School of Medicine

# Direct EntryIntroduction to Clinical Medicine

# Student guide

## Doctor & Patient Theme

# Problem Based Learning and

# Personal and Professional Development courses

2012/13

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**http://education.med.imperial.ac.uk**

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**Problem based learning Course (PBL) - Student Guide Introduction**

This Guide is designed for students entering the Year 3 course of the Faculty of Medicine at Imperial College. The following is a description of the PBL Course. Some students may have already used the PBL process in their learning but it will be an unfamiliar ‘tool’ for others. The PBL Course at Imperial has its own particular characteristics because it was conceived as one of many different ways of learning (alongside lectures and other types of tutorial) rather than being the principle ‘tool’. PBL is the main way of learning at some medical schools in the UK.

Your tutors for the PBL sessions/tutorials in your Introductory teaching block will be a number of senior academics and clinicians- there will be two facilitated sessions and you will need to make time for study between these sessions.

**What is PBL?**
PBL is an educational strategy based on research into how adults learn most effectively. Students explore a series of cases that are based on real patients’ stories, such as will be faced in professional life. The cases are designed to act as challenges to stimulate students to go and gather information and to apply it to understanding the underlying principles involved in the case. During the course students therefore develop skills that can be directly transferred to understanding and managing real patients and clinical situations. Throughout the course students should use their previous knowledge and expertise to inform the discussions in the group.

**PBL, Imperial-style.**

**Years 1 and 2 of the Six-Year Course** During Years 1 and 2 Imperial College students work in small groups with a tutor for PBL and cover a number of complex cases about patients (six cases in Year 1 and four cases in Year 2 of the six-year course. Students on the Graduate Entry programme study six cases drawn from the Year 1 and 2 courses).

The cases are designed to complement the learning in other parts (themes) of the course.

**Years 3 – Final- using PBL in the clinical setting.** Any situation in the clinical setting can be considered using the PBL process. **See Appendix F**- this outline structure may be of help to transfer the PBL process into your clinical working life. In addition, we have provided many further cases for you to study in the later years whilst working on clinical attachments. Numerous cases are available on the Intranet (see the virtual hospital) and in Course guides. You are strongly recommended to study these in your own time. Clinical teachers may also use the tool to assist in the management of certain patients. The PBL ‘tool’ will continue be very helpful to you when you qualify as a doctor. The ‘tool’ is also used by the professional teams that care for patients.

**Aims of the course**

Students will develop skills in analysing cases, gathering relevant information and critically appraising it. Students will also improve their **professional skills** in team-working, feedback to peers and tutor, medical decision-making and evaluating the use of data in evidence based practice as well as teaching one another through explanation of concepts and presentation.

The Imperial PBL Course aims to help you develop life-long learning skills and to encourage you to show **creativity**, work in **collaboration** with your peers and develop ways to **cope** with uncertainty

Students are provided with the ‘Abstract' and the ‘Aims' in the student guide. You should formulate your own list of ‘Specific learning objectives' in the first tutorial. These should be compared with the given list (held by your Tutor) after discussion in the second tutorial.

Some references are provided for the case – they are neither all-inclusive nor exclusive but they do provide valuable information relevant to the case. You should apply your critical appraisal skills to the references that you find and use. **Students entering in Year 3 are expected** be experienced at finding references and appraising sources of information. However, our working lives as medical practitioners require you to be able to use these skills under severe time limits- that is the **challenge** henceforth!

**Objectives** In addition to these general objectives, each case has specific knowledge based objectives that should be achieved. Herewith the objectives for Years 1,2 and GE for you to consider.

##### a. Case Analysis Students should use their prior knowledge to begin to understand the issues of the case. The group needs to organise itself to become effective at analysing cases. This requires skills to be developed in asking questions, evaluating and challenging colleagues.

##### b. Accessing information

Students will be able to access information in a variety of ways using libraries and other sources (e.g. texts, journals, people, on-line databases). The sources should be varied, reliable and applicable to the case.

**Referencing: tutors will encourage you to state the sources of their information so that others will be able to retrieve it – in a positive way to discourage plagiarism**

**c. Critical appraisal skills and application of evidence based medicine**

Students will be:

* skilled at searching for varied sources of information
* confident at appraising information, whether from learned journals, the media or other sources
* able to describe and understand the basis of Evidence Based Medicine (EBM) and know its benefits for clinical practice
* able to describe the impact of EBM on clinical practice, including treatment
* aware of the limitations of EBM (Clinical trials, ethical issues)

**d. Team-working and Teaching skills**

 Each student will be

* able to work effectively within a small group to process the PBL cases; to perform as a leader and scribe
* confident at presenting his/her self-directed work to colleagues
* skilled at questioning, evaluation, feedback, peer and self-assessment- verbally and in written formats

(see Appendices A-E).

# The PBL process in Years 1, 2 and GE and for the single case for Direct Entry students joining the course in Year 3.

***The tutorials.***

PBL is focused upon the clinical details of ‘real’ cases and usually organised into two tutorials for each case, with time for you to search for information in between. In the first tutorial you should examine the case/problem, identify the important factors or events taking place, build on existing knowledge and speculate about the mechanisms behind these events. In the process of doing this you should identify the areas in which you are uncertain or ignorant and list these as learning goals, and return to the second tutorial equipped to be able to discuss your findings (and perhaps identify new learning goals in this subject).

***The case/ problem.***

This is the scenario/abstract that is presented to you at the beginning of the first tutorial and given in this course guide. It is probably better called a case rather then a problem.

**PBL is not about problem solving** but about students discovering and learning the theoretical background behind the events described. This having been said, there is no reason why a case should not include a question for you to answer, as long as in answering it, you will achieve the educational objectives desired. The cases are drawn from real life, and are written to direct you towards the objectives decided on in advance (rather than the other way round).

***The tutor as Facilitator.***

The role of the Facilitator is to ensure that the Group works towards its goals, achieving the objectives by examining the case as described above, and does not go up blind alleys, or become dysfunctional, and allows all students to take part. During the tutorial the Facilitator ensures that the group is heading in the right direction to achieve the objectives and process. The Facilitator will do this by intervening with comments about the process, or with questions which will redirect, or concentrate the students’ thoughts, rather than by providing the answers.

***The tutorial process.*** See process map on next page.

***First tutorial***

The tutorials should follow the steps detailed below which are developed from the original Maastricht 7 Jump model. The Imperial model has 10 steps!

1. In the first step – identify leader (chairman) and scribe for the session.

2. Clarification of the case. The students read the case, and clarify any unknown words or phases contained in it.

3. Identify the important events/issues. Students list all the events and issues they consider important.

4. Propose mechanisms. Students attempt to explain why and how these events or issues take place and they should attempt to come up with their own hypotheses, based on prior knowledge.

5. List areas of uncertainty and ignorance, the learning goals, as specific questions- in sentence format, for example, What is the genetic change that cause disease x?

***‘Work alone session****’*.

6. Students will be expected to use the time between the tutorials to attempt to resolve and investigate the areas of uncertainty and ignorance listed as questions or learning objectives.

Students should prepare a succinct typed handout of their’ homework’ (highlighting key information) for distribution to their colleagues and tutor, together with a list of the resources accessed, with detailed references. This distribution can be by e.mail or in paper format.

***Second tutorial***

7. Students discuss their findings with the rest of the group. During the second tutorial the students attempt once again to explain the events and issues they identified in the forst tutorial.

8. Identify new learning goals and compare the group’s goals with the stated learning

objectives.

9. Give feedback to the leader and scribe – see guidelines and the appendices about

feedback and assessment.

10. Evaluate the tutorials. *One of the process objectives is for students to learn about teamwork, an objective which is helped if there is an opportunity to talk about what has happened.*

To help this process along, the students will elect a group leader, who will chair the discussion, and a scribe to write up on the white board/flip chart the points that are raised in the group’s discussions. (In Years 1 and 2 these jobs rotate among the students.) The student leader leads the discussion (but is not expected to provide the answers), the facilitator/tutor guides where necessary (and should not provide the answers).

**Everyone present has a role to play** – see Process map.

Consider the roles in the **second session**- what should the chairman and scribe do?

Chairman: is s/he an organiser of the presentations; timekeeper; enabler of questions? Who takes on these roles whilst the chairman is presenting?

What should the scribe do during the second session? S/he could record matters of contention or ignorance and take responsibility for the evaluation of the case.

All Participants have a role to play in\*\*

PBL Process Map

* Lead the group through the process
* Encourage all members to participate
* Maintain group dynamics
* Keep to time
* Ensure group keeps to task in hand
* Ensure scribe can keep up and is making an accurate record
* Lead feedback and case and tutor evaluations
* Follow the steps of the process in sequence
* Participate in discussion
* Listen to and respect contributions of others
* Ask open questions
* Research all the learning objectives
* Share information with others
* Assess self
* Evaluate case and tutor
* Encourage all group members to participate
* Assist chair with group dynamics and keeping to time
* Check scribe keeps an accurate record
* Prevent sidetracking
* Ensure group achieves appropriate learning objectives
* Check understanding
* Prompt feedback and evaluation
* Assess performance

See Tutor Evaluation

Appendix C

* Record points

by group

* Help group order their thoughts
* Participate in discussion
* Record resources used by group
* Summarise outstanding learning objectives at end of 2nd tutorial
* Record all learning objectives on Case Evaluation Sheet

Scribe

Case Analysis

Accessing Information

Critical Appraisal

Teamwork

Chairman

Group member

Tutor

\*\*see Student Assessment

Appendix B

(BMJ Vol 236 Feb.03 Diana F. Wood)

Amended version

***A theoretical background.***

PBL has been demonstrated to do a number of things that have been shown to improve learning.

* PBL mobilises the students’ prior knowledge. All students entering the medical school will have some **prior knowledge**, gleaned from personal experience, from newspapers or from previous studies, about the events taking place in the cases presented. Learning appears to be more effective if new learning is attached to previous learning, as happens when their prior learning is activated and used. A second advantage is that very often misconceptions come to the surface which can be challenged, something which rarely happens in a lecture, and not often enough in other types of tutorial.
* PBL enables people to **explore uncertainty**.

As students become more senior it may be increasingly difficult for them to admit to ignorance or imperfect understanding about a topic that has been covered earlier in the Course. In terms of Patient Safety it is vital that students and doctors **learn to admit** such difficulties and that such an admission is respected by colleagues.

* PBL allows ’constructive conflict’. By having the students discuss amongst themselves the possible explanations for events, there is a certain amount of conflict, which if constructive and positive, increases motivation for learning.
* PBL allows discussion around the subject. Learning appears to be enhanced when the learners have the opportunity to discuss it freely.
* PBL allows students to identify their own learning goals. Students should be more motivated to learn if they set their own goals.
* PBL allows students to learn at their own speed and in their own style. Students differ very much in how they learn, and often in ways that conflict with the way they are taught.

**Expectations of students – professional behaviour**

Whilst on PBL courses students are expected to behave in ways that are consistent with future membership of the medical profession.

For example, you are expected to attend **all** scheduled sessions, punctually and to complete any tasks agreed by the group and the tutor.

In particular, during PBL sessions we expect students to demonstrate:

* a willingness to participate in group discussions
* evidence of taking responsibility for your own learning
* a commitment to the attainment of group goals as well as a realisation of your own personal learning objectives
* honesty in stating the sources of information and care in critically appraising sources
* respect for other members of the group, by responding positively to their contributions, even when questioning their ideas
* concern for the efficiency of the learning process by expressing any reservations you might have about the level and direction of the group effort.

**Assessment in the Graduate Entry and Years 1 and 2 – for information**

# Students are expected to attend all sessions. Attendance is monitored and the tutor assesses each student on his/her attendance record and general contribution to the tutorial groups. Naturally, people differ in the way that they work within groups, but it is important that all students contribute to the group and are able to play their part in helping the group to develop learning objectives and reporting information discovered. On occasions each student should be prepared to lead the group discussions. At the end of each term tutors and students complete a formative assessment form, a copy of which is kept in the student’s personal file in the Faculty Education Office. (Appendix B).

# As students assess themselves as well as being assessed by the tutor it is recommended that any discrepancies are discussed at the final tutorial session each term and a note added to explain the differences.

Students sit a formal examination based on a PBL Case at the end of the Spring term in Year 1. (GE students are exempted)

**Peer assessment**

Please see Appendix G. Students assessed one another and themselves in terms of the effort put into discussing cases and the quality of presentations. These assessments were submitted anonymously via the E-portfolio.

## Course evaluation

The cases are evaluated by each group of students with their tutor through completion of evaluation forms (Appendix D). Tutor’s facilitating skills are also evaluated by each student confidentially (Appendix C).

**Library resources**

Information about library services, including support for PBL, is available on the Intranet.

To help you find reliable information, please access the Blackboard and OLIVIA (OnLIne Virtual Information Assistant). This contains units which will develop your skills in planning a search, finding different kinds of information, using the internet, etc. This will be of use to you not just for the PBLs, but throughout your course and into your practice.

Campus libraries provide a wide range of resources such as textbooks, journals, videos, and CD-Roms. Imperial College staff and students have access to a wide range of networked electronic resources: the library catalogue which gives details of the holdings of all Imperial libraries; databases such as MEDLINE, Cochrane, EMBASE and Psycinfo; electronic journals which allow searching and downloading of full text articles; reference material such as the Medical Directory and the Encyclopedia of Life Sciences; electronic books such as the Oxford Textbook of Medicine; and internet tutorials and guides such as Internet Medic. Further details and access from the Library website http://www.imperial.ac.uk/library or via the teaching intranet.

**Library contacts**

For general information or help, email: medlib@imperial.ac.uk

For questions to do with each campus:

Charing Cross librarycx@imperial.ac.uk Tel: 020 7594 0755

Chelsea & Westminster librarycw@imperial.ac.uk Tel: 020 8746 8107

Hammersmith lib.hamm@imperial.ac.uk Tel: 020 8383 3246

St Mary's sm-lib@imperial.ac.uk Tel: 020 7594 3692

South Kensington medlib@imperial.ac.uk Tel: 020 7594 8840

Royal Brompton br.library@imperial.ac.uk Tel: 020 7351 8150

 **Introduction to PBL and Case**:  **A textbook patient**

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**Foundations of Clinical Practice theme**

## Part 1. The PBL Process

Introductions and ground rules

Explore experience and expectations of students of PBL.

Discuss the Imperial model of PBL.

Discuss expectations of the Tutor’s role

Refer to the PBL process chart and 1-10 steps (modified Maastricht model).

Cover steps 1-5

**Part 2.**

**A textbook patient.**

**This case has been studied by the Year 2 students that will join you in Year 3 at Imperial. It was timetabled just before the students started their first hospital attachment in 2011. We hope that it will assist you in preparing for your role as a medical student.**

***Aims of case***

In preparation for your clinical attachment to: explore the roles and responsibilities of students and doctors towards patients and the topics of stroke and safety for patients and ‘self’.

**Abstract**

This case is in the form of a film, designed to stimulate thought and discussion about some of the issues which may be encountered by medical students on a clinical attachment. The film follows the experiences of Ron, a second-year medical student, and some of his friends, on one of their first days on a medical ward placement.

It is suggested that the video is **played once**.

Students may wish to **read the script** to identify any unfamiliar words or phrases.

We recommend a **discussion** of the general issues raised, in line with the PBL process.

The recording may then be played a second time, to allow all students a chance to appreciate and develop their learning objectives.

The recording is available for further viewing on the intranet, and the script provided below.

**Should there be problems with the video, that the IT team cannot resolve, please allocate roles and read the script.**

Script – copy

***Scene 1***

Ron – Morning Dad.

Dad – What you up to today?

Ron – Ahh I don’t know. There’s lots of stuff going on, it’s hard to keep track. Year 2’s very different to Year one.

Dad – yeah?

Ron – think I need to follow some more ‘patient journeys’.

Dad – what’s that?

Ron – I’m not sure, need to write some stuff online I think. Or present some patients to the rest of the team. Hopefully our consultant will be in today to tell us what to do.

Dad - That the slacker Dr Lanka?

Ron – Yeah that’s him. But I’m sure he’s just very busy! Well, I’m off. Remember you’ve got physio at 3. Seeya.

***Scene 2***

Ron arrives at hospital, and meets Jim in ward.

Jim – Hey mate.

Ron – Hi, y’alright? Dr Lanka about?

Jim – Oh he’s never in. We had might as well not be here. Honestly, I don’t feel that I’m being taught anything.

Ron – But hey, you still get a chance to talk to patients, and to see what the doctors are doing?

Jim – Yeah yeah, I know, but I’m paying a heck of a lot for this, y’know? We haven’t had any proper teaching or supervision in weeks, because that consultant hasn’t turned up. I think it’s well unfair. I mean, what are we meant to actually do here?

Ron – Yeah, point taken. But it’s all experience, right? And what about that nice registrar, Dr Bemba? He’s quite good at getting us doing stuff. Here he is!

\*Dr Bemba arrives\*

Dr B – Hey, hey, come see these notes. \*Walks\* It’s about a 50 year old male stroke patient, came in after a 999 call early this morning. I tell you, a textbook case. I think he’s having some scans at the minute, but maybe talk to his wife.

Jim – I’ve got to read up on a case from the other day, will you be ok doing this? I’ll catch you later...

***Scene 3***

With Mrs TB.

Ron – Hi, Mrs Trancher-Bower. My name is Ron Larsson. I’m a second year medical student at Imperial College. Do you mind if I talk with you for a few minutes?

Mrs – Umm, yeah ok, that’s fine.

Ron – Can you tell us why you’re in here today? I understand that your husband was admitted this morning.

Mrs – Yes, that’s right. It must have been about 8. Well, I mean, I thought he seemed fine when we went to bed – a little tired maybe, but we’ve been working hard the last few weeks.

Ron – What does he do?

Mrs – He’s a taxi driver. Or was, I don’t know what’s going to happen now...

Ron – Can you tell me a little about what happened last night?

Mrs – Yes, well, we went to bed about 10pm, as normal. When we woke up, I don’t know – he had difficulty getting up. He couldn’t really move his right arm or leg, and his face seemed a little droopy on this side. And I asked how he was, and he didn’t seem to make a lot of sense, and his speech was all slurred. And you know those FAST rules? I thought of them and dialled 999.

Ron – and where is he now?

Mrs – *(getting increasingly distressed*)– Well I think they’ve taken him off for some scans. I’m so worried though, we really need the money, I don’t know what will happen if he can’t get back to work soon. They’re talking about rehab, saying that this place is a HASU? Whatever that is. I don’t know, what normally happens after a stroke case? Will our life ever be the same again? Can you help?

***Scene 4***

Lunchtime. Un-named doctor runs in with a CT scan.

Doc - Guys, look at this! So remember his symptoms – the drooping face, the right hemi-paralysis, the slurred speech, and remember how we predicted exactly where the neurological event would have taken place? Well we got it right! See here on the scan.

\*General excitement and chatter; other doctors and members of the public getting involved.\*

Jim – so that would be in the, err.

Doc – yeah that’s right. Go and speak with him when you have a chance! Check out his Babinski – classic. Seriously, fantastic case.

Both students leave.

***Scene 5***

A short while later, Ron is on the phone to his father.

Hey Dad…it’s me

Um yeah it’s been a tough day today, I’m just back from seeing a patient.

Well it started out alright, so we just got this patient in, his name was…Mr Tra… umm Mr TB

So, yeah, he came in this morning, and he was like really interesting, the doctors kept calling him a “textbook case”. And I suppose he was, so he’d had this stroke... yeah, like you, but otherwise he was really healthy, never had a day’s illness in his life.

Anyway, Dr Bemba, …no the slacker’s Dr Lanka….Dr Bemba’s the nice one, yeah he was really excited about him, and started showing me all this stuff that we’ve learnt about in lectures... yeah... like his scans, and a Babinski sign, which I still don’t think I entirely understand... and some other doctors showed me the neurological exam, which I hadn’t seen before.

Yeah..., no, you’re right, I guess it was really interesting, but it kinda felt like the patient didn’t really know what we were doing, and I just felt quite uncomfortable, like we were in some kind of, I dunno, medical zoo or something.

So yeah, that was all a bit tough. But the hardest part was talking to his wife. I was told to talk with her whilst her husband was off having his scans, it was just the two of us, and we went through all the usual stuff... uhuh, that kinda thing..., but she started getting really upset when I got to asking her about her home situation. And I couldn’t stop thinking about when you had your stroke, and how everything changed for us in an instant... anyway, it was really bad, I felt tears welling up, I just couldn’t control myself. I felt awful, I’m supposed to be a professional now, and didn’t know what to do, or if I should mention my experiences to her...

Yeah…Yeah…

Well Dr Bemba must have noticed I was upset, because took me aside afterwards, he was really good about it. I told him about you and he made some really helpful suggestions…

Yeah, thanks dad. Oh I’ve just noticed the time, I need to get back, yeah love you too. Bye!

***Scene 6***

A little later that afternoon, at the nurses’ station.

Nurse - would one of you mind taking Mrs Reeves’ blood for me?

Ron – umm yeah that would be good, we haven’t actually done it on a patient before. Oh Dr Bemba!

Dr B – hullo?

Ron – is it alright for me or Jim to have a go taking blood?

Dr B – Have a go?

Ron – yeah I mean we’ve practiced on each other, but if you’re too busy…

Dr B – Errrr… i don’t know we’ve had a few “incidents” in the past, lot of paperwork, it’s all a bit risky.

Nurse – Oh I’m sure the patient will be more than happy to let them practise!

Dr B – It’s not the patient I’m worried about. Look, guys, think of the risks? I think best not, not today.

Jim – this is absolutely rubbish, what a dull day. We’re not getting taught anything here.

Ron – I sure something will come up. There’s always Pebblepad to fill in...

Jim – Why would I want to do that? Nah mate I’m off, got a pub crawl to get ready for and they’re hardly going to notice.

Both students leave.

***Work alone session***.

Step 6.

Prepare presentations that explain the information gathered about the learning objectives.

**We anticipate that you will use and critically appraise varied resources: textbooks, patient literature, expert persons, UK internet links etc.**

**2nd session with your Tutor**

Cover steps 7-10- see Appendices

Presentations - with appraisal of resources used

Feedback on presentations and Group effectiveness

Case evaluation

Self-assessment

Tutor evaluation

In your own time: Peer assessment- consider how you would fill in these assessments for your colleagues.

**Links to other parts of the course:**

Year 3 Clinical attachments

Personal and Professional Development

Cardiovascular

Neuroscience and neurology

**Appendix A**

###### PBL Guidelines for Giving and Receiving Feedback

When you are a doctor you will have regular appraisals and be asked to do appraisals for your work colleagues. As a medical student you have the opportunity to develop your skills at giving feedback to your fellow students and also to your tutors during many of the courses and attachments. You should also practise asking patients for their feedback on your skills.

We recommend the following way of offering feedback:

* Invite the person receiving feedback to state what s/he did well
* Invite your colleague to describe what s/he would like to do differently and to ask for advice on particular matters
* Respond to the requests for advice and add your own observations about what could be done differently.

**Guidelines for GIVING Constructive Feedback**

1. Give feedback only when asked to do so or when your offer is accepted.
2. Give feedback as soon after the event as possible.
3. Focus on the positive.
4. Be descriptive (of behaviour) not evaluative (of motives).
5. Talk about specific behaviour and give examples where possible.
6. Use “I” and give your experience of the behaviour

(“When you said…, I thought that you were…”)

7. When giving negative feedback, suggest alternative behaviours.

8. Ask yourself, “Why am I giving feedback?” (Is it for yourself? or for the

person concerned?)

9. Remember that feedback says a lot about you as well as about the person to

whom it is directed.

10. Try to confine negative feedback to things that can be changed.

11. Do not overload

**Guidelines for RECEIVING Constructive Feedback**

1. Listen to it (rather than prepare your response/defence).

2. Ask for it to be repeated if you did not hear it clearly.

3. Assume it is constructive until proven otherwise: then consider and use those elements that are constructive.

4. Pause and think before responding.

5. Ask for clarification and examples if statements are unclear or unsupported.

6. Accept it positively (for consideration) rather than dismissively (for self-protection).

7. Ask for suggestions of ways you might modify or change your behaviour.

8. Respect and thank the person giving feedback.

**Appendix B**

|  |
| --- |
| **Example**  **PBL Student assessment** Year ....... Term: Autumn/Spring Group....................Student Name.......................................... |
| Key to performance: M-merit;S- satisfactory;US- unsatisfactoryTutor please indicate:**Attendance:** **( ) out of ( )****Punctuality**: MSUS | **Case Analysis:** Utilises prior knowledgeAsks questionsEvaluates & challenges arguments Takes responsibility for tasks e.g. GL or scribe \*\* add comment | **Accessing Information:** Accessesmaterial from reliable, varied & original sources Shares correctly referenced material | **Critical Appraisal**: Challenges the quality & pertinence of materialOffers constructive feedback to peers and tutorYr 2. demonstrates an understanding of the principles and limitations of EBM  | **Team Working:** Participates actively in discussionsRespects others in GroupTakes responsibilityfor own learningActively contributes to setting learning objectivesMakes effective presentations | **Tutor Comments + about roles**\*\* |
| Student | Tutor | Student | Tutor | Student | Tutor | Student | Tutor |
| Student opinions: Specific areas to improve, including roles \*\*Please complete in **last** session and return to: Faculty Education Office, Reynolds Building Charing Cross Campus.  2012 |

|  |
| --- |
| Appendix C |
| DE Tutor Evaluation Form, Tutor’s Name…………………………….. Date …………. |
| **Tutor encouraged participation by all members** | Always | Usually | Sometimes | Never |
| Please give constructive feedback on any aspect  |
| **Tutor encouraged students** **to share prior knowledge** | Always | Usually | Sometimes | Never |
| Please give constructive feedback on any aspect  |
| **Tutor encouraged constructive conflict in group discussions** | Always | Usually | Sometimes | Never |
| Describe how |
| **Tutor led constructive feedback on individual performance** | Always | Usually | Sometimes | Never |
| Describe how |
| **Tutor guided learning process well** | Always | Usually | Sometimes | Never |
| Describe how: |
| **Other comments about your tutor’s skills** |
| Please note the information written on these forms may well be sensitive. The forms should be returned to the FEO in an envelope marked **‘Confidential’** - DE students |

# Appendix D

# SCHOOL OF MEDICINE

 **IMPERIAL COLLEGE LONDON**

**Doctor and Patient: Problem Based Learning – Yr3 DE**

**CASE [ ] [ ]**

**CASE EVALUATION**

*(To be completed by students* *and tutor together at the end of each case.)*

Date...........................................Tutor’s Name...................……………….....................

###### Overall Evaluation of Case and Suitability for PBL

######  4 3 2 1 [Please circle one number ]

Excellent Good Satisfactory Unsatisfactory

**Compare this list of objectives and mark degree of student achievement by ticking appropriate box.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Case Objectives** | **Identified by group** | **Not identified** | **Partially achieved** |
| **1** |  |  |  |  |
| **2** |  |  |  |  |
| **3** |  |  |  |  |
| **4** |  |  |  |  |
| **5** |  |  |  |  |
| **6** |  |  |  |  |
| **7** |  |  |  |  |
| **8** |  |  |  |  |
| **9** |  |  |  |  |
| **10** |  |  |  |  |
| **11** |  |  |  |  |

|  |
| --- |
| Please list the additional objectives identified by your group and not the author. Please write out in full. |
| *a* |  |
| *b* |  |
| *c* |  |
| *d* |  |
| *e* |  |
| *f* |  |
| *g* |  |
| *h* |  |
| *i* |  |
| *j* |  |
| *k* |  |
| **Tutor: at the final session- please invite the students to give their opinion about applying the PBL process in future years of study, as below.****Student: Having finished the PBL course, I feel confident about identifying learning objectives, using relevant resources and presenting my findings effectively to colleagues.****Please score independently and then tot up as follows:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Number of students** | **Strongly agree** | **Agree** | **Neither agree or disagree** | **Disagree** | **Strongly disagree** |
|  |  |  |  |  |

**Additional comments e.g. on this case, the PBL process or other issues.** **Please return to: Faculty Education Office (Medicine), Imperial College London, Reynolds Building, Charing Cross campus** |

**Appendix E Making presentations**

***Summary sheet from the Communication Programme session, Year 1.***

The features of effective presentations: students should be aware that in most presentations they should state who they are, what they are going to do, how they are going to do it, do it and then review what they did.

That is, there is a beginning, middle and an end.

**Beginning**

* Introduce self
* Introduce topic
* State aims/goals
* Outline structure
* Outline time
* Invite questions/interruptions (throughout? At end?)

**Middle**

* Interesting
* Stay with theme
* Avoid jargon or explain it
* Talk to basic level of group
* Aids – e.g. overheads/power point –
* clear; not too much information (5-6 lines) i.e. main points; highlight.
* Don’t read from slides
* Don’t make them distracting

**Closure**

* Summarise
* Return to aims – have you met them?
* Questions

**Personal characteristics**

* Lively, enthusiastic
* Interested
* Audible
* Pace and tone of voice
* Confident
* Knowledgeable
* Appearance

**Environment and Environment**

* Appropriate setting
* Arrangement of seating
* Equipment works
* Lighting
* Background noise

**Appendix F**

From; Macallan *et al.,* (2009). A model of clinical problem-based learning for clinical attachments in medicine. *Medical Education,* 43(8), pp799-807

Table 1 Outline of clinical problem-based learning structure for medical and surgical attachments

|  |
| --- |
|  |
|

| **Session** | **Tutor** | **Student/group** | **Key questions/issues** |
| --- | --- | --- | --- |
|  |
| Beforehand | Allocate case and designate lead student | Lead student clerks patient  |  |
|  |  |  |
| Allocate scribe to annotate discussion (whiteboard/flip-chart) | Lead student brings appropriate investigations (bloods, X-rays, electrocardiogram, etc.) to session |  |
| Tutorial 1 | *Tutor acts primarily as facilitator*  |
|  |  |  |
| Presentation | Lead student: one-line summary of presentation, then stops |  |
|  |  |  |
| Hypothesis generation | Group brainstorm to develop hypotheses to explain presentation | What might be going on here? |
|  |  |  |
| Develop the focus of history acquisition | Group discussion to relate hypotheses to history | How do these different conditions present? What are the important things we need to know about the patient? |
|  |  |  |
| Detailed history | Either, lead student plays the role of the patient, other students take history from him or her, or lead student presents history in the third person |  |
|  |  |  |
| Identify learning issues | Students collectively agree on what they need to research before the next tutorial | What do we need to understand to approach this case effectively? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| Focus on clinical signs | Relate examination to hypotheses and historyLead student presents examination findings by answering questions raised by the other students | What should we look for on examination? |
|  |  |  |
| Review hypotheses | Group discussion | What do examination findings tell us? |
|  |  |  |
| Focus on mechanisms | Group discusses likely pathology and underlying aetiology | What disease states or processes are involved? |
|  |  |  |
| Finalise learning objectives | Group agreement | All objectives are for all students |
|  |  |  |
| Review at bedside | The whole group visits the patient on the wardReview historyDemonstrate clinical signs |  |
| Learning interval |  | Students use textbook, online and staff resources to answer learning objectives | Lead student follows case daily, referring to notes and further investigations |
| Tutorial 2 | *Tutor switches from facilitator to expert role*  |
|  |  |  |
| Summarise case; set agenda | Group members review what they have found out about their learning objectives | Patient-focused: what have you learned that specifically applies to this case? |
|  |  |  |
| Case progress; explain decision making | Review investigations, management, progress | What management decisions were made and why? |
|  |  |  |
| Revisit patient at bedside | Demonstrate key issues discussed | Expert discussion of clinical management and reasoning |
|  | Summarise learningIdentify outstanding issues and any further learning objectives | Tutor leads discussion and ensures students have covered all appropriate aspects |  |
| Write-up | Case report | Lead student produces case reportReport is distributed to whole group | Part of summative assessment |

 |

#### *Appendix G*

**Doctor and Patient course Year 2 and GE**

PBL peer feedback and professional assessment form

Please fill out the following table for each member of your PBL group, including yourself, for this term. Transfer your assessments to the E-portfolio and submit, after the session.

Please \* the colleague you worked with, if appropriate.

First session: mark your colleagues on a scale of 1-5 (1 = minimal effort, 5 = excellent effort) for their effort.

Second session: mark your colleague on the quality of the latest presentation (1 = poor in terms of style and content, 5 = excellent style and content. Date……………………

|  |  |  |  |
| --- | --- | --- | --- |
| **Self, then Names of peers**  | **Effort1-5** | **Presentation1-5** | **Comments** |
| 1. Self
 |  |  |  |
| 2. |  |  |  |
| 3.Etc. |  |  |  |

**Context.** About peer assessment: throughout your professional career there is a duty to give constructive feedback (honest, specific and detailed) to colleagues and to reflect on the feedback that others give you. This is for the appraisal and revalidation process and it is often called ‘multi-source feedback’.

The grades are awarded for the contribution to group work, that is, the effort your team members think you have put in and the quality of your presentation. **You should assess yourself too**. See the PBL process map in your Guide for a reminder about the expectations you should have of performance in the various roles. Refer to the Clinical Communication course and appendix E in your PBL guide to refresh your memory about presentations. **Please write notes** during the sessions and access your E-portfolio as soon as possible after the session to upload your assessments. Complete the section on the page provided for each of the members in your group. **Use the full range of marks**, 1-5 and write **specific** constructive comments and explanations of your marks. A summary of your marks and the comments will then be reviewed by your tutor prior to release to you. Some students will be invited to a 1-1 meeting with your tutor. All assessments will remain confidential. It is recommended that you reflect on this formative assessment process in your E-portfolio. **Descriptors**

|  |
| --- |
| **Effort** |
| **1 Minimal** | **2 Poor** | **3 Satisfactory** | **4 Good** | **5 Excellent** |
| No contribution to discussion of the case either through sharing prior knowledge or asking questions of peers; lack of enthusiasm to develop learning objectives or give feedback. Or, dominating the process to the severe detriment of others. | Little contribution to discussion of the case either through sharing prior knowledge or asking questions of peers; little enthusiasm to develop learning objectives or give feedback. Or, over-dominant, not allowing others to contribute. | Contributes to discussion of the case either through sharing prior knowledge or asking questions of peers; shows enthusiasm to develop learning objectives and give feedback. | Active contribution to discussion of the case either through sharing prior knowledge or asking questions of peers; enthusiasm to develop learning objectives and give feedback. | Participates actively in case discussion, questioning & drawing in quieter peers, challenging and giving feedback but not dominating in group. Works enthusiastically with partner and peers to prepare for the presenting session. |
| **Presentation** |
| **1 Inadequate** | **2 Poor** | **3 Satisfactory** | **4 Good** | **5 Excellent** |
| If paired- no contribution to preparation for presentation Objectives unclear; no beginning, middle and end; timing – too long or short; lack of interaction with audience; voice projection inadequate | If paired- minimal contribution to preparation for presentation. Objectives stated but not achieved. Style of presentation lacking in several components. | Shared preparation with peer. Objectives achieved and style of presentation satisfactory. | Shared preparation with peer. Objectives achieved and style of presentation good but not memorable. | Shared preparation with peer. Clear objectives and content delivered in an engaging way with good voice projection and appropriate interaction and to time and memorable. |

#### Personal & Professional Development Course

#### The 21st century Doctor

#### ‘Sample’ Session

**Aims**

For Direct Entry students: an introduction to the Personal and Professional Development course topics studied in Year 2 of the six-year course

For GE students: a third PPD session

and a ‘taster’ of the multidisciplinary team work engaged in by Year 2 students on the six-year course during their 3 week ‘firm’ attachment.

We hope that this session will help you to prepare for your clinical work in the years to come. In order to study for your assessment in this subject area please refer to the materials on the Intranet.

**Programme**

Based on the GMC guidance: Medical students: professional behaviour and fitness to practise. You are expected to have read and considered this guidance.

**Introduction**

**Part 1 The role of the medical student: duties and responsibilities**

Definitions of medical professionalism

Debate issues raised - Scenarios about professional life and the duties of a medical student

Review the activities described in the Summary of the Year 2 Clinical attachment- see Guide and Intranet.

**Part 2. The role of the medical student and the Multidisciplinary team**

Review of your Belbin descriptor scores

Discussion of past experiences based onsomeone that you have met who had complicated health and social care needs.

Analysis of Case: roles and responsibilities

**Part 3. Tools for the analysis of medical error and cases to illustrate Patient Safety issues**

Case discussions

Resilience and leadership

**See Appendix 1. Extract from: Overview of the Year 2 PPD Course for Direct Entry Students.**

**The aim** of this course is to promote your understanding of the key aspects of becoming a professional practitioner in medicine so that you qualify as a highly competent doctor aware of your own strengths and weaknesses in your approach to work and self care.

By the day you qualify you should have:

**skills in:**

self–evaluation & criticism

decision making and clinical reasoning with judgement

personal development

**understanding of:**

your role within the health service

your ethical and legal responsibilities

the effects that your attitudes have upon your behaviour

The course provides teaching, information and resources about a number of key aspects related to professional life with examples from topical issues which are challenging doctors.

**Students joining the Imperial College Faculty of Medicine in Year 3** are expected to have considered and studied the educational material of the Personal & Professional Development course, as described below and in the Appendices.

Medical students on the six-year course are offered the PPD sessions described in Appendix 1. Documents relating to these sessions may be viewed on the Intranet:

 <http://education.med.imperial.ac.uk> under the relevant year and the **Doctor and Patient** heading.

The information that you require is under Year 2, 2010-11.

Graduate Entry students have received two tutorial sessions during their Year 1. See the Appendix 2 for details of the Learning Objectives.

 **1**. **Duties of a medical student**

 **2. The Self-Aware Doctor: Physician Heal Thyself**

**Assessment**

The written examination for the PPD course content will be in the paper with Ethics and Law plus Clinical Communication (CC) in 2013 with the other Year 3 examinations.

A case story will be released in advance to enable you to prepare. The PPD assessment will be in the style of short answer questions. The content will be based around the stated aims and learning objectives of the PPD course, as described on Blackboard and the Intranet for the five sessions of the six-year Course.

The short answer questions will be distributed in percentage terms as 60: 20; 20% for Ethics, PPD and CC, respectively.

Please refer to The Medical Ethics and Law and Clinical communication course guides for further information.

Contact the FEO-Exams team if you have any questions.

Part 1. **Professionalism**

In this session, we have only been able to include a brief discussion on the definitions of what it is to be a ‘professional’ but you are expected to be familiar with the current definition. Herewith a summary.

The Royal College of Physicians Working Party (2005) defined medical professionalism as follows:

**Medical professionalism signifies a set of values, behaviours, and relationships that underpins the trust the public has in doctors.**

 In order to set out in more detail the meaning of these values, behaviours, and relationships, the Working Party described medical professionalism in the following way:

Medicine is a vocation in which a doctor’s knowledge, clinical skills, and judgement are put in the service of protecting and restoring human well-being. This purpose is realised through a partnership between patient and doctor, one based on mutual respect, individual responsibility, and appropriate accountability.

In their day-to-day practice, doctors are committed to:

• integrity

• compassion

• altruism

• continuous improvement

• excellence

• working in partnership with members of the wider healthcare team.

These **values**, which underpin the science and practice of medicine, form the basis for a moral contract between the medical profession and society.

Each party has a duty to work to strengthen the system of healthcare on which our collective human dignity depends.

**You are also expected to have read and considered the Guidance from the GMC and Medical Schools Council in the booklet:**

**Medical students: professional behavior and fitness to practice.**

**Personal and Professional Development Scenarios for DE students.**

 **What would you say?**

* 1. During your first month at Imperial you are injured on the hockey pitch and taken to A & E at Charing Cross hospital. You are in a lot of pain. A testicular torsion is diagnosed and the Surgical Registrar comes to consent you for theatre, accompanied by three students from

your year. She tells them to examine you, as they will ‘rarely see such a severe torsion’. **What are the issues here? How do you feel?**

**2.** You and two colleagues are starting your first clinical attachment at a busy clinical teaching hospital only to find that the sole doctor around is an FY1. As you approach you overhear him saying to the nurse: ‘oh, here come some more medical students ...’ in a patronising tone. You approach him and introduce yourselves, and the FY1 doctor explains that he is currently too busy to teach students. **What do you do?**

**3.** On your last Year 3 attachment the Registrar asks you to clerk the 60 year old patient, Mr. B. admitted from Wormwood Scrubs prison. He has two officers guarding him because he is serving ‘life’ for the assault and murder of a child.

 Mr. B. confides in you that he is terrified that he will die and wants to see a priest for the last rites and absolution. When you ask the nurses on the ward about this they suggest that you sort it out for Mr B. as he asked you. **How do you respond?**

**4.** You are a final year medical student doing professional work experience on a medical ward in the lead up to finals. It has been a very busy weekend and the FY2 is tired and still has lots of patients to deal with. Patient Mr. A. needs to be catheterised and the FY2 is going to supervise you passing the catheter. The patient urges you to get on with the task as he is in great discomfort. You are poised to insert the catheter and the FY2's bleep goes off, as she leaves she shouts 'carry on, I want to see that catheter inserted when I come back'. This sort of thing keeps happening, and you have tried talking to her but the FY2 always mutters: ‘you just wait, you don’t know the meaning of the word stress’. **What are the issues?** **Where should you go for help?**

**5.** You are now a Registrar in General Practice. You are going on holiday to Cornwall tomorrow with your flat- mate who has developed a severe sore throat. You carry spare prescriptions and drug samples in your on-call bag.

**a.** **What would you say to him?**

Three days later you develop similar symptoms .**b. What would you do?**

**c. What if this was a family member?**

## See: BMJ Career Focus  2004;329:199 (13 November) How to be a good relative

**6**. Back in the 3rd Year, summer, just before the OSCE - Miss Y will still be in your firm. Since October she has been turning up on the wards looking ‘stoned’ or ‘hungover’. She never says a word in teaching sessions & misses quite a few. You’ve tried to be friendly and she did come out for a drink with you. After four vodkas she got really chatty and loud. **What would you say to her? What would you do?**

**In student’s own time.**

**7.** Consider the following yourself and talk to those who know you…**How would you describe your personality? How will your personality type affect your communication with patients**?

See BMJ Careers Series on Personality. Oct. 2003– Feb. 2004 by A. Houghton

and E. Paice, M. Aitken, A. **Houghton**, and Jenny Firth-Cozens

**We strongly recommend the BMJ Career website, especially** ‘Personal Development’ heading, for a wide range of papers.

Also,

BMJ, Sep **2004**; 329: 658 - 659. **Bullying among doctors in training: cross sectional questionnaire survey**

**FY1 Case diaries of ‘on-call’ work - see Intranet PPD Modules 2011-12**

And, see below for advice from last year’s GE/DE students on **making the most of Year 3**.

**Musings** from DE/GE students at the end of Year 3

Various authors including Claire Taylor and Herman Tam

Be warned about the change pace. Moving into the 3rd year crawl from the rush of the first year was hard to adapt to. A lot of us spent the first term desperate to learn facts and maybe missed the point a bit. 3rd seems to be more about exposure to the clinical environment and learning from experience rather than from teaching.

We were surprised at the lack of structure, but with hindsight it allowed us to learn practical clinical skills and examinations in our own way. It felt like there was a lot of repetition in the teaching but again it provided the practice which is necessary for the skills we needed to learn.

One thing I found really useful was finding a peer and working together giving feedback and watching each other examine and take histories – this provided a good time filler and substitute when consultant/reg teaching was delayed/cancelled/moved etc. I learned that everything is self motivated – most of the time you are able to pick and choose what you do – don’t follow the crowd. Do what you find useful. If you’re sitting in clinic never getting spoken to, only go when it’s absolutely necessary, likewise with theatre, but when you find a Dr, be it junior or consultant, stick to them like glue – show interest and read up – it pays dividends for the learning you will achieve during the firm.

Learn all the practical skills as early as possible; you can then be useful on the wards, practice your skills throughout the year and get really good at the them, and furthermore OSCEs CANNOT be crammed for – despite practicing beforehand I heavily relied upon skills I had learnt throughout the year.

Try to familiarise yourself with talking to patients (PCC) in your limited encounters. It is a skill that can only be mastered with experience. If there is a particular specialty that you are interested in, talk to the lecturer afterwards and ask to sit in their clinics, which may help you add-in or cross-off your specialties wish list.

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

Get in! While Year 3 can be rather relaxing, what you get out of it depends on how much you put in. During your 'free time' on the wards, why not go talk to someone (patient/nurse/doctor) instead of hanging out with your firm buddies in the coffee room. Above all your OSCE stuff, clinical experience is the most valuable in this year. I came across 3 cardiac arrests, all of which happened during non-scheduled ward visits. I froze during the first 2 because I was overwhelmed with the whole situation but I managed to assist with the third one since I learnt how to react in emergencies. (no ALS training could match this!) However, do not be ashamed to express that 'you don't know' at times because the patient's health trumps over your education. Most junior doctors, if given the time, will be happy to guide you through a procedure or examination. Remember, its their job to teach you, too.

Instead of reading chapters of textbook, I spent around 15 minutes daily to look up conditions or signs I saw earlier (perfect time on the tube). Your memory works much better with real examples than textbook pictures. Also, make friends with the doctors and nurses (even those outside your firm), and they will help you in return. If there's nothing to do, go to the acute areas (A&E, AMU) and ask junior doctors for any jobs (bloods, cannulas, ABGs) or patients with good signs or histories. Get an OSCE book and go through simulated stations in pairs with real patients. Find yourself an OSCE tutor as they will know what to expect in your exams.

Good luck!

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

**Overall**

I enjoyed my 3rd year – it was a rollercoaster of the mundane and the exotic and I saw a great deal of things that made me think. I saw three completely different styles of leadership in my three main consultants and a vast range of behaviours in the staff. I guess it was all about getting involved and trying to see things from as many different perspectives as possible – and then trying to cobble together a perspective of your own.

**General advice**

Turn up

Be responsible for your own education -if there is something you want to see -ask

If you aren't being taught be the people who are meant to teach you - find someone who will

Don't turn up hung-over - it's disrespectful to the patients - they don't need to deal with your issues

It isn't a social club it's a hospital

Know when to step in and when to step back

Read around the subject and make a list of things you see that you need to look up later

Try to learn at least one drug per day - I found going through the PTs drug chart the best test

Take the opportunity to talk to pts

You will meet people you don't like - get over it

Form a study group early

Clerk as many patients as you can

Keep your portfolio updated

Learn your basic clinical skills - bloods etc and go and offer your help - if you make the f1's lives easier they will help you more

Grab a copy of every form and see what you will be working with later on

Do some nights

Tell your mates if you see something interesting - they should do the same for you - but don't treat the hospital like a zoo

Teach yourself what you need to be a good doctor - not what the exam will need (though you also need that too)

Don't be intimidated - you may be the lowest rung on the ladder but you still have worth

Don't get discouraged by some of the seemingly random and arbitrary hoops you will have to jump through – don’t waste effort on complaining - just take a run up and jump

Get as many different points of view as possible

Be realistic in your objectives

Respect everybody from the low to the high

Develop a systematic approach

Develop your own approach – but be able to defend every component

***Further musings: on Intranet, see diaries in PPD course Year 2 module 4, Stress***

**Part 2. Multidisciplinary Team (MDT)**

* 1. **Belbin descriptors- pre-course task and team working**
	2. **Past experiences of living with or caring for people with long term medical problems.**
	3. **Case Scenario 1**

It is 15 months on from when you last met Mrs Maureen Baker. She was admitted as an emergency last week. She had collapsed while out for dinner with friends but insisted on going home. Her grandson (a 2nd year medical student) had come round but she told him that she was “fine” and sent him away. Later in the evening, her daughter visited and found her mother cold, clammy and very agitated. She immediately took her to A/E where she was found to be in sinus bradycardia (pulse rate 40/min) and was hypotensive (BP 70/50). She rapidly improved with intravenous fluids and stopping various medications. Within 2 days, Mrs Baker was insisting on going back home.

Mrs Baker still lives alone in her own house in Greenwich. While in hospital, she was very confused about time of day and easily became agitated if on her own and at night. Her arthritis has become more severe, particularly affecting her hands and she has been finding it increasingly difficult to dress herself. Her daughter was very concerned that her mother had not been taking care of herself. The weather had been very hot and her mother had not been drinking despite regular phone calls to remind her; she was always “too busy”. She was frequently not dressed when her daughter called to see her in the evening and often did not have anything to eat during the day. She had severe kypho-scoliosis due to osteoporosis and needed a stick to walk.

The ward nurses suggested to Mrs Baker that she should consider having help at home. She was adamant that she did not need any and that she should be allowed to live her life as she wanted.

Questions:

1. Should she just be discharged from hospital?
2. What further assessments may you need to enable discharge?
3. What other health care professionals would be helpful?
4. Whom would you communicate with after discharge?
5. What would you do if Mrs Baker refuses to stay in hospital to allow the social side to be sorted out?
6. What would you do if Mrs Baker refuses to have any help at home despite being advised to do so?

MDT Case Scenario 2

It is 5 years on from when you first met Mrs. Maureen Baker. She has recently been admitted with a chest infection.

Three years ago Maureen Baker was diagnosed with dementia. One year earlier, her niece, Sandra, moved back to the UK from New Zealand following the breakdown of her marriage and Maureen had suggested that Sandra stay with her until she found her own place. Maureen’s daughter moved to Glasgow last year. Since Maureen was diagnosed with dementia, Sandra has gradually provided more and more care for Maureen and more recently has also taken over the management of her day to day finances. Maureen has gradually deteriorated in her ability to carry out activities of daily living and had become increasingly dependent.

During previous admissions, concerns had been expressed about Sandra’s “rough handling” of Mrs. Baker. She was also noted on occasions to be raising her voice when talking to Maureen.

Sandra had excused her rough handing on the basis that “you have to do it that way or she would never move at all”. She was anxious to continue caring for her aunt, although she admitted she was finding it more difficult. Sandra felt it was her duty particularly as Maureen had been so kind to her when she her marriage broke down and because Maureen’s daughter was now so far away.

On this admission, following recovery from her chest infection, Mrs. Baker frequently showed periods of agitation. She would often say “I want to die”. When asked where she would like to go on discharge from hospital she said “the cemetery”. When asked if she wanted to go home, she said “no, no, no, no. I want to stay here” and appeared to be quite frightened at the thought of going home, but subsequently said “I must go home, she wants me to go”

Maureen’s daughter has spoken to the team by phone and said that she trusts Sandra completely and she knows that Sandra was always very close to Maureen. She says that she knows her mother would hate to be moved out of her own home.

# Questions

1. What discharge options are available to Maureen Baker when she leaves hospital?
2. What further assessments may you need to enable discharge?
3. What other healthcare professionals would be helpful?
4. How would you involve Sandra in planning the discharge?
5. What possible risks could be associated with discharge home?

**Part 3. Patient Safety. Framework for analysing medical error.**

**Contributory Factors underlying an Adverse Event caused by Human Error**

Derived from work by James Reason, Professor of Psychology at Manchester who published analyses of how error occurs based on work for the Aviation & Nuclear Medicine industries. Also see <http://www.npsa.nhs.uk/-> from 2011 onward there may be a new safety agency within the NHS.

1. Third party characteristics

* communication problems: language, aphasia, edentulous, different expectations
* illness: confusion, pain, depression
* disability (e.g. deaf)
* inadequate self-care
* personality
* angry, sad, distrusting, obsessional
* unknown feature (e.g. thin skull)

2. Task -related

* New, untested or difficult task
* Inadequate instructions
* Poor design

3. Individual factors (self)

* Stretching beyond expertise
* Lack of knowledge or skill e.g. poor interviewer
* Attitude/ motivation
* Tired/ under pressure
* Problem with attitude/ motivation

# 4. Team factors

* Poor teamwork
* Inadequate supervision
* Poor communication
* Poor team morale

5. Environmental factors

* Defective equipment
* Inadequate support services
* Inadequate staffing
* Out of usual environment
* Distraction e.g. noise, relatives

# 6. Organisation/management

* Inadequate leadership
* Poor co-ordination of services
* Poor management

**Case Studies** **to illustrate teamwork & error.**

**Apply the framework.**

1. 10 year old Maria Thermopolos, from the island of Ithaca, is visiting family but has been admitted by the FY2 to the Paediatric ward to have a blood transfusion for thalassaemia. She has a bad reaction (fever, low blood pressure) but no-one notices for an hour.

**How could this happen?**

1. Mr. Rodilla has woken up in the post-operative ward to discover that the wrong knee has been operated on. He had been admitted as an elective patient for a revision of right total knee replacement- the bandages are on the left side and he is still wearing the compression stocking on his right leg under which the surgeon had put the arrow to mark the operation site.

**What could have gone wrong?**

1. Mrs. Pulmonaria’s chest radiograph report suggesting a possible lung cancer was received by a fax at the Newport Pagnell Surgery. The Duty doctor was given the fax & asked the secretary to ring the patient to arrange an appointment with her usual GP. She did not attend the appointment. The next time she presented with chest discomfort was two months later-her GP then arranged for an urgent Chest clinic appointment.

**How could this loss of information been avoided?**

1. Harry felt his fingers close on the cold Snitch but was now only gripping the broom with his legs… he headed straight for the ground. With a splattering thud he hit the mud. His arm was hanging at a very strange angle. He fainted. .He came round …with someone leaning over him. He saw a glitter of teeth. ‘Oh no, not you,’ he moaned. ‘Doesn’t know what he’s saying.’ Said Lockhart loudly, to the anxious crowd of Gryffindors pressing around them. ‘Not to worry, Harry. I’m about to fix your arm.’

‘No!’ said Harry. ‘I’ll keep it like this, thanks….’ ‘Lie back, Harry,’ said Lockhart soothingly. ‘It’s a simple charm that I’ve used countless times.’

‘Why can’t I just go to the hospital wing?’

…….. ‘Stand back,’ said Lockhart, who was rolling up his jade-green sleeves.

‘No- don’t-‘said Harry weakly. A strange and unpleasant sensation spread down to his fingertips. He didn’t dare look at what was happening. He had shut his eyes, his face turned away from his arm, but his worst fears were realized as the people about him gasped. His arm didn’t hurt anymore- but it didn’t feel remotely like an arm………‘Ah, said Lockhart. ‘Yes. Well, that can sometimes happen. But the point is the bones are no longer broken. That’s the thing to bear in mind.’

Harry looked down at his right side….. Poking out of his robes was what looked like a thick flesh-coloured rubber glove. He tried to move his fingers. Nothing happened.

Lockhart hadn’t mended Harry’s bones. He had removed them.

Harry Potter and the Chamber of Secrets Bloomsbury 1998

**FY1 Diary ‘Nights’ Dr. Tamara Keith**

My third week as a house officer.... night one.....

Arrive at the hosp 8.30pm in time for hand over and to discover if my on call room exists... my magic badge thingy worked!

Day team arrive in the mess 8.50 ish to give a summary of each patient admitted through A&E today

Day house officer hands over patients I need to review over night, 3 ABGs (arterial blood gases)that had to be done at various points during the night, guy with Hb (haemoglobin)of 5 who needs transfusion and platelets, various patients they hadn’t got round too and endless cannulas

9.15 - 9.30 pm bleep started going mad with jobs for me to do.

Ealing hospital consists of many wards medical wards that I was looking after - 8S, 6S, 6N, 5S, 5N, 4S, 1S, all by myself! Im only a baby doctor I think to myself.

Called at 11pm to CCU- Coronary Care Unit (that’s the bad end of the cardiac ward, generally when they bleep you, they mean business) soon realise the nurses up there no FAR more than me

Man v breathless, looks ill, looks frightened, nurse suggests frusemide, I oblige, do ABG, get CXR (chest radiograph), after realising radiographers generally arn’t the most friendly people at 1130pm when they are 7 months pregnant.

Man’s CXR looks worse than the one in the xray book I used for finals, I go and ask the nurse if more frusemide is a good idea, she's nice and really wants to help, gives me the low down on what they normally do, then the whole acute pulmonary oedema I learnt for finals comes into action

Bleeped to one south (like MAU- Medical Assessment Unit) the ward pts go to straight from A&E when they are admitted. Young patient 24 year old very breathless, I arrive, having never seen an asthma attack before, is this moderate, severe, very severe or life-threatening I think to myself going through the criteria Prof Partridge tried to drum into me for finals... I’m starting to worry its very severe, she's not looking great and then I think mmm actually I think life threatening, remembering I am only in week three of house officership I fast bleep the medical registrar (procedure generally reserved when you think life in danger) he came quickly, I was impressed and reassured and then he said "is this a house officer emergency or a real one!" He then saw the patient and agreed with me she needed ITU.

Went to take Gentamicin level from very old person on 5N, the oldies ward, got a needlestick, panic set in, wanted to cry, nurse got cross, got more upset, went to find SHO, who didnt really care, went to A&E who equally couldn’t give a damn, sorted it out myself, oldie thankfully didn’t have HIV, Hep B or C.

With one of the patients I knew from the day, having an MI, she was alright did all the ECG, and general stuff then got bleeped to neighbouring ward saying relatives demanding doctor see there daughter. Dilemma who do I treat MI lady, or other lady. All other docs with a multiple stabbing in A&E. Its me or no-one I decide better to stabilise one and then move on.

By the time I get to the other one she had died. Felt dreadful and worse was to come –
23-year old had died with lung cancer, 7 relatives watched me certify her death as asked to be present. I thought who was I to stop them seeing the last ever thing done on their daughter. Very sad night.

Sun started to come up, realised I still hadn’t sat down, had a drink or eaten anything - what had happened to the on call room! I went to sit on the bed to read through the list of jobs I had to get through and then the bleep went off again that was the last I saw of that bed.

On to evaluate someone for blood transfusion, blood transfusion lady very grumpy on phone, clearly woke her up, I was following Haem Reg instructions in notes on what to do for various scenarios but she wasn’t having any of it!

Called to another asthma pt, felt like a bit of a pro on that front now and a couple more pulmonary oedema.

Called to write up a sliding scale - a whatty I thought, my genius little how to be an F1 book came out in the lift on the way up, wrote up what I thought, checked with friendly nurse, he said all looked good and smiled.

8am now only an hour until hand over.

Had to write list of patients that needed reviewing during the day - as now it was Saturday morning so day on calls take over.

9am hand over meeting, dragged on, all I could think of was bed. Left hosp 9.45am

Went home couldn’t sleep as it was day time, couldn’t eat was too tired.

This continued for 7 nights in a row, 7 x 13 hours in a row, slavery as far as I was concerned and then two days off (as in the weekend) to recover to start again on Monday.

The first three nights were pure hell, couldn’t sleep couldn’t eat could barely think

by night 4 fairly in the swing of it, almost enjoying it, for the first time I actually felt like a doctor.

by night 7, could barely walk straight. Lovely nurse I had made friends with on one of the wards made me lie down on the sofa and tucked me up took my bleep and when it went off said I was dealing with an emergency on her ward and would be half an hour!

I soon learnt that nurses were my best friend generally, make friends with them and your life is 200% easier, make them your enemy and everything is a 100 times harder.

**Apply the Framework**

***See more diaries by FY1s about their ‘on call’ work and further ‘musings’ from Year 3 students- on the Intranet in the PPD course Year 2 module 4, Stress section.***

**Topic Coping with stress and mistakes**

**Resilience Pre-course task**

Factors that determine resilience:

* Optimism
* Freedom from anxiety
* Openness
* Adaptability
* Positive & active approach to problem solving

**Rate your resilience quotient**

To get a general idea of how resilient you are, rate yourself on these characteristics, using this scale:

0 = Not at all accurate

1 = Somewhat accurate

2 = Moderately accurate

3 = Very accurate

4 = Extremely accurate

**Characteristics of resilient people**

**Your rating Statement**

1. I'm able to adapt to change easily.
2. I feel in control of my life.
3. I tend to bounce back after a hardship or illness.
4. I have close, dependable relationships.
5. I remain optimistic and don't give up, even if things seem hopeless.
6. I can think clearly and logically under pressure.
7. I see the humour in situations, even under stress.
8. I am self-confident and feel strong as a person.
9. I believe things happen for a reason.
10. I can handle uncertainty or unpleasant feelings.
11. I know where to turn for help.
12. I like challenges and feel comfortable taking the lead.

Your score /48

Submit to your PPD tutor

#### Topic Leadership Pre-course task.

#### Please ask those who participate to fill in the following form, grading the following attributes on a scale of 1-6 or uncertain-the scale has been deliberately reduced. Submit 2 examples to your PPD tutor

| THE STUDENT: | Uncertain | Strongly disagree | Disagree | Agree | Strongly Agree |
| --- | --- | --- | --- | --- | --- |
|  |  | 1 | 3 | 4 | 6 |
| **DEMONSTRATING PERSONAL QUALITIES** |
| 1. Is aware of own values and principals
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Is Reliable
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Is organised
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Is good at reacting to feedback
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Acts in an honest and ethical manner
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **WORKING WITH OTHERS** |
| 1. Is good at communicating with others
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Works well in partnership with others
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 1. Builds and maintains relationships well
 | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 9. Encourages others to contribute | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 10. Works well within teams | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **MANAGING** |
| 11. Good at planning | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 12. Motivates others and provides sound advice | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 13. Is responsibility for his/her own actions | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **IMPROVEMENT** |
| 14. Critically evaluates information well | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 15. Strives to improve | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 16. Has a willingness to change for the better | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| **SETTING DIRECTION** |
| 17. Is able to see the wider picture | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 18. Excels at application of knowledge | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 19. A competent decision maker | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |
| 20. Acts logically and well to overcome barriers | [ ]  | [ ]  | [ ]  | [ ]  | [ ]  |

####  Any further comments regarding leadership and professionalism:

**Appendix 1. Overview of the Year 2 PPD Course**

Summary of the PPD Course for Imperial students on the 6-Year Course, commencing study in 2010.

**Year 1 Term 1 Foundation Course**

**Study skills**

**Personal tutor meetings**

**Year 1 Term 2** ‘**Wit’** film session and tutorial.

**Year 2 The 21st Century Doctor**

**5 sessions in the autumn and spring terms**

Co-ordinators: Dr Elizabeth Muir and FY2 and other clinical colleagues

The Personal and Professional Development Course in Year 2 is a mixture of small group tutorial sessions and open learning. The open learning is mainly delivered using materials on the Education Intranet supported by activities which should be completed in the timetabled sessions. The course aims to provide information and resources about a number of key aspects of becoming a professional practitioner in medicine, highlighting topical issues that are currently challenging doctors.

**Duties of a medical student (taught session in Autumn term)**

This session takes as its starting point the GMC document, Duties of a Doctor and looks at the role of medical students in the light of this. What are their rights and responsibilities? What are the boundaries? Where do they go for help and advice? What common problems and issues do medical students encounter and, more importantly, what strategies can be adopted to help them through their time as medical students?

* + Understand the relevance of the Personal and Professional Development Course
	+ Identify the characteristics of a professional
	+ Describe and discuss the concept of medical professionalism in terms of attributes identifiable as virtues
	+ Apply Belbin descriptors to aspects of teamworking
	+ Compare and contrast differences in the duties of a medical student and qualified doctor
	+ Judge how to behave appropriately as a medical student and what to do when medical professional values are put ‘at risk’

**The Globally Aware Doctor (computer assisted learning session, CAL)**

This session focuses on a major aspect of the professional relationship, that between the doctor and the patient. In this session, class, age, ethnicity, gender and disability will all be considered in relation to evaluating and understanding the impact of prejudice and discrimination on medical practice. Global influences on healthcare including poverty and the influence of the pharmaceutical industry will also be explored.

Having worked through this module on Blackboard, you should be able to:

* + describe the socio-economic, environmental and cultural factors which determine health and access to healthcare
	+ apply understanding of how patients’ experiences in other countries and cultures can affect their health and our capacity to provide healthcare in the UK
	+ describe the roles of doctors and other healthcare professionals in influencing health and health services
	+ evaluate the influence of the pharmaceutical industry in healthcare
	+ apply an understanding of issues concerned with prejudice and discrimination
	+ describe the impact of factors contributing to discriminatory practice (including class, race, religion, culture, ethnicity, gender, age, sexuality, disability)
	+ identify aspects of your own background and behaviour and that of others which may affect relationships with patients and colleagues

 **The Self-aware Doctor: teamworking and professional relationships (computer assisted learning session)**

This session will provide an opportunity for you to identify and reflect upon difficult or demanding aspects of professional relationships; develop effective coping strategies to deal with difficult situations; investigate the professional view of team work and how this works in practice and recognise your own strengths as a team member

* + Identify and reflect upon difficult or demanding aspects of professional relationships
	+ Develop and be able to describe effective coping strategies to deal with difficult situations
	+ Define the professional view of team work and describe how this applies in practice
	+ Develop an appreciation of your obligations as a team member to colleagues and to patients and be able to apply this understanding to your work-related experiences (academic and clinical)
	+ Recognise your own strengths and areas for improvement as a team member
	+ Reflect on how your own professional life is maturing and how you deepen your knowledge, challenge your attitudes and broaden your experience through the humanities.

**Physician Heal Thyself (computer assisted learning session)**

Doctors are often regarded as better at caring for others than themselves. This session aims to develop skills and understanding of self care and looks at some of the major issues for medical students and doctors. The issues of responsibility for other doctors and ‘whistle blowing’ will be explored and you will be encouraged to participate in identifying strategies and skills which you will be able to use throughout your career.

The GMC has the following section in 'Tomorrow's Doctors' about the responsibility of medical students to protect patients

80. Good medical practice requires doctors to take responsibility for their own health in the interests of public safety. Medical students should also follow this guidance. If a student knows that he or she has a serious condition which could be passed on to patients, or that their judgement or performance could be significantly affected by a condition or illness (or its treatment), they must take and follow advice from a consultant in occupational health or from another suitably qualified doctor on whether, and in what ways, their clinical contact with patients should be altered. Students should not rely on their own assessment of the risk to patients.

* + Describe how to identify stress in yourself and others
	+ Explore the boundaries of responsibility towards yourself and other colleagues and be able to apply this knowledge to academic and clinical settings
	+ Define ‘whistle blowing’ and analyse its consequences
	+ Develop awareness of and begin to develop skills and strategies to manage stress and potential professional conflict.

**(also see Medical students:professional behaviour and fitness to practise, section 37)**

**Session 5: “Coping with mistakes” (taught session in Spring term) and Review of CAL sessions**

Why do doctors make mistakes? What factors underlie an adverse event caused by human error? Consideration of this topic of error-proneness will enable students to explore how their knowledge, skills, attitudes and personalities interact in the professional setting with either beneficial or potentially disastrous effect. The session aims to persuade students to feel positive about error in order to promote a culture that seeks for continuous improvement rather than blame.

Learning Objectives

* apply learning from clinical attachments & Blackboard modules to scenarios
* know how to cope with mistakes
* analyse mistakes using the 6 contributory factors of the London protocol- including studies of the cases of Victoria Climbie and Baby Peter
* coping with mistakes: resilience
* improve patient safety- you as a servant-leader with awareness of your leadership skills

**References for Session 5:**

Gawande, Anul Complications: a surgeon’s notes on an imperfect science. London: Profile Books 2002 ISBN **1861974981**

Vincent, Charles, Ed. Clinical Risk management 2nd Edition 2000 BMJ publications. ISBN 07279 13921

**Appendix 2 Graduate Entry Programme PPD Course, 2011-12**

Session 1  **Duties of a medical student; Teamwork and professional relationships**

**Aims**

To prepare for clinical work through exploring the roles and responsibilities of medical students and contrasting these with those of qualified doctors.

**Objectives**

By the end of this tutorial the student should be able to:

* understand the relevance of the Personal and Professional Development Course
* identify the characteristics of a professional
* describe and discuss the concept of medical professionalism in terms of attributes identifiable as virtues
* compare and contrast differences in the duties of a medical student and qualified doctor
* apply Belbin descriptors to aspects of teamworking
* judge how to behave appropriately as a medical student and what to do when medical professional values are put ‘at risk’

Session 2 **The Self-Aware Doctor: Physician Heal Thyself**

Doctors are often regarded as better at caring for others than themselves. This session aims to develop skills and understanding of self care and looks at some of the major issues for medical students and doctors. The issues of responsibility for other doctors and colleagues will be explored and you will be encouraged to identify strategies and skills which you will be able to use throughout your career.

This session will also look in more detail at difficult or demanding aspects of professional relationships and develop effective coping strategies to deal with difficult situations (e.g. shift and on-call work); investigate the professional view of team work and how this works in practice and reflect more on your own strengths as a team member

 **Learning Objectives**

The GMC has the following section in 'Tomorrow's Doctors'.

The responsibility of medical students to protect patients: section 80 in **Good Medical Practice** –this section requires doctors to take responsibility for their own health in the interests of public safety. Medical students should also follow this guidance. If a student knows that he or she has a serious condition which could be passed on to patients, or that their judgement or performance could be significantly affected by a condition or illness (or its treatment), they must take and follow advice from a consultant in occupational health or from another suitably qualified doctor on whether, and in what ways, their clinical contact with patients should be altered. Students should not rely on their own assessment of the risk to patients.

The new Guidance (**Medical students:professional behaviour and fitness to practise**) from the GMC and Medical Schools Council has several sections on Health. See 37- 39 and 56+57.

<http://www.gmc-uk.org/education/undergraduate/undergraduate_policy/professional_behaviour.asp>

**You should be able to:**

* Describe how you identify and seek help for your own health (physical, psychological and spiritual) needs
* Describe how you identify stress in yourself and others
* Explore the boundaries of responsibility towards yourself and other colleagues and be able to apply this knowledge to academic and clinical settings
* Define ‘whistle blowing’ and analyse its consequences
* Develop awareness of and begin to develop skills and strategies to manage stress and potential professional conflicts
* Give examples of the statements pertinent to health related issues in the Guidance for Medical students: professional behaviour and fitness to practice.

**Appendix 3**

Contact sheet of the people to talk to about any matter of concern

For students on the DE Introduction to Clinical Medicine Course 2012

Personal & Professional Development session

## All discussions are confidential

See Year 3 & subsequent Year Guides for names and contact details

Other members of your Hospital Firm/team e.g. the FY1 or 2, Registrar, Consultant Firm Leader

The Director of Clinical Studies for your site, for example, Professor Edwina Brown at the Charing Cross campus, e.a.brown@imperial.ac.uk

The Head of your year, for example, for Year 3 Dr Sarvesh Saini sarvesh.saini@imperial.ac.uk

Head of Welfare, Dr Mike Schachter, m.schachter@imperial.ac.uk

The Faculty Education Office, FEO, at South Kensington, Ms Janette Shiel, j.shiel@imperial.ac.uk

Or, the Teaching Co-ordinator at your site, Mrs Teresa Collins at Charing Cross, teresa.collins@imperial.ac.uk

In General Practice: your GP Teacher or the Practice Manager

the GP Facilitator for the practice concerned – via the Administrators in the Department of Primary Care on the 3rd floor of the Reynold’s Building 0207 594 3352 gpteaching@imperial.ac.uk

Or the GP Academic Co-ordinator, for example, in Year 3.

The Student Union President and Student Welfare representatives

Your Personal Tutor …………………………………………

It is strongly recommended that you let your tutor know about any issues that are affecting you or that you are worried about. It is particularly important to do so before any examinations and to submit information that may be considered mitigating circumstances.

**Appendix 4. Self-Perception Inventory, based on Belbin’s work - Team roles**

|  |  |  |
| --- | --- | --- |
|  | Team role contribution | Allowable weaknesses |
| **Plant (PL)** | Creative, imaginative, unorthodox. Solves difficult problems. | Weak in communicating with and managing ordinary people. |
| **Resource Investigator (RI)** | Extrovert, enthusiastic, communicative. Explores opportunities. Develops contacts. | Loses interest once initial enthusiasm has passed. |
| **Co-ordinator (CO)** | Mature, confident, and trusting. A good chairman. Clarifies goals, promotes decision-making | Not necessarily the most clever or creative member of the group. |
| **Shaper (SH)** | Dynamic, outgoing, highly strung. Challenges, pressurises, finds ways round obstacles. | Prone to provocation and short-lived bursts of temper. |
| **Monitor Evaluator (ME)** | Sober, strategic and discerning. Sees all options. Judges accurately. | Lacks drive and ability to inspire others. |
| **Teamworker (TW)** | Social, mild, perceptive and accommodating. Listens, builds, averts friction. | Indecisive in critical situations. |
| **Implementer (IM)** | Disciplined, reliable, conservative and efficient. Turns ideas into practical actions. | Somewhat inflexible, slow to respond to new possibilities. |
| **Completer Finisher (CF)** | Painstaking, conscientious, anxious. Searches out errors and omissions. Delivers on time. | Inclined to worry unduly. Reluctant to delegate. |
| **Specialist (SP)** | Single-minded, self-starting, dedicated. Provides knowledge or technical skills in rare supply. | Contributes on only a narrow front. |

**Appendix 5**

**Year 2** **Clinical Attachment (3-weeks)** (completed during the autumn term, on the six-year course)

**Learning aims and activities**

1. **Overall aims**

The main purpose of this attachment is to develop an understanding of the patient journey during a hospital admission, and to familiarise you with clinical working environments, and with hospital-based self-directed learning. The attachment will also have:-

* Introduce you to many different medical specialities and potential careers in medicine, and the professional qualities required in doctors.
* Introduce you to the work of a wide range of healthcare professionals and enable you to participate in multi-professional learning.
* Familiarise you with delivery of care in a hospital environment, including basic clinical observations, use of clinical equipment and patient documentation.
* reinforce the history taking skills you acquired during communication skills teaching in years 1 and 2;
* introduce you to basic clinical skills, and important concepts of infection control learnt in clinical skills labs;
	1. **Learning Activities**

You would have been attached to a lead Consultant and Firm for the duration of this attachment, but will also have undertaken activities throughout the hospital. The primary intention during this attachment is familiarisation with clinical working environments, rather than in depth learning about the particular firm’s specialty, though you should of course have taken advantage of the clinical experience available in that setting.

By the end of the attachment you should:-

* Have taken several patient histories and presented at least one;
* Become familiar with the hospital environment and
	+ participated in three ward rounds;
	+ stayed out of hours on at least one occasion
	+ attended at least one take;
	+ considered the care of patients with disability; \*\*
	+ seen the care of infusions and IV drug administration;
	+ seen pressure area care;
	+ seen endoscopies;
	+ seen physiotherapy;
	+ followed patient samples – blood tests, biopsies etc;
	+ attended x-ray and understood radiation protection;
	+ followed one patient journey e.g. x-ray, endoscopy, theatres;
	+ had contact with the multiprofessional team, eg.dieticians, speech therapists & applied your understanding of teamworking principles to real meetings; \*\*
	+ visited the pharmacy and attended a drug round;
	+ collected and analysed **3** discharge reports; \*\*
	+ focussed on patient safety.\*\*
* Spent one session per week in the Clinical Skills Laboratory.

\*\* objectives: reports to be submitted for discussion at the next PPD tutorial.

**Clinical Skills Programme, Year 2 Clinical Attachment**

|  |  |
| --- | --- |
| **Wk** | **Session** |
| 1 | **Basic Clinical Observations**1. **Obtaining and recording basic observations.** To include:
* Blood pressure, radial pulse, Respiration, Temperature (oral, axilla & tympanic), blood glucose monitoring, and Glasgow coma scale.
1. **Familiarisation with local patient documentation.** As an example:
* Observation, neurological, fluid balance chart, Drug, patient history, diabetes, stool/food,
 |
| 2 | **Introduction to Clinical Equipment & Consumables**As an example: * Respiratory equipment (different types of O2 masks, suction)
* Specimen collection
* Medication administration equipment (different giving sets, syringe types, needle sizes)
* Common consumables found within the ward area.
 |
|
|
|
| 3 | **Infection Control & Clinical and patient Safety**To include:* Sharps awareness and safety
* Hand washing procedures & techniques
* An awareness of the clinical application of patient safety
 |
|
|
|

**Inter-Professional Learning**

As a doctor you will always be **part of a team** looking after patients. It is therefore important for you to know how other members of the team approach patients and what skills they bring which will complement your own. In Year 3, but including the introductory attachment in Year 2, most of this will be in the form of multidisciplinary team meetings, ward rounds and clinics. There are a number of **learning outcomes** however with regard to inter-professional interactions and these will be assessed in the OSCE at the end of Year 3.

1. Understanding effective and appropriate communication between health professionals with the aim of improving patientcare
2. Demonstrating an understanding and respect for the role of others
3. Demonstrating sound clinical judgment across a range of differing professional and care delivery contex