.

Braunwald's heart disease (2012) 9th ed. Elsevier

Harrison's Principles of Internal Medicine (2011) 18 ed. McGraw-Hill Medical Publishing

OBSTETRICS AND GYNAECOLOGY

Finn, Bowyer, Carr, O'Connor & Vollenhoven (eds). (2005) *Women's Health: A Core Curriculum*. Elsevier

Hacker NF, Moore JG, Gambone JC. (2004) *Essentials of Obstetrics and Gynaecology*. 4 ed. WB Saunders & Company.

Oats J & Abraham S. (2010) *Llewellyn-Jones fundamentals of Obstetrics & Gynaecology*. 9 ed. Mosby

PAEDIATRICS

Required

PEMSoft online

UTAS medical students access for 2012

1)type www.pemsoft.net into your web browser
2)Click on TOP button "sign into your PEMSoftOnline account"
3)Username = pemsoft
4)Password = edu-utas2012

Recommended

Paediatric Medicine

South M and Roberton DM. (2007) *Practical Paediatrics,* 3 ed. Churchill Livingstone (new edition due April 2012)

Lissauer T, Clayden G. (2012) *Illustrated Textbook of Paediatrics*, 4 ed. Mosby

Paediatric Surgery

Hutson, Woodward, Beasley (ed.) (2008) *Jones' Clinical Paediatric Surgery*, 6 ed Blackwell Publishing

Paediatric Clinical Skills

Goldbloom R., Saunders eds. (2011) *Pediatric Clinical Skills* 4 ed

Other Useful Resources

Kliegman RM et al. (2011) *Nelson Essentials of Pediatrics* 6 ed. Elsevier Saunders

Staff of the Royal Children's Hospital, Melbourne. (2010) *Paediatric Handbook.* 8 ed. Blackwell Publishing

9th Australian Immunisation Handbook 2008
http://www.immunise.health.gov.au/internet/immunise/publishing.nsf/Content/Handbook-home

NETS VIC Neonatal Handbook:
http://www.netsvic.org.au/nets/handbook/index.cfm?doc_id=447, available online, in hard copy and PDA format.

CD Child Growth and Development in the first 12 months. Version 2.4

www.neoresus.org.au contains modules you may be required to work through. Check your paediatric workbook.

PSYCHIATRY

Bloch S and Singh BS (2001) *Foundations of Clinical Psychiatry* 2 ed. Melbourne University Press

Blashki G, Judd F, Piterman L (eds) (2007) *General Practice Psychiatry* McGraw Hill

Singh B, Kirkby KC. *The Psychiatric Interview, the mental state and the formulation*. Chapter in above text *Bloch S & Singh BS Foundations of Clinical Psychiatry*

Kaplan HI and Sadock BJ. (2007) *Synopsis of Psychiatry – Behavioural Sciences Clinical Psychiatry* 10 ed. Lippincott, Williams & Wilkins

Pridmore S. (2000) *The Psychiatric Interview* Harwood Academic

Pridmore, S. (2006) *Download of Psychiatry.* University of Tasmania http://eprints.utas.edu.au/287/

RADIOLOGY

Banerjee AK. (2006) *Radiology made easy,* 2 ed. Cambridge University Press

Begg JD. (2004) *Accident and emergency X-rays made easy.* Churchill Livingstone

Patel PR. (2005) *Lecture notes: radiology.* Blackwell

Sacharias, Nina *Radiology for Students*, CD resource available on dedicated computer at the Hobart Clinical School Library

4. ASSESSMENT REQUIREMENTS AND CRITERIA

(see also Assessment Section in Unit Outline)

The desired learning objectives listed in the document *"Learning Outcomes for the Year 4&5 Clinical Attachments 2012"*, and the outcomes and sub-outcomes of the Medical Graduate Profile (MGP) provide the basis for assessment. These latter are found in the Unit Outline for Year 4 (see Appendix 1).

Assessing the range of desired outcomes requires a breadth of assessment formats. Most assessments will be formative, i.e. designed to help both student and teacher identify strengths and weaknesses in order to plan further study. Feedback is an important feature of formative assessments and feedback after exams will be provided to students in line with UTAS policy and obligations under the worldwide IDEAL database from which some exam questions are drawn. Students will not be permitted to see summative questions (MCQs, EMQs or OSCEs) after assessment but can receive feedback based on their performance from their Associate Head of School, Unit Coordinator or delegate.

Formative assessment scores are not used to decide progress into Year 4, but all assessments must be completed in order to sit the end of year summative exams, i.e. those that determine progress into Year 5. In addition, students must attend a **minimum of 80%** of scheduled teaching and learning sessions. To ensure that minimum standards are met for successful completion of the year, students are required to sign the attendance register (when provided) for tutorials and other group sessions.

The result awarded for this unit is an ungraded pass (UP), supplementary pass (SP) or fail (NN).

4.1 Components of Assessment

Consult your Unit outline for these.

5. ADMINISTRATIVE REQUIREMENTS AND SUPPORT

5.1 Medical Education Advisers (MEA)

Each Clinical School is supported by a Medical Education Adviser (MEA). The role of the MEA varies from School to School and may include:

- assisting the unit coordinators and clinical teaching staff to deliver their programs using sound educational principles;
- assisting and guiding the learning methods used by students in their coursework; (students are reminded that the MEA role is not a clinical role);
- assistance in the logistics of CBL delivery, but not the clinical content;
- advise on assessment issues and evaluation, e.g. Student Evaluation of Teaching and Learning (SETL); and
- assisting students who identify specific learning difficulties and be active in remediation programs.

5.2 Guidelines for Students on Clinical Placements with the Department of Health and Human Services (DHHS) – this policy also applies to all clinical placements outside the DHHS

Introduction

Prior to undertaking a professional practicum placement, it is expected that students will attend a briefing or orientation session or be able to demonstrate knowledge of the issues covered in the briefing sessions.

Whilst undertaking clinical placements with DHHS, students are expected to comply with the specific "Standards of Behaviour and Conduct" (2005) that have been developed for DHHS employees to provide direction and guidance on responsibility and standards of conduct and performance.

Students are also expected to familiarise themselves with the health care agency protocols and policies relating to the area in which they are undertaking placement (e.g. Occupational Health and Safety procedures, emergency procedures, dress code and conduct). It is acknowledged that certain areas within DHHS (e.g. Correctional Health, Forensic Mental Health)[1] will have additional policies which students must be aware of and adhere to and individual Schools/Hospitals may have additional requirements (e.g. Infectious Diseases Policy) as outlined in their manuals.

[1] Students on placement with Correctional Health and Forensic Mental Health refer Appendix 1

Before being granted access to patient care areas in the DHHS, students are required to sign an undertaking that they have read the following guidelines. Disciplinary action may be taken in the case of breaches under the General Misconduct provisions of the University's Ordinance of Student Discipline (Ordinance 9). **In extreme cases penalties could include suspension or exclusion from the course.**

1 Dress

1.1 If not in uniform[2], students visiting patient contact areas must be appropriately dressed and conform to the standards of the hospital or practice setting. Your supervisor may require you to wear a white coat.

1.2 Appropriate dress cannot easily be prescribed or itemised, but some examples can be given.

- Generally, neat casual wear is acceptable but very casual wear is not appropriate in most clinical settings[3]. Your supervisor has the capacity to advise on this matter.
- Revealing attire generally is considered inappropriate to the work environment (e.g. necklines, midriff and hemlines).
- More stringent or more relaxed requirements may be necessary for particular areas or activities (e.g. theatre, hyperbaric medicine).
- Enclosed footwear should be worn in clinical areas to protect from potential sharps and crush injuries.
- Hair that is longer than collar length should be neatly tied back
- Jewellery may be inappropriate in some placements (e.g. radiography) – advice should be sought from the clinical supervisor.

1.3 Identification badges

Security in practice sites is essential. Students must wear official identification badges at all times while in patient care areas of the DHHS. These are to be displayed in an immediately visible position such as the lapel of the white coat, rather than the belt or trouser pocket.

1.4 Mobile telephones are only to be used in accordance with the policy of the relevant hospital or service.

2 Medical Records

2.1 Medical and prescription records are highly privileged documents and are to be treated with absolute confidentiality. Any significant breach of this instruction will attract serious disciplinary action.

2.2 Students have authorisation to access the medical and prescription records of patients on the ward or treatment area to which they are appointed. Students are not authorised to view the records of patients unless they have a particular and appropriate purpose for doing so.

2.3 Students are <u>not</u> authorised to consult case notes from Medical Records Department unless they are given specific permission from the clinician in charge of the case.

2.4 Students must not remove medical and prescription records from the immediate vicinity in which they are accessed (i.e. the ward or Medical Records Department).

[2] Nursing students refer to Appendix 2 in relation to uniform

[3] e.g. jeans, T-shirts, trainers are not appropriate wear in clinical settings such as hospital wards

3 Examination of Patients

3.1 The consent of the ward Clinical Nurse Manager (or deputy) must be obtained before examining or speaking to a patient3.2 Hygiene is important when examining patients and hands should be washed between each patient contact.

3.3 Unless otherwise instructed by an appropriate Senior Clinician, students are required to work in pairs when they examine patients so that there is always a chaperone present.

3.4 For paediatric patients, if a parent is not available as a chaperone during an examination, the clinical supervisor should be asked to advise on an appropriate chaperone.

3.5 Additional guidelines for examination of patients by medical students are attached as Appendix 3.

4 General Behaviour

4.1 Hygiene is particularly important on the wards prior to examining patients and in practice sites generally and is required on entry to some wards such as ICU and the Cardiac Surgery Unit. Particular attention should be paid to the cleanliness of hands and fingernails.

4.2 Medical ethics forbid any personal relationship, currently or subsequently, between staff (including students) and patients. The DHHS "Standards of Behaviour and Conduct" 2005 provides guidance on maintaining professional boundaries with patients. If further guidance is required, the student should seek assistance from the Senior Clinician.

4.3 Students are not to hold themselves out to be a fully qualified practitioner or to allow a patient to make this assumption.

4.4 Students are expected to display courtesy to all patients and their relatives, fellow workers and staff members during the clinical session.

4.5 It is the student's responsibility to notify the health care supervisor if they do not attend placement. If there are any issues or problems that are impacting on their ability to attend practice, they should seek assistance and contact the Clinical Teacher or Unit Coordinator.

4.6 If a student has a health condition that may impact on their ability to participate on a placement, they should raise this with their Clinical Teacher or Unit Coordinator.

4.7 Any student who is concerned about an activity or procedure that they are requested to undertake by an on-site supervisor is required to speak in confidence, to the Head of the appropriate School.

5 Confidentiality

5.1 The student must hold in strictest confidence any information gained from any source concerning the patient.

5.2 It is a breach of confidentiality to discuss patient details outside the confines of the DHHS/FHS School or for any reason other than professional purposes. Highly specialised services such as Correctional Health Services and Forensic Mental Health Services may have further specific requirements concerning confidentiality and safety.

5.3 It is absolutely forbidden for any student to pass on any information whatever concerning an individual patient to any person not directly involved in the patient's medical or pharmacy care.

6 Communications with the Media and Members of the Public

6.1 Students are NOT authorised to speak to the media, either about individual patients or about more general issues of high media interest unless provided with authorisation from the relevant Manager/CEO/Director and University supervisor.

6.2 Any individual student who is concerned about any issue they believe to be of public interest is required to speak, in confidence, to the Head of the appropriate School or the Associate Head, Student Affairs (School of Medicine) before committing to any course of action.

6.3 Further information concerning communicating with the media is contained in the:

- Partners in Health Media Protocol;
- DHHS Media Protocols;
- relevant Divisional and hospital policies; and
- University of Tasmania Media Policy.

DHHS Divisional policies may be accessed on the DHHS Intranet
http://intra.dhhs.tas.gov.au
Partners in Health Media Protocol can be accessed on:
http://www.healthsci.utas.edu.au/pih/publications.html
University of Tasmania Media Policy can be located on:
http://www.utas.edu.au/universitycouncil/legislation/policies.html

5.2 APPENDIX 1

Additional Guidelines for Students on Placement with the Correctional Health Service and/or Forensic Mental Health Service.

Safety Requirements

- Students shall display their first name only on their Identification Badges**.**
- Students are forbidden to bring mobile telephones into the workplace.
- Students must provide a current police check and obtain security clearance prior to commencement of the placement. The Correctional Health Service requires the police check to be received at least 7 days prior to placement to ensure the relevant security clearances can be obtained.
- Students will obtain a Duress Alarm each day and wear the alarm at all times whilst in the workplace. Students will ensure they understand how and when to operate the alarm.
- Students will ensure they do not divulge any personal information whilst in the workplace. If unsure of what can be discussed students are to check with their supervisor.
- Students will have to comply with all security practices and procedures including biometric identification at the Wilfred Lopes Centre (Secure Mental Health Unit).

Trafficking and Associated Behaviours

- Students shall not have any pecuniary dealings with prisoners/detainees (i.e. at no time shall a student involve a prisoner/detainee in the buying, selling or trading of items, unless such buying, selling or trading occurs as part of authorised Prison Service operations, such as the canteen system).
- Students shall not provide or arrange to provide any substance, goods, messages or services to any prisoner/detainee, member of staff or other person within the prison, unless properly authorised to do so.

- Students shall not convey or arrange to convey any item or message from a prisoner/detainee, or from elsewhere in a prison, to any other party, unless properly authorised to do so.

Conflicts of Interest

- Where a conflict or potential conflicts of interest with official duties (whether from financial interest, outside activities or personal relationships) arise, they should be immediately reported to your immediate supervisor. Any Manager/Supervisor receiving such information must act on the information immediately by making a verbal report to the State Manager, Correctional Health Service.
- If a person with whom a student has, or has had, a close relationship comes into custody, the student shall immediately notify their immediate Supervisor. Any relationship formed with a prisoner/detainee, beyond a proper and professional relationship, is considered to be a direct conflict of interest.

Use of Alcohol and Other Drugs

- Students shall not smoke cigarettes or tobacco products in any of the Correctional Health Service or Prison Service buildings or vehicles and shall comply with any relevant legislation or policy regarding the use of tobacco products.
- When within the prison environment students shall not take any drug or other substance that is not prescribed for their use.

Students shall be immediately sent from the workplace if it is believed he/she is intoxicated by alcohol or another substance and a full examination of the situation will occur.

Dated the 29th day of November 2005

5.2 APPENDIX 2

Additional Guidelines For Nursing Students Regarding Dress

Students from the Tasmanian School of Nursing and Midwifery are required to wear the TSNM uniform as described in the student manual except in particular settings where a uniform may not be required (e.g. mental health and some community nursing areas) as advised by your supervisor.

5.2 APPENDIX 3

Additional Guidelines: For Medical Students Regarding Examination of Patients

3.6 Students may only conduct intimate, invasive physical examinations under the direct supervision of an appropriate clinician and with the prior, informed consent of the patient according to the procedures of the clinical setting. This verbal consent should be noted in the patient's records as part of the examination notes.

3.7 Students must not conduct internal examinations of sedated or anaesthetised patients without the patient's prior written informed consent.

3.8 Students in the clinical years (years 3 and beyond) may conduct chest examinations of patients as part of the normal cardiovascular examination with the prior verbal consent of the patient.

5.3 Occupational Health and Safety (OH&S)

The University is committed to providing a safe and secure teaching and learning environment. Students are required to demonstrate compliance with policies relevant to learning in the workplace. The health sciences "Safety in Practice Kit" is the relevant policy and is found at:
http://fcms.its.utas.edu.au/healthsci/healthsci/files/Safety%20in%20Practice%20Kit.pdf

As well, students working in different Clinical Schools should consult the OH&S website for the hospital or other worksites to which they are attached.

5.4 Course Evaluation

Evaluations can be undertaken of academic staff members as part of the Student Evaluation of Teaching and Learning (SETL) program.

In addition to the official SETL evaluations, individual teachers may seek feedback from students via focus groups or their own evaluation forms.

CAM431/432 (Launceston Clinical School)
CAM433/434 (Rural Clinical School, Burnie)
CAM435/436 (Hobart Clinical School)

Associate Professor Jan Radford
Associate Professor Deborah Wilson
Professor Richard Turner

Medicine Year 4

Appendix 1: Unit Outline
Appendix 2: Forms

Appendix 1: Unit Outline

Contact Details

HOBART CLINICAL SCHOOL

Unit coordinator/lecturer:	Professor Richard Turner
Unit web site URL:	http://www.medicine.utas.edu.au/schools/hcs/index.html
Campus:	Hobart
E-mail:	richard.turner@utas.edu.au
Phone:	03 - 62264840
Fax:	03 - 62264787
Consultation hours:	by appointment
Medical Education Adviser	Wendy Page (phone: 6226 4844)

LAUNCESTON CLINICAL SCHOOL

Unit coordinator/lecturer:	Associate Professor Jan Radford
Unit web site URL:	http://www.medicine.utas.edu.au/schools/lcs/index.html
Campus:	Launceston
E-mail:	J.Radford@utas.edu.au
Phone:	03 - 6348 8791
Fax:	03 - 6348 8798
Consultation hours:	by appointment
Medical Education Adviser	Robin Ikin (Phone: 6348 7428)

RURAL CLINICAL SCHOOL

Unit coordinator/ lecturer:	Associate Professor Lizzie Shires
Unit web site URL:	http://www.utas.edu.au/rural-clinical-school/
Campus:	Burnie
E-mail:	rccsstudent.enquiries@utas.edu.au
Phone:	03 - 6430 4550
Email:	03 - 6431 5670
Consultation hours:	by appointment
Medical Education Advisers:	Rose Moore or Dr Nick Towle (Phone 64 304 550) or email rosemarie.moore@utas.edu.au or Nick.Towle@utas.edu.au

1. Unit Summary

Unit code	CAM431, 432; CAM433, 434; CAM435, 436,
Unit title	Medicine Year 4
Unit description	This unit is integrated with the programme in the following year of the course. Students will be placed in a range of clinical attachments. Overall objectives are organised by the themes of Human Health & Disease (HHD), Communication & Collaboration (C&C), Community Health & Disease (CHD), Personal & Professional Development (PPD) and Integration (INT). Weekly integrated teaching sessions will cover key common problems expected to be managed by interns, will be case-based and will require self-directed learning approaches.
Special notes	
Teaching staff	Coordinators: Prof Richard Turner HCS, Assoc Prof Jan Radford LCS and Assoc Prof Lizzi Shires RCS. Teaching by academic members of the clinical disciplines of the School of Medicine, consultants of the HCS, LCS and RCS and affiliated hospitals, General Practitioners, and other health professionals.
Campus & mode	Hobart, Launceston and Cradle Coast Internal
Unit weight	CAM 431, 433, 435 = 50%; CAM 432, 434, 436 = 50%
Teaching pattern	Case-based class teaching; presentation of topics relating to key common problems; ward and school based small group tutorials for development of clinical skills, clinical attachments to hospital staff and general practitioners.
Pre and Co-requisites	Successful completion of 3rd Year Medicine of the 5 year course
Mutual exclusions	N/A

2. Assessment

2.1 Portfolio of learning

The portfolio of learning contains both formative and summative aspects.

The formative components of the portfolio may vary across Clinical Schools. Check your Clinical School's guidelines.

There are essential components of the portfolio which are common to all Clinical Schools and become part of the summative unit assessment. These essential components are:

1) **An introduction, to the reader of the portfolio, about yourself especially your professional attributes, capabilities, aspirations, community engagement and achievements:** This is an opportunity to describe your professional journey to date so the reader of your portfolio can contextualise the contents of the portfolio and make a judgment about your overarching ability to be a reflective practitioner, and future competent medical practitioner. Sections of the portfolio may be used as evidence against your claims or other evidence may be introduced into this section. A guiding framework and method of assessment for this component of your portfolio will be developed with input from students by August 2012.

2) **Clinical Attachment Assessment:** an assessment for each clinical attachment of 2 weeks or longer signed off by the discipline coordinator or delegate based on performance during the attachment including performance in any assessment tasks set by the discipline concerned during the attachment.

   Attachment workbooks should provide evidence of more than 15 logged patients per week, using short, disease-orientated descriptors. At least 4 of these patient encounters are to be used to write detailed reports. It is assumed you will have either clerked or had a deeper learning involvement with these 4 patients. Detailed reports should convey a clinically organised appreciation of relevant positive and negative features of the patient presentation and learning points supported by high quality references. If your rotation offers fewer than 15 patient contacts per week speak to your rotation co-ordinator about this.

   It is each student's responsibility to ensure that this form is submitted to the clinical attachment assessor **and returned to the Year supervisor's office within 1 week of completion of the clinical attachment.**

Where there is an unsatisfactory clinical attachment report, a meeting will be held between the student, the discipline coordinator and the Unit Coordinator at which a decision as to remediation requirements and processes will be made. Where a student has two unsatisfactory clinical attachment reports remaining after appropriate remediation, this will be considered as a fail and the student will not be eligible to pass the unit.

3) **A Log of Skills** in which student's record information about procedures seen and/or performed during the hospital and community placements. Each procedure must also note an identifying code for the patient involved such as a hospital UR number, or initials and date of birth, to aid possible random audit of claims made. Students are to be supervised in performing skills in the patient care setting and are expected to seek feedback on how to improve their performance from their supervising clinicians. However a signature from the supervising clinician to evidence assessment of student competence in performing a skill will only be required for the following 6 key competencies.

   Six key competencies must be assessed by a registered clinician as being performed competently by the student. By the end of 4th year these 6 competencies should at least have been signed off as competently performed in simulation teaching. By the end of year venepuncture and intravenous cannulation should be assessed in patient care scenarios as being performed competently. The 6 are:

   - **CPR**
   - **Airway management**
   - **Venepuncture**
   - **Male urinary catheterisation**
   - **Female urinary catheterisation**
   - **Cannulation**

4) **Two reflective pieces**, to be submitted on dates specified by the individual Clinical Schools, written in a prescribed format of 1,000 to 1,500 words each (with a word count included) that reflect the learning outcomes of the themes Personal and Professional Development and Communication and Collaboration. Your clinical school may specify discussion areas for a reflective piece.

5) **Mini clinical examination exercise (mini-CEX)**

   In each of years 4 & 5, two (2) mini-CEX per rotation lasting 2 weeks or longer and one (1) per rotation one week rotations, will be required to be placed in your portfolio. The mini-CEX submitted must have been assessed as satisfactory or superior in the overall clinical competence criteria. A mix of complexity and domain focus for the compiled mini-CEX is also expected. Students may practice their mini-CEX for formative purposes but the summative mini-CEX will be with clinicians designated by the Clinical School.

6) **Evidence of ongoing participation in CBL learning tasks.** The requirements for this portfolio component may vary among the Clinical Schools. Students should consult their Clinical School handbook or MyLO website for requirements.

During the year, students will be assessed on the components of their portfolios and will have an opportunity for formative assessment. The exact nature of these formative assessment

components will be determined by each Clinical School. The content of formative assessment will be standardised across all three schools.

2.2 End of year summative

2.2.1 Passing 7 out of 10 OSCE stations: early November 2012

2.2.2 An EMQ/MCQ written examination. This will consist of 2 written papers of 2 hours each: early November 2012.
Students are required to pass the summative EMQ/MCQ written examination as per the Hofstee method of determining the pass mark.

2.2.3 Satisfactory completion of portfolio as outlined above is required to obtain the ungraded pass (UP) awarded for this unit.

If any components of a student's portfolio are missing from the portfolio a student's work may be graded as NS until all components of the portfolio are completed upon which the NS grade may be converted to a supplementary pass (SP). The SP grade will then appear on the student's academic record. Students who have a legitimate reason for missing components of the portfolio by the due assessment date will have their grade withheld (WT) pending completion within the supplementary period. They may then be eligible for an ungraded pass (UP).
Supplementary examinations for the EMQ/MCQ written exam and OSCE exam will be offered to students if:

- The EMQ/MCQ written exam mark is above minus 1 standard error of measurement of the pass mark
- 5 or 6 OSCE stations have been passed

A student who meets both of these criteria will fail outright and will not be offered a supplementary examination in either examination

The result awarded for this unit is an ungraded pass (UP), supplementary pass (SP) or fail (NN).

2.3 Required texts, recommended reading

These are listed in the Year 4 Handbook and any additions will be provided at the beginning of each attachment.

Websites: There are a number of websites that medical students will find useful such as Up-to-Date and MD Consult. These can be found on the UTAS Library website, under 'data bases'.

2.4 Further learning resources

Faculty website http://www.healthsci.utas.edu.au/

School web site http://www.medicine.utas.edu.au/

MyLO Online resources https://mylo.utas.edu.au/webct/entryPageIns.dowebct

2.5 Access to information technology

Computer facilities are provided for students in each of the three Clinical Schools. Access to a personal computer would also be advantageous.

3. Learning Outcomes/Medical Graduate Profile

The outcomes of this unit are reflected in the overall objectives and competencies of the MBBS. The Tasmanian School of Medicine has defined the attributes that medical students should exhibit on graduation in the Medical Graduate Profile (MGP) which is organised by the themes of

1) human health and disease,
2) communication and collaboration,
3) community health and disease,
4) personal and professional development, and
5) integration.

Theme 1: Human Health & Disease (HHD)

1. Understands the scientific basis of health and disease

1.1 understands the molecular, cellular, tissue, organ and system organisation of the human body
1.2 understands the relationship between structure and function of cells, tissues, organs and systems
1.3 demonstrates the ability to observe and interpret aberrant structure and dysfunction of cells, tissues, organs and systems using correct terminology
1.4 describes the pathogenesis and clinical manifestations of a range of specific common diseases
1.5 understands the use of common therapeutic interventions in health care.

2. Understands the relevance of basic science to the clinical setting

2.1 demonstrates knowledge of the applicable basic science in common clinical presentations
2.2 demonstrates the ability to develop a differential diagnosis based on interpretation of clinical manifestations, laboratory tests and other investigational technology
2.3 demonstrates the ability to select and interpret appropriate diagnostic investigations
2.4 demonstrates an understanding of the evolution of the scientific and evidence-based approach to clinical practise.

3. Understands the role of technology in medicine

3.1 demonstrates understanding of role of technology utilised in laboratory and other investigational methods
3.2 demonstrates understanding of technology used in patient monitoring and eliciting clinical signs
3.3 understands the role of information technology as a resource for diagnosis, prescribing and monitoring within clinical practise.

4. Demonstrates the ability to systematically elicit and interpret clinical symptoms and signs

4.1 demonstrates the ability to take a systematic history in all clinical settings
4.2 demonstrates the ability to examine a patient on both a regional and a systems basis.

5. Demonstrates the ability to perform clinical procedures, especially those required in life saving situations

5.1 demonstrates the ability to perform all clinical procedures outlined in the "clinical procedures" section of the learning portfolio document.

6. Understands the limitations to scientific knowledge

6.1 understands that medical science knowledge is rapidly evolving and requires frequent critical review
6.2 understands the current limitations in the scientific understanding of disease processes and therapeutic approaches
6.3 understands the role and contribution of medical science to the overall concepts of health and disease in individuals and populations
6.4 understands the effect that social, mental and spiritual factors have on health and disease.

Theme 2: Communication & Collaboration (C&C) (N.B. the ability to communicate effectively in English is considered a pre-requisite for meeting outcomes in this theme)

7. Demonstrates an understanding of the therapeutic relationship between patient and doctor

- 7.1 understands and manages issues of boundaries between patient and doctor
- 7.2 demonstrates respect for patients' differing cultures and values, and understands how these effect the therapeutic relationship
- 7.3 understands and applies concepts of patient confidentiality
- 7.4 understands the potential therapeutic effect of the medical consultation process
- 7.5 understands the importance of the role of doctor as patients' advocate (acting in the patient's best interest).

8. Demonstrates appropriate and effective communication skills in a variety of settings

- 8.1 demonstrates appropriate communication skills in consultations/interviews with patients, their families and their carers
  - 8.1.1 demonstrates the ability to open (including establishing rapport), control and close a consultation
  - 8.1.2 demonstrates the ability to identify the ideas, concerns and expectations of patients, their families and carers
  - 8.1.3 demonstrates the ability to consult appropriately with children, adolescents, persons with an intellectual disability and with more than one patient at a time
  - 8.1.4 demonstrates the use of the following communication skills: open and closed questioning, active listening, reflecting, silence, empathy, summarising, clarifying
  - 8.1.5 demonstrates appropriate non-verbal communication
  - 8.1.6 demonstrates the ability to break bad news appropriately
  - 8.1.7 demonstrates the following skills in patient education: providing information, aiding understanding, achieving shared understanding
  - 8.1.8 demonstrates counselling skills relevant to a medical consultation.

- 8.2 Demonstrates the ability to access, record, organise and present information particularly through technology based activity
  - 8.2.1 demonstrates the ability to produce a written case history for acute and chronic, and physical and mental health problems
  - 8.2.2 demonstrates the ability to write a referral letter
  - 8.2.3 demonstrates the ability to write a discharge letter
  - 8.2.4 demonstrates the ability to present a case in a clinical setting (e.g. ward round, case conference, verbal referral)
  - 8.2.5 demonstrates the ability to record and input health information electronically
  - 8.2.6 demonstrates the ability to present information and concepts in written format, particularly using standard formats for reports and papers
  - 8.2.7 demonstrates the ability to present information and concepts verbally (includes the use of PowerPoint)
  - 8.2.8 understands the role of telemedicine and its application in health care.

9. Demonstrates the ability to work collaboratively with colleagues in the healthcare team setting

- 9.1 understands theoretical concepts of teamworking
- 9.2 demonstrates the ability to work in teams with other medical students/doctors
- 9.3 demonstrates the ability to work in a multi-disciplinary team.

10. Understands the principles of providing a leadership role, where appropriate, to health care teams

- 10.1 understands theoretical concepts of leadership
- 10.2 identifies the application of leadership skills in a health care team environment.

Theme 3: Community Health & Disease (CHD)

11. Understands the Australian Health Care System including its funding, planning and major national priorities and contrasts this with the global context of healthcare provision

11.1 understands the major principles of a universal health care system
11.2 understands the roles and operation of Medicare Australia
11.3 understands how Australian health services are funded
11.4 understands the roles and operation of the Pharmaceutical Benefits Schedule, the Medicare Benefits Schedule
11.5 understands the roles of, and differences between, public and private health care systems in Australia
11.6 understands the national health priorities, how they are defined, and how they are interpreted at State/Territory level
11.7 understands the major Australian Government health care programs and policies
11.8 compares and contrasts the Australian health care system with those in SE Asia, Europe, and North America
11.9 understands the role and consumers and consumer groups in the design, development and delivery of health care.

12. Understands the social, political, economic, cultural and spiritual factors that impact upon the health of individuals and communities

12.1 understands the WHO definition of health and its relevance to 21st century Australia
12.2 understands the principles of primary health care
12.3 critically appraises health-related political policies
12.4 understands the role of health professional and consumer bodies in relation to improving the health of individuals and communities
12.5 applies an understanding of an individual's social, economic, environmental, cultural and spiritual context in the construction of a management plan
12.6 understands the relationships between the environment (natural and man-made) and the health of individuals and communities.

13. Understands the principles involved in the effective utilisation of hospital and community based resources and networks

13.1 understands the burden of disease upon populations
13.2 describes the factors which affect public hospital usage
13.3 describes the methods used by hospital services to cost and ration their services
13.4 understands the divisions of labour in hospital and community health service delivery in terms of medical, nursing and allied health workforce
13.5 understands the roles of community based/charitable organisations in the provision of healthcare
13.6 understands the scope of community based health care in Australia and its connection to mainstream tertiary care services
13.7 understands how integration between health services and networks in hospital and the community can effect outcomes of care.

14. Understands the various roles of the doctor in health promotion, health maintenance, disease prevention and treatment at both population health and individual patient levels

14.1 understands the evidence base for changing behaviour in both patients and clinicians
14.2 understands the concepts of health promotion, health maintenance and disease prevention
14.3 understands the roles of doctors in treating individual patients and understands the difference in approach between curative, health maintenance and palliative treatment
14.4 understands the role of doctors in health promotion and disease prevention at the individual patient level
14.5 understands public and population health approaches to health care
14.6 understands the role of the doctor as the patient's advocate.

15. Demonstrates an understanding of knowledge generation and application through community based research and education programmes

15.1 identifies and accesses the major sources of knowledge and information available to medical practitioners working in community health care
15.2 understands the means by which medical practitioners can engage with their community in research and education programs including the identification of barriers and strategies to overcome these
15.3 understands methods that allow interaction with other health professionals in the community around research and education collaboration.

16. Understands the special needs of certain communities including access and equity issues

16.1 understands the socio-cultural perspectives of health and health care needs of Aboriginal and Torres Strait Islanders
16.2 understands the difference in the health status of rural and remote living Australians compared with those in urban and outer metropolitan areas
16.3 understands the cultural practices of non-Western people around traditional healing methods and practices
16.4 understands how the context of the health care setting influences clinical practice.

Theme 4: Personal & Professional Development (PPD)

17. Demonstrates a commitment to compassionate, professional and ethical behaviour

17.1 understands and applies bioethical principles in discussions of clinical cases
17.2 demonstrates the ability to gain informed consent for medical procedures
17.3 demonstrates an understanding of the role of ethics committees in bio-medical and social research.

18. Demonstrates the ability to recognise one's own strengths and weaknesses and to be open to assistance from others when needed

18.1 demonstrates the ability to critique their own performance
18.2 demonstrates the ability to recognise the limitations of their own expertise in caring for a patient
18.3 demonstrates the ability to refer a patient when appropriate.

19. Understands the legal responsibilities of a medical practitioner

19.1 demonstrates the ability to analyse a clinical case drawing upon both legal and ethical responsibilities
19.2 understands and applies the concept of duty of care
19.3 demonstrates the ability to create and defend a reasoned position upon ethical issues throughout the life cycle (fertility and assisted reproduction, termination of pregnancy, caring for two patients in the antenatal setting, adolescence, onset of impairment, death and dying)
19.4 understands substituted decision making
19.5 understands the provision of medical indemnity
19.6 understands the Mental Health Act and legal responsibilities associated with the delivery of public health.

20. Understands the need for respect of the inherent dignity of every human being

20.1 demonstrates the ability to explore their own reactions to patients with physical and mental disability, social disadvantage, ageing and death in terms of the normative aspects of health, and their own personal value system.

21. Understands the principles of quality improvement, risk management and patient safety

21.1 understands the concepts of open disclosure and safety and quality principles in terms of trust, ethics, and systems
21.2 demonstrates the ability to undertake quality improvement activities.

22. Demonstrates personal, organisational and time management skills

22.1 understands concepts of stress, and applies strategies for self-care
22.2 understands and applies time management skills.

23. Demonstrates a commitment to lifelong learning, self-appraisal and reflection

23.1 understands and applies concepts of reflective practice
23.2 demonstrates ability to define their own learning needs in a given situation.

Theme 5: Integration (INT)

24. Demonstrates an ability to apply critical and creative thinking to a range of problems

24.1 creates and defends reasonable, individualised differential diagnoses for a variety of patient presentations
24.2 creates and defends reasonable, situational, cost-effective investigation plans for a variety of patient presentations
24.3 enunciates and defends appropriate ethical positions in relationship to proposed actions in a variety of clinical situations.

25. Demonstrates an ability to integrate and synthesise disparate material to arrive at the most appropriate solution to a problem

25.1 understands the principles of evidence-based healthcare, health economics, and decision analysis
25.2 demonstrates the ability to identify their own information needs, and devises appropriate search strategies to address them
25.3 demonstrates an ability to critically review scientific and clinical literature and apply it to patient care
25.4 demonstrates the ability to appropriately prioritise patients' problems.

26. Demonstrates the ability to develop, in consultation, an appropriate patient-centred management plan

26.1 enunciates the extent and limitation of contributions by other health professionals to the management of a given patient
26.2 outlines appropriate medical interventions for a variety of patient presentations, in various clinical settings.
26.3 integrates hospital discharge, referral, investigations, rehabilitation planning, and patient review into patient management plans as appropriate.

27. Demonstrates an understanding of the principles of medical research and its application

27.1 understands methodologies underlying major research approaches from experimental basic to population-based investigations (quantitative and qualitative)
27.2 understands and applies statistical approaches to the level required to extract and apply data to clinical settings.

28. Demonstrates information literacy skills

28.1 recognises the need for information in given situations
28.2 demonstrates the ability to find information, particularly through electronic sources
28.3 demonstrates the ability to critically evaluate information
28.4 demonstrates the ability to manage information
28.5 demonstrates the ability to synthesise new information with existing information to create new understanding.

4. Details of teaching arrangements

4.1 Clinical attachments

Clinical attachments and community placements will be outlined in detail in the guidelines and workbooks for each Clinical School.

4.2 Electives

The elective term is a compulsory component of the MBBS course. Year 4 students in 2012 are required to do an elective placement of 4-6 weeks in one of the following areas:

- a hospital or medical institution (including General Practice) in Australia or overseas; or
- with a medical practitioner in Australia or overseas.

It is the responsibility of students to organise their elective and it is strongly advised to start making arrangements early in the year, especially for overseas placements. It is especially

important to request an appropriate person to act as a supervisor. For further information contact the Electives Co-ordinator, Electives@med.utas.edu.au.

As part of your portfolio requirement, in your final year the elective report is to be delivered publically to peers and teachers in any of a range of formats – written, class presentation, poster or by electronic means. Each school will advise on the schedule and/or preferred means for public deliver of reports. Keep this in mind as you undertake your elective and prepare your final year portfolio components.

4.3 Integrated case-based learning (CBL)

Weekly case-based teaching sessions will occur in each Clinical School covering a set of core topics. A schedule of the weekly case-based learning topics will also be found in the individual Clinical School Guidelines and in MyLO.

4.4 Lectures/intensive sessions/tutorials

Teaching sessions will be organised by each Clinical School, and details will be found in the Guidelines for each Clinical School and in MyLO.

4.5 Online activities

Each Clinical School will provide information about on-line activities.

Therapeutics teaching will include the web-based resources of the National Prescribing Service:
http://npsprescribe.lamsinternational.com/lams (students can register online)
www.nps.org.au and click on Health Professionals;
and
http://nps.org.au/health_professionals/publications/nps_radar

4.6 Videoconference activities

For information about videoconferencing at UTAS and how to participate effectively, see the Students' guide to Videoconferencing available at:
http://fcms.its.utas.edu.au/files/policies/videoconfguidelines(3).pdf.

4.7 MyLO (My Learning Online)

Use of MyLO to support learning will be used by all Clinical Schools in 2012.
https://mylo.utas.edu.au/webct/entryPageIns.dowebct

4.8 Practical/laboratory/simulation sessions

Practical sessions may be organised from time to time, depending on student needs. These will be announced by the individual Clinical Schools.

4.9 National Registration of students in the Health Professions (AHPRA)

Australia's new national registration and accreditation scheme began on 1 July 2010 under a new National Law (the *Health Practitioner Regulation National Law Act2009*) and 10 health professions (including nursing and midwifery, medicine and pharmacy) will be regulated by a consistent piece of legislation. From March 2011, all students enrolled in an accredited course will be included in the national scheme.

Individual students from relevant courses do NOT need to do anything now to register with their National Board. Students will be registered automatically from March 2011. Please read the *AHPRA Student Registration Fact Sheet* or visit the AHPRA website for further information.

4.10 Occupational health and safety (OH&S)

The University is committed to providing a safe and secure teaching and learning environment. Students are required to demonstrate compliance with policies relevant to learning in the workplace. The health sciences "Safety in Practice Kit" is the relevant policy and is found at: http://fcms.its.utas.edu.au/healthsci/healthsci/cpage.asp?lCpageID=469

As well, students working in different Clinical Schools should consult the OH&S website for the hospital or other worksites to which they are attached.

4.11 Faculty of Health Science – Code of Conduct

The Faculty of Health Science *Code of Professional and Ethical Conduct* contains rules which must be adhered to by all students, particularly those undertaking professional placements – clinical placements, community visits, laboratory work or field work placements. It is consistent with other university codes (Teaching & Learning Code of Practice) and policies (e.g. misconduct). These rules are as clear, precise and unambiguous as possible and constitute basic, non-negotiable requirements for completion of a degree at the University of Tasmania. It is not possible to create a rule for every situation or contingency, hence the Code also provides a framework for you to apply to different circumstances during training but also later on in professional practice. The Code can be found on the Faculty of Health Science website http://fcms.its.utas.edu.au/healthsci/healthsci/files/Safety%20in%20Practice%20Kit.pdf

4.12 National Police Record Check

Students enrolled or enrolling in courses offered by Health Sciences that have compulsory professional placements, laboratory and/or field activity must provide the School, and if requested the placement agency, with an original copy of their National Police Certificate in order to be eligible to undertake placements. Certain convictions will require the University to make a decision as to whether you may take up or continue a placement. Where this occurs you will be notified by the relevant University staff member.

Students will be required to undertake a National Police Record Check in years 1 and 4 (if applicable) of their course and sign a Compulsory Declaration in each of the other years of the course that states there has been no change to their criminal history record.

Students whose criminal history changes at any time during the course of their studies are required to immediately notify the School and may be required to undertake a new National Police Record Check. If you are a prospective student the National Police Certificate should be supplied upon enrolment.

Students who do not supply a Police Certificate or a signed Compulsory Declaration to the School cannot complete placements and therefore risk not being able to complete the course.

For further information on how to obtain a valid Police Check Record please refer to the Health Science National Police Record Check Procedures and Guidelines. Details can be found on the Faculty of Health Science website
http://fcms.its.utas.edu.au/healthsci/healthsci/files/Safety%20in%20Practice%20Kit.pdf

4.13 Safety in practice

The University is committed to providing a safe and secure environment for all students, staff, patients and other community members. In accordance with the University of Tasmania Safe to Practice Policy and Occupational Health & Safety Policy, all students intending to undertake professional experience placement, laboratory or fieldwork (either on- of off-campus) are required to establish and maintain their medical, physical and psychological capacity to practice safely. In signing Student Placement Agreements, students are obliged to declare any condition that may impact upon their ability to safely engage in professional placements, so that peers, staff and community members are not at significant risk of harm. Details can be found on the Faculty of Health Science website
http://fcms.its.utas.edu.au/healthsci/healthsci/files/Safety%20in%20Practice%20Kit.pdf

The University is committed to anti-discrimination practices and will provide reasonable adjustments to enable students to participate in placement, laboratory and field activities as long as safety requirements are not compromised.

4.14 Infectious Diseases and Exposure to body fluids

The Faculty of Health Science actively promotes measures to prevent or minimise the risk of transmission of infectious and/or blood-borne diseases including infection control practices; immunisations; serological and other testing of immunity and student access to OH&S management programs within placement agencies. Students who undertake healthcare placements/rotations are subject to and covered by the individual health care establishment/agency's Occupational Exposure to Blood and Body Fluids Policy. Students must become familiar with such policies and act in accordance with the procedures if exposure occurs. Students must subsequently notify the University in accordance with the UTAS OH&S Policy if exposure occurs. More details are provided in the Infectious Diseases Toolbox. Details can be found on the Faculty of Health Science website
http://fcms.its.utas.edu.au/healthsci/healthsci/files/Safety%20in%20Practice%20Kit.pdf

Students who are required to undertake Workplace Learning Placements (including professional placements, clinical placements, community visits, laboratory and/or field activity) must read and document their understanding of the Health Sciences Infectious Disease Guidelines and Procedures by providing a completed Health Care Provider Form and, if applicable, a completed Tuberculosis Screening Form to the School in which they are enrolled upon enrolment or, if already enrolled, prior to commencing a placement.

In order to commence workplace learning outside of the University of Tasmania students are required to demonstrate compliance with the University Workplace Learning Placements Policy and familiarise themselves with Health Sciences Safe to Practice guidelines and procedures relevant to workplace based learning. Students who do not comply with University policy or adhere to relevant guidelines and procedures may not be placed or will be removed from placements and therefore risk not be able to complete this course. Students who have not complied or are unsure of the policies, guidelines and procedures should seek guidance from the School.

5. Learning Expectations and Strategies

The University is committed to high standards of professional conduct in all activities, and holds its commitment and responsibilities to its students as being of paramount importance. Likewise, it holds expectations about the responsibilities students have as they pursue their studies within the special environment the University offers.

The University's Code of Conduct for Teaching and Learning states:
Students are expected to participate actively and positively in the teaching/learning environment. They must attend classes when and as required, strive to maintain steady progress within the subject or unit framework, comply with workload expectations, and submit required work on time.

6. Further Information and Assistance

If a student is experiencing difficulties with studies or assignments, has personal or life planning issues, disability or illness which may affect their course of study, they are advised to raise these with their Associate Head of School in the first instance.

There are a range of University-wide support services available including Teaching & Learning, Student Services, International Services. Please refer to the *Current Students* homepage at: http://www.utas.edu.au/students/.

Should students require assistance in accessing the Library, visit their website for more information at http://www.utas.edu.au/library/.

Medical Education Adviser
Each Clinical School has a Medical Education Adviser (MEA) whose role is to work with the clinical teaching staff and support the sound educational delivery of the clinical program offered by the school. The MEA may advise on assessment strategies and evaluation of course work; may be involved in remediation programs; and may refer students appropriately in the event of dispute or appeal.

For additional information refer to the Learning Support website:
http://www.learningsupport.utas.edu.au/

7. Specific Attendance/Performance Requirements

A student enrolled in this unit must -

a) attend a minimum of 80 % of lectures, tutorials and clinical attachments. Students are strongly encouraged to attend all scheduled classes. Students are reminded that satisfactory clinical reports are summative components of the portfolio. Such assessments will obviously be significantly influenced by attendance patterns. Students must apply on the appropriate form available from your clinical school for absences due to illness/other reasons, either before, or as soon after the event as possible.

b) carry out all formative and summative assessment tasks as specified.

8. How your Final Result is Determined

Establishing a pass/fail standard

In the written papers the Clinical Schools use a mixed method of standard setting with elements of absolute and relative standard- setting procedures.

In the OSCE the Clinical Schools use an absolute standard, not a relative standard, against which student work or performances are assessed. Thus a student's assessment outcome is dependent

on their own efforts alone judged against an absolute standard not on their performance relative to their peers. Thus the standard to achieve a pass is not automatically fifty percent.

The methods used for each assessment task are described below.

8.1 Objective Structured Clinical Examination (OSCE)

The discipline-integrated OSCE consists of 10 summative stations at the end of the year with rest and/or reading stations in between. Each station will be assessed in two ways:

1) Thirteen marks out of 20 are awarded using a scoring grid against a set of predetermined criteria. Seven marks out of 20 are awarded for global performance. The sum of these marks becomes the score out of 20.
2) An overall assessment of the student's performance against the criteria will be graded as fail, borderline, or pass. The mean scores of the borderline students are used to establish the pass mark for that station. This method of standard setting is the "borderline group" method

Dangerous responses

Potentially lethal responses (actions that might result in serious harm to a patient in this or a related scenario) may result in zero marks being awarded for the global performance for that station; remediation may be required.

Reference:

Boursicot K, Roberts T & Burdick W. (2010) Structured assessments of clinical competence. In Swanick T(ed) *Understanding medical education: evidence, theory, and practice* , pp246-258. Association for the Study of Medical Education & Wiley-Blackwall, Chichester.

Students are required to pass at least 7 out of the 10 summative OSCE stations held throughout the year to attain a pass in this assessment.

8.2 MCQ/EMQ

The multiple choice paper will consist of both extended matching (EMQ) and best answer out of five (MCQ) types of questions delivered as 2 papers of 2 hours duration each. The marks are awarded as follows:

Correct - 1 mark
Not attempted or incorrect - 0 mark

To set the standard for the pass mark for the MCQ/EMQ examination the Hofstee Method is used. The following explanation, including diagram is found in the USA's National Board of Medical Examiner's publication "Item Writing Manual", 3rd edition, chapter IV. This publication is recognised internationally as describing best practice in the area of assessment in medical education. It is available from the NBME's website, accessed 15 November 2011 at www.nbme.org/PDF/ItemWriting_2003/2003IWGsectionIV.pdf

The steps of the Hofstee Method of standard setting are:

1. Six or more judges (university academic clinicians) are asked to review a copy of the written exam.
2. The judges then indicate the following values, which define acceptable standards:

a. Lowest acceptable percentage of failing candidates (minimum failure rate)
b. Highest acceptable percentage of failing candidates (maximum failure rate)
c. Lowest score which would allow someone to pass (minimum passing point)
d. Highest score required for someone to pass (maximum passing point)

3. After the exam, the candidates' results are plotted showing the fail rate as a function of the passing score.
4. The 4 values obtained in points 2(a to d) are drawn, forming a rectangle. The median values of the judges are used.
5. A line in drawn on the diagonal from upper left to lower right. The point where this intersects the curve is the pass mark.

8.3 Portfolio Contents

The portfolio contents should be present and have been assessed to meet a minimum standard as outlined in section 2.1

8.4 Remediation and Supplementary criteria

8.4.1 Remediation in submitted (written) assessments

Students failing to submit, or submitting unsatisfactory written work, may be given one further opportunity to resubmit for assessment. Students will be notified of the agreed process by the Unit Coordinator. The maximum mark obtainable for resubmitted, graded work is 50% (where percentages are given). Students who then resubmit unsatisfactory written work, or fail to comply, will be deemed to have failed. Failure in an element of the portfolio results in a fail for the unit and the student will not be eligible to sit the summative exam.

8.4.2 Remediation in clinical attachments

Students who receive a borderline or an unsatisfactory clinical attachment report are required to meet with the Assessor (usually the Head of the relevant discipline) and the Unit Coordinator. As a result of these discussions, a remediation program may be instituted. Remediation may require the students to repeat the clinical attachment in their own time, or use the elective period for further time in a clinical attachment and specific learning activities to be undertaken during that time. If remediation is agreed upon, a formal reassessment of the student will be conducted by the Discipline Head and the Unit Coordinator, or their representative after completion of remediation activities.

If after remediation, the assessment remains unsatisfactory, this will be recorded. If a student receives two adverse or failed clinical attachments, they are deemed to have failed and will not be eligible to progress to Year 5.

8.4.3 Remediation in skills or related activities

If the portfolio is not complete or not satisfactory, the student may be given additional help or guidance in achieving a satisfactory result. As the portfolio is reviewed at the end of each Semester, students will be notified of any deficiencies that require attention.

8.4.4 Supplementary OSCE

Students are expected to pass at least 7 of the 10 OSCE stations for the year. If a student has an unsatisfactory result, but has passed 5 or 6 OSCEs they may be offered to sit a 10 station OSCE supplementary examination. Students must pass at least 7 of these stations to pass this section of the exam. Students are reminded that this supplementary examination will be offered at only one of the Clinical Schools. The requirement to sit a supplementary assessment will not be released until the usual university Semester 2 results period. Students should bear this in mind when arranging and booking/paying for end-of-year travel plans.

8.4.5 Supplementary MCQ/EMQ examination

Students are expected to pass the written examination using the pass mark determined by the Hofstee method. If a student's mark is more than 1 standard error of measurement below this pass mark they will not be eligible to sit a supplementary examination. Students' performance in their OSCE examination will also determine if a supplementary written examination will be offered.

8.5 Requests for extensions

Where there are genuine reasons, requests for extensions can be made. They have to be made on the prescribed form and submitted to your clinical school office before the due date. They cannot be accepted on the due date. If an emergency occurs on the day of submission then supporting medical certification will be required.

8.6 Penalties

In the absence of an extension being applied for and granted, a penalty will be applied for the late submission of written work, which may result in the student failing that piece of work. Given that all components of the portfolio must be submitted and satisfactory; this may then impact on the student's final result in the unit.

8.7 Review of results and appeals

Information on procedures to request a review of assessment or to lodge an appeal against a decision can be found at:

http://www.utas.edu.au/governance-legal/student-complaints/how-to-reslolve-a-student-complaint/self-help-checklist#aca

8.8 Academic referencing

In written work students will need to support their ideas by referring to scholarly literature, works of art and/or inventions. It is important to understand how to correctly refer to the work of others and maintain academic integrity.

Failure to appropriately acknowledge the ideas of others constitutes academic dishonesty (plagiarism), a matter considered by the University of Tasmania as a serious offence.

The Vancouver style of referencing should be used for this unit.

For information on presentation of assignments, including referencing styles:http://utas.libguides.com/content.php?pid=27520&sid=199792

8.9 Academic Misconduct, Dishonesty and Plagiarism

Academic misconduct includes cheating, plagiarism and any other conduct by which a student seeks to gain, for themselves or for any other person, any academic advantage or advancement to which they or that other person are not entitled; or to improperly disadvantages any other student.

Academic integrity is about mastering the art of scholarship. Scholarship involves researching, understanding and building upon the work of others and requires that you give credit where it is due and acknowledge the contributions of others to your own intellectual efforts. At its core, academic integrity requires honesty. This involves being responsible for ethical scholarship and for knowing what academic dishonesty is and how to avoid it.

Plagiarism
Plagiarism is a form of cheating. It is taking and using someone else's thoughts, writings or inventions and representing them as your own; e.g., using an author's words without putting them in quotation marks and citing the source; using an author's ideas without proper acknowledgment and citation; copying another student's work.

If you have any doubts about how to refer to the work of others in your assignments, please consult your lecturer or tutor for relevant referencing guidelines, and the academic integrity resources on the web at http://www.academicintegrity.utas.edu.au

Self-copying/Re-submission of assessment. It is inappropriate to copy your own work, in part or in whole, and submit it for assessment in more than one Unit of study at this, or another, university. This also applies to students repeating a Unit. Unless otherwise approved, all assessment tasks undertaken in a unit must be done within the enrolment period.

Group work. It is important that all group members make appropriate contributions to the required task. Copying from others, or contributing less, little or nothing to a group assignment and then claiming an equal share of the marks are not appropriate. When working as a member of a group or team, it is important to keep records of your own work. Even though you may have group discussions and work together – always write your own notes, and keep records what you have personally contributed to any group assessment product/s.

Collusion. Protect your academic work. The intentional sharing of your work potentially allows others to copy your work and cheat and gain an academic advantage. In these circumstances, both you and the person that copied your work may be subject to allegations of academic misconduct.

Falsification and fabrication of data
Academic writing. Increasingly the use of patient data and reflection on experience are embedded in assessment tasks. The falsification and fabrication of student experiences that form the basis of assessment tasks (such as reflective essays) are inconsistent with academic integrity. This may include the fabrication or misrepresentation of patient encounters, interactions with peers, staff or members of the community. The creation of records of experiences for which there is no basis in fact, that misleads or deceives the reader/assessor, is a break of academic integrity and the standards expected of health professionals and University of Tasmania graduates.

Experimental Sciences. In addition to plagiarism, responsible and ethical conduct of research requires that all researchers have confidence in research undertaken and reported to peers. The

falsification and fabrication of data are inconsistent with academic integrity. Falsification of data refers to the selective modification of data collected in the conduct of experimental research, or the misrepresentation of processes or uncertainty during statistical analysis of the data. Falsification may also involve the selective omission, deletion, or suppression of data inconsistent with the research objectives. Fabrication of data refers to the creation of records of research for which there is no basis in fact, that misleads or deceives the reader/assessor, is a breach of academic integrity and the standards expected of health professionals and University of Tasmania graduates.

Penalties.
Breaches of academic integrity are serious offences punishable by penalties that may range from a fine or deduction/cancellation of marks and, in the most serious of cases, to exclusion from a unit, a course or the University. In some cases, students of the health professions may be notified to the Australian Health Professional Regulatory Authority (AHPRA).

Details of penalties that can be imposed are available in the Ordinance of Student Discipline – Part 3 Academic Misconduct, see
http://www.utas.edu.au/__data/assets/pdf_file/0006/23991/ord91.pdf

The University and any persons authorised by the University may submit your assessable works to a plagiarism checking service, to obtain a report on possible instances of plagiarism. Assessable works may also be included in a reference database. It is a condition of this arrangement that the original author's permission is required before a work within the database can be viewed.

9. Examination and Holiday planning

Students are expected to remain on campus at least until the end of the formal University examination period, in mid-November. Deferred Ordinary and Supplementary examinations are held in early- to mid-December. You will be expected to attend the supplementary examination on campus if required."

For further information on this statement and general referencing guidelines, see http://www.utas.edu.au/plagiarism/ .

Software designed to detect plagiarism may be used to screen student's written submitted work.

10. Orientation Program

Attendance at orientation programs is compulsory in all schools. Check your clinical school's requirements.

Appendix 2: Forms

2.1 Clinical Attachment Assessment Form

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FACULTY OF HEALTH SCIENCE
School of Medicine

Clinical Attachment Assessment Form

This Clinical Attachment Assessment form should be completed in consultation with the student who has been assigned to you. This appraisal forms a significant part of the student's portfolio and will form the basis of final year assessment. Please adhere to the following steps:

1. Student completes section 1 and 2A at the beginning of the attachment
2. Student completes section 2B and submits to supervisor at least prior to end of attachment.
3. Supervisor completes section 3.
4. Student initiates a meeting with supervisor to discuss feedback in the final week of the attachment.

Section 1

Student Name	
Student ID Number	
Year of Study	
Title of Attachment	
Dates of Attachment	
Doctor to whom student is assigned	
Attachment Supervisor	
Supervisor's address/phone number	

Section 2

(Student to complete)

A. Personal learning goals for the attachment (establish in first week);

_____
_____
_____
_____
_____
_____

B. End of attachment review of attainment of learning outcomes (in conjunction with ongoing reflective journal and attachment requirements e.g. case histories, log of patients, workbook activities, log of skills):

_____
_____
_____
_____
_____

Section 3

Clinical Attachment Form: Supervisor's Report

To be completed by supervising specialist (or Registrar if more appropriate).

Student Name: _____ Attachment:

	Unsatisfactory	Borderline	Satisfactory	Above average	Excellent	Could not be assessed
Human Health & Disease						
Knowledge						
Evidence based approach						
Communication & Collaboration						
History taking						
Clinical examination						
Management						
Clinical management						
Use and interpretation of investigations						
Communication with patients and relatives						
Procedural skills						
Community Health and Disease						
Understands social aspects of disease						
Disease prevention and health promotion						
Personal and Professional Development						
Professional approach						
Patient confidentiality						
Motivation and reliability						
Participates in the teaching of others						
Teamwork						
Communication with staff						
Medical record keeping						
Appreciation of ethical issues of clinical practice						

Comments:

_____

_____

_____

_____

_____

_____

_____

_____

Areas for improvement

_____

_____

_____

_____

_____

_____

_____

Overall assessment of student's performance during the placement:

Satisfactory **Borderline** **Unsatisfactory**

(Please circle)

Have you provided this feedback to your student? **YES / NO**

_____ _____

Student's signature *Please print name*

_____ _____

Supervisor's signature *Please print name*

_____

Supervisor's position

(Specialist, registrar, attachment co-ordinator) please circle your role(s)

2.2 Short Duration Attachment Form

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School of Medicine

School of Medicine Short Duration Attachments

Note to Students: *Please present this form to your supervisor for each attachment at the beginning of each Attachment.*

Student Name:		
Student ID Number:		
Attachment:		
Did the student attend all the sessions?		
Yes	No	If no, how much did they attend?

During the student's attendance were their dress, manner, deportment etc appropriate?	Yes	No
Did the student ask appropriate questions regarding the placement and the patients?	Yes	No
Did the student's clinical skills seem appropriate to their level of training?	Yes	No
Did the student adhere to appropriate ethical guidelines?	Yes	No

Could you please comment on the following:

1. Were there any factors regarding the student's placement which were a concern?

.....
.....
.....
.....

2. Were there any aspects of the attachment which the student could have improved?

.....
.....
.....
.....

3. Other comments

.....
.....
.....
.....

Have you provided this feedback to the student? Yes No

Supervisor's Name and clinical role: .....
(please print your name)

Supervisor's Signature: ..... Date: .....

Student's Signature: ..... Date: .....

THANK YOU FOR YOUR TIME

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School of Medicine

2.3.1 Simulated CPR

Assessment of Competency Form

Student name…… has completed instruction in CPR and airway management and demonstrated an appropriate level of competence for entry into intern training.

Signed _____ Name *(print)* _____

Position _____

Date _____

URN or Patient Initials and date of birth _____

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School of Medicine

2.3.2 Venepuncture

Assessment of Competency Form

Student name…….…… has demonstrated an appropriate level of competence in venepuncture for entry into intern training.

Signed _____ Name *(print)* _____

Position _____

Date _____

URN or Patient Initials and date of birth _____

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School of Medicine

2.3.3 IV cannulation

Assessment of Competency Form

Student name……..…… has demonstrated an appropriate level of competence in IV cannulation for entry into intern training.

Signed _____ Name *(print)* _____

Position _____

Date _____

URN or Patient Initials and date of birth _____

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School of Medicine

2.3.4 Simulated maintenance of the airway

Assessment of Competency Form

Student name……..…… has demonstrated an appropriate level of competence in Maintenance of the airway for entry into intern training.

Signed _____ Name *(print)* _____

Position _____

Date _____

URN or Patient Initials and date of birth _____

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School of Medicine

2.3.5 Simulated urinary catheter insertion - female

Assessment of Competency Form

Student name……..…… has demonstrated an appropriate level of competence in Urinary catheter insertion – female for entry into intern training.

Signed _____ Name *(print)* _____

Position _____

Date _____

URN or Patient Initials and date of birth _____

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School of Medicine

2.3.6 Simulated urinary catheter insertion – male

Assessment of Competency Form

Student name……..…… has demonstrated an appropriate level of competence in Urinary catheter insertion – male for entry into intern training.

Signed _____ Name *(print)* _____

Position _____

Date _____

URN or Patient Initials and date of birth _____

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School of Medicine

2.3.7 Log of clinical skills summary sheet

Please use the following summary sheets as you compile your evidence. Ticks denote the required level of competence you must demonstrate as a minimum requirement.

Procedural Skill	**1. Number of times observed**	**2. Number of times performed in a simulated environment (Novice)**	**3. Number of times performed in the clinical environment under structured supervision (Competent)**	**4. Number of times performed routinely in the clinical environment under minimal supervision (Proficient)**
EMERGENCY				
Basic First Aid (assumed entry requirement)	✓	✓	✓	✓
Basic Life Support (see ARC guideline)				
D.R.S.A.B.C.D.	✓	✓		
external cardiac massage	✓	✓		
Airway Management (see ARC guideline) including:	✓	✓		
chin lift/head tilt	✓	✓		
manage partial airway obstruction	✓	✓		
or complete airway obstruction	✓	✓		
effective cough	✓	✓		
ineffective cough	✓	✓		
geudel & nasopharyngeal insertion	✓	✓		
bag & mask ventilation	✓	✓		
CPR	✓	✓		
Advanced Life Support (see ARC guidelines) including:	✓	✓		
Good quality CPR	✓	✓		

Rhythm assessment	✓	✓		
(shockable or non shockable)	✓	✓		
Defibrillation	✓	✓		
Immediate CPR	✓	✓		
Procedural Skill	1. **Number of times observed**	2. **. Number of times performed in a simulated environment (Novice)**	3. **Number of times performed in the clinical environment under structured supervision (Competent)**	4. **Number of times performed routinely in the clinical environment under minimal supervision (Proficient)**
Post resuscitation care	✓	✓		
Volume resuscitation	✓	✓		
Appropriate oxygen administration	✓	✓	✓	✓
Nasal prongs and face mask	✓	✓	✓	✓
Cervical spine stabilisation	✓	✓		
GENERAL DOCTOR & PATIENT				
Peak flow meter function testing	✓	✓	✓	✓
Spirometry	✓	✓		
ECG	✓	✓	✓	✓
Blood pressure measurement	✓	✓	✓	✓
Height ,weight/BMI adults and children	✓	✓	✓	✓
EYE, EAR, NOSE & THROAT				
Foreign body removal - ear & nose	✓	✓		
Eye foreign body removal including padding as appropriate	✓	✓		
Ophthalmoscopy	✓	✓	✓	
Slit lamp use	✓	✓		
Eyelid eversion	✓	✓	✓	
Fluroscein - staining of cornea	✓	✓		

External auditory canal irrigation	✓			
External auditory canal ear wick insertion	✓			
GENERAL PROCEDURAL				
Nasogastric tube insertion	✓	✓		
Procedural skill	1. . **Number of times observed**	2. **Number of times performed in a simulated environment (Novice)**	3. **Number of times performed in the clinical environment under structured supervision (Competent)**	4. **Number of times performed routinely in the clinical environment under minimal supervision (Proficient)**
IV cannulation (including set up and IV fluid administration)	✓	✓	✓	✓
Venepuncture for venous blood sample	✓	✓	✓	✓
Collection of arterial blood sample from the radial artery	✓	✓		
Measures blood glucose levels using finger prick testing	✓	✓	✓	✓
Collects blood culture specimens using aseptic techniques	✓	✓	✓	✓
Samples, analyses and reads urinary dipsticks	✓	✓	✓	✓
Lumbar puncture	✓	✓		
Simple swab using standard microbial collection	✓	✓	✓	✓
Preparation for sterile procedures including hand washing.	✓	✓	✓	✓
Sterile preparation techniques for operating theatres including scrub, glove and gown	✓	✓	✓	✓
Use of personal protective equipment	✓	✓	✓	✓
WOMEN'S HEALTH				
Urine pregnancy testing	✓	✓	✓	✓
Pap smear	✓	✓		
Collects vaginal and endocervical swabs	✓	✓		
Female catheterisation	✓	✓		

Communication via Documentation Skill	1. Number of times observed	2. Performed in simulation	3. Performed in a clinical environment but simulated
Write up drug chart	✓	✓	✓
Write a discharge summary or letter	✓	✓	✓
Fill out order forms for investigations	✓	✓	✓
Writing out a death certificate	✓	✓	✓
Write a referral to other health professional	✓	✓	✓

2.4 Reflective Piece Assessment Form

FACULTY OF HEALTH SCIENCE
School of Medicine

Student Name _____ **Date** _____

DISCIPLINE _____

Theme and subsection from Medical Graduate Profile addressed:

_____

	Criteria for a Pass	Examples of Unsatisfactory work	Comments
Doing	The student describes fluently, legibly and clearly the experience. The experience matches the learning outcome.	Writing is illegible or barely legible. There is poor grammar. The examiner is confused or doesn't have a clear idea of the experience. The experience doesn't reflect the learning outcome.	
Reflecting	The student reflects on all the issues relating to the experience. Writing appears honest and non judgmental. Reflection includes demonstrating new insights about knowledge, skills, attitudes and behaviours as appropriate.	The student appears not to understand the experience properly, fails to reflect on obvious/important aspects of the experience. Writing appears clichéd, crafted to telling the examiner what the student thinks the examiner wants to see.	
Connecting	The student describes the "connecting" process. One or more options are described and supported by literature, discussion with colleagues, teaching staff etc.	The student hasn't bothered to "research" the topic or issue. No new ideas emerge or are so superficial as to demonstrate a lack of engagement.	
Deciding	The student describes how he or she would approach a similar situation next time and gives a rationale for his or her choices where appropriate.	There is no logical reason given for the decision. There is no flow through the phases of the cycle. The decision is inappropriate, illegal or dangerous.	

Overall assessment: Satisfactory Borderline Unsatisfactory/Resubmit

Comments:

_____ _____

Examiner's Signature *Please print name and position*

2.5 Mini CEX

Mini CEX assessment form

Student Name:	**Date of assessment:**
Year of study : ❑ **Year 4** ❑ **Year 5**	**Student Number:**
Assessor:	**Assessor's Position:**
Patient problem:	**Specialty:**
Patient age: **Patient gender:** ❑male ❑female	**Case complexity**: ❑low ❑medium ❑high

Focus of assessment: ❑ **history taking** ❑ **examination** ❑ **diagnostic reasoning** ❑ **management** ❑ **explanation**

Setting: ❑ **inpatient** ❑ **outpatient** ❑ **emergency** ❑ **general practice** ❑ **other (please specify)**

Strengths	**Suggestions for improvement**

	Unsatisfactory			**Satisfactory**			**Excellent**			**Not observed**
Medical interviewing skills	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**n/a**
Physical examination skills	1	2	3	4	5	6	7	8	9	n/a
Professional qualities/communication	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**n/a**
Patient education	1	2	3	4	5	6	7	8	9	n/a
Clinical judgement	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**n/a**
Organisation/efficiency	1	2	3	4	5	6	7	8	9	n/a
Overall performance	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**n/a**

Time taken for observation:	**Time taken for feedback:**

Assessor satisfaction with using the Mini CEX	Low	1	2	3	4	5	6	7	8	9	High
Students satisfaction with using the Mini CEX	Low	1	2	3	4	5	6	7	8	9	High

Assessors Signature:_____

Student Signature:_____

Date:_____

Ratings

Unsatisfactory – Gaps in knowledge or skills that you would not expect at this stage of the course. Concerns about professionalism and patient safety

Satisfactory – Standard you would expect for a student at this level at this stage of the year. Generally they are clinically competent and with satisfactory communication skills and professionalism.

Excellent - Performing well above the level that they are at. No concerns about their clinical method, professionalism, organisation, communication etc.

The details below outline the skills associated with each domain in the Mini CEX rating form and Mini CEX framework. Not all skills will necessarily be examined during a single encounter.

Medical Interviewing skills	**Professional qualities/communication**
• Interacts well with patient • Directs questions at key problems • Uses second order of questioning to refine focus • Integrates information from questions • Observes and responds appropriately to non-verbal cues • Considers a range of diagnostic options • Takes a history appropriate to the clinical situation.	• Shows respect for patient • Explains as well as asks • Listen as well as tells • Aware of potentially embarrassing or painful components of interaction • Respects patient confidentiality • Able to adapt questioning and examination to patient's responses. • Presents clinical information in a clear and coherent manner.
Clinical Judgement	**Physical Examination Skills**
• Weighs importance of potentially conflicting clinical data. • Determines appropriate choice of investigations and management. • Relates management options to the patient's own wishes or context. • Considers the risks and benefits of the chosen management/treatment options. • Comes to a firm decision based on available evidence.	• Conducts a systematic and structured physical examination. • Shows sensitivity to patients comfort and modesty. • Detects abnormal signs when present and assesses the significance of these findings. • Gets informed consent • Focuses the examination on the most important components. • Integrates findings on examination with other information to clarify diagnosis.
Patient Education	**Organisation/Efficiency**
• Explains rationale test/treatment • Provides information in a way that is clear and tailored to the patient's needs. • Responds to patient and modifies or repeats information when appropriate. • Listens to patients wishes • Avoids personal opinion and bias	• Synthesises a collection of data quickly and efficiently. • Uses appropriate judgement and synthesis. • Demonstrates optimal use of time in collection of clinical and investigational data.

2.6 Sample Assessment Form for CBL Tasks

UTAS
FACULTY OF HEALTH SCIENCE
School of Medicine

CBL TOPIC _____

CLINICAL TEACHER _____

DATE _____

STUDENT(s) Name(s) _____

LEARNING TASK _____

PRESENTATION MODE **Individual Activity** **Short (5 minutes)** **Long (15 minutes)**
Team Activity **Short (5 minutes)** **Long (15 minutes)**

Task Outcome	Performed Competently	Performed but not yet fully competent	Not performed Competently	Not performed	Not Applicable
Demonstrates understanding of the topic.					
Presents relevant information in a clear manner.					
Actively engages other students in discussion.					
Allows students to question and responds well to their questions.					
Uses communication tools effectively (white board, overheads, power point, presentation, handouts)					
Uses innovative strategies (quizzes, group/pair work, creative illustrations)					

Overall assessment: **Satisfactory** **Borderline** **Unsatisfactory/Resubmit**

CLINICAL TEACHER SIGNATURE _____

Position _____

2.7 Electives: Student Performance Review Information Sheet

Assessment in the School of Medicine
The School of Medicine assessment programme has been designed to test the understanding and application of core medical knowledge and skills as well as the personal and professional behaviour of its medical students.

The Student Performance Review Form
The SOM assesses student performance in the clinical setting via the Student Performance Review Form. This involves supervisor review and assessment of the evidence of a student's clinical activity as well as their performance across a range of important elements of clinical practice.

What is expected of those completing Student Performance Review Forms?
An honest and objective rating of the student's performance as observed during contact session/s with the student.

How do I complete a Student Performance Review Form?
When a student gives you the Student Performance Review Form, please complete each section as indicated below:

- Record the name, details location of placement and the amount of time you have spent with the student.

PART A

- Consider all aspects of the student's performance that you or your colleagues have observed throughout the current performance period. Provide a rating for each of the behavioural domains listed in the Student Performance Review Form by ticking the option that you feel best represents the student's performance.

PART B

- Tick the global rating you think best summarises the students overall level of performance.
- Note: the global judgement is not a summation of the individual criteria listed in the form, but an overall impression of the student's performance as observed during each contact period. Students should be considered "satisfactory' unless their positive/negative performance warrants a different grade. If a student is Unsatisfactory, please contact Dr S Bettiol email sbettiol@utas.edu.au.

- Provide feedback for the student by considering their overall performance and indicating areas of strength and any that need attention. Indicate whether you would have the student as an Intern or Junior Medical officer on your clinical team by ticking the appropriate box.
- Print your name and contact number, and sign and date the form.

What do I do with the completed Student Performance Review Form?
The form can be returned to the student who will ensure completed forms are returned to SOM staff or returned to:

Electives Coordinator
Private Bag 34
Hobart Tas 7000

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School of Medicine

Student Performance Review Form
Year 4 – Elective
Form to be completed by the supervisor at the end of the placement

Student name_____

Time spent with student (please cross)
□ Little of no contact □Sporadic superficial contact □Infrequent in-depth contact
□ Moderate in-depth contact □Frequent in-depth contact

Part A; Rating of Student performance **Instructions:** Consider all aspects of performance observed by yourself or colleagues throughout the placement period and provide a rating for each behaviour listed below	**Unsatisfactory**	**Satisfactory**	**Excellent**	**Not observed**
History taking skills		□	□	□
Examination skills		□	□	□
Communication skills Ability to effectively exchange information with supervisors , colleagues and patients		□	□	□
Professional boundaries/Sensitivity to patient Maintains appropriate boundaries with supervisors, colleagues and patient. Shows respect and discretion with all patient regardless of culture, age, gender or disability		□ □	□ □	□ □
Teamwork/Attendance Maintains cooperative working relationships, promoting positive group interaction. Participation across learning opportunities throughout the placement period		□ □	□ □	□ □
Resilience/Flexibility Ability to bounce back from professional and personal set-backs Ability to reprioritize tasks and duties as necessary		□ □	□ □	□ □
Ethical and legal standards Applies ethical and legal standards in all professional situations		□	□	□
Clinical decision making/Knowledge base Ability to analyse, synthesise and interpret information to form appropriate clinical decisions Demonstrates appropriate knowledge and understanding of relevant medical sciences and clinical skills		□ □	□ □	□ □
Sharing knowledge/Seeking help				

Participates in a collaborative educational role with supervisors, colleagues and patient. Identifies own limitations and seeks appropriate advice or assistance as necessary	□ □ □ □ □ □ □ □

PART B : Overall level of student performance

□ □ □

Unsatisfactory Satisfactory Excellent

Preceptor comments:
Strengths

Areas than need attention

Have you discussed this with the student □ □

YES NO

Would you have this student as an Intern or Junior Medical Officer on your clinical team. □ □

YES NO

Supervisors Name…….Signature……Date……..

Official Stamp

Students signature……Date……..

2.8 Sample Objective Structured Clinical Examination Station and Marking Sheet

UTAS
FACULTY OF HEALTH SCIENCE
School of Medicine

Student information
You are a surgical intern about to see Mr Albert Whiteside, a 70 year old diabetic with a gangrenous right foot. The pain in Mr Whiteside's foot is intolerable and he has been admitted for assessment and management. Earlier today, the surgical registrar spoke to Mr Whiteside and fully explained the diagnosis and prognosis, confirming that the only suitable therapy was a below knee amputation. The registrar believed he fully explained the risks and benefits of the operation and felt that Mr Whiteside understood the issues and implications. However Mr Whiteside then refused to give consent for the operation.

Being concerned that he might have missed something and indeed being appreciative of a second opinion, the registrar asks you specifically to discuss with Mr Whiteside his decision, and to clarify the management paths possible.

Task
Your task is to engage Mr Whiteside in a discussion regarding his decision and assure yourself he is fully informed about his options.

MARKING SHEET

Core Mark

Marking criteria	Not attempted	Partially achieved	Fully achieved
Identifies the main concerns of the patient – loss of independence, burden to family	0	1	2
Elicits relevant background • Emotional state • Cognitive competence • Depressed? • Suicidal?	0	1	2
Asks about significant others and explores future care options – offers to talk to others	0	0.5	1
Gives specific information about the leg – patient will die without surgery	0	1	2
Agrees to respect the patient's decision, e.g. states that he has the right to refuse, etc.	0	1	2
Asks if patient will consent to other palliative care	0	1	2
States the patient can change his mind but only up to a point after which the decision becomes irreversible	0	1	2

OSCE MARKING SHEET (continued)

Overall Score:

Key:

0	1	2	3	4	5	6	7
Critical error made	*Very poor performance*	*Well short of expected standard*	*Short of expected standard*	*Expected standard*	*Better than expected standard*	*Much better than expected*	*Exceptional performance*

Overall	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**

Out of 7 _____

Total mark out of 20 _____

Global Assessment: (for standard setting):

FAIL **BORDERLINE** **PASS**

Examiner's Name: …… **Signature:** …….....

Comments:

Overall Marking

0	Critical error	Tries to bully the patient and dismisses his concern aggressively.
1	Very poor performance	Major omissions in history taking. Poor engagement and synthesis.
2	Poor performance	
3	Just less than expected standard	Several minor omissions. Poor time organisation
4	Expected standard	Copes with emotional reaction of patient and identifies major concerns of the patient, and attempts to prioritise them and suggests some resolution.
5	Just better than expected standard	
6	Good performance	Demonstrates good listening skills. Gives sound information. Checks understanding. Suggests a plan.
7	Exceptional performance	Mature, poised and professional interaction with accuracy of assessment and prognosis. Identifies key issues of competence, depression and independence. Checks patient's understanding of his situation. Is proactive in planning management.