



MB ChB Phase II

Core Clinical Education Learning Logbook

Academic Year 2022/23

Student Name:

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Introduction

Welcome to the Core Clinical Education learning logbook.

This learning logbook provides a practical guide to CCE, along with some forms, which will help you organise your timetable, and identify and complete the CCE requirements. It should be used in conjunction with your eportfolio.

Using this logbook and the eportfolio will give you practice at building up evidence of your clinical and professional development; something you will need to do as a foundation year doctor and for the rest of your career.

You can also use them as a record of your evidence of engagement required for your progression to Year 3 (in conjunction with the Phase II summative examinations). These criteria are detailed later in this logbook.

This logbook and the eportfolio have been designed to promote contact with those professionals who can help you maximise your learning during CCE by providing you with teaching, observation and discussion of your knowledge and skills. So do use them fully to document your learning and the feedback you receive.

Support & Resources

If you experience difficulties with any aspect of the block material, please ensure that you seek help early from the appropriate member of staff. Your faculty team and GP are important sources of help as are the Administrative Leads in the Trust. Academic queries may also be directed to the lecturer, Theme lead or the CCE lead (Amy Attwater). The Core Clinical Education Moodle pages contain contact details for all relevant staff members.

Pastoral and personal tutoring queries should be directed in the first instance to your Clinical Personal Tutor, or the Deputy senior tutor (Judy Purkis) as identified in this logbook. Issues with CBL groups/process can be discussed with your facilitator or the CBL lead (Louise Davis).

Meet the teams: Names and contact details

Medical Teaching Centre Team

Phase II Academic Lead	Professor Olanrewaju Sorinola Warwick Medical School Tel: 02476 528208 Email: olanrewaju.sorinola@warwick.ac.uk MTC Room 022	
Clinical Skills Lead	Professor Vinod Patel Education & Development, Warwick Medical School Hon. Consultant in Endocrinology and Diabetes George Eliot Hospital NHS Trust, Nuneaton Tel: 02476 865212 Email: Vinod.Patel@warwick.ac.uk	
Admin Team	Emma Hall Administrative Lead Room 014, MTC Tel: 02476 150898 Email: e.hall.2@warwick.ac.uk	Emma Sweenie-Fuller Phase II Secretary Medical School Office, MTC Tel: 02476 574044 Email: e.j.sweenie-fuller@warwick.ac.uk
	Jane Cardew Phase II Assistant Medical School Office, MTC Tel: 02476 574761 Email: j.i.cardew@warwick.ac.uk	
Teaching fellows & other Phase II staff	Dr Lindsay Muscroft Academic lead for AC1 Phase II deputy MTC 103 Tel: 02476 528933 L.Muscroft.1@warwick.ac.uk	Dr Amy Attwater Academic lead for CCE Phase II deputy MTC 103 Tel: amy.attwater@warwick.ac.uk
	Professor Kirstie Haywood EDI Lead Phase II Deputy Room A029 Contact via Teams or K.L.Haywood@warwick.ac.uk	Associate Professor Peter Kimani Academic Day Lead for Phase II MSB B-152 02476151187 Peter.K-U.Kimani@warwick.ac.uk

Do not hesitate to contact any of us if you have any questions or feedback.

Senior Tutor Team

Senior Tutor	Dr Anne-Marie Chilton Tel: 02476 573808 Email: a.chilton.1@warwick.ac.uk
Deputy Senior Tutor Phase II	Judith Purkis Email: Judith.Purkis@warwick.ac.uk Tel: 02476 573111

If you have a pastoral issue, you should go first to the Deputy Senior Tutor. If she isn't available, then you can contact the Senior Tutor.

GP Team

Lead	Dr Helen Gabathuler GP Lead WMS General Practitioner H.Gabathuler@warwick.ac.uk
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Community Learning Non-GP

Lead	Associate Professor Jan Cooper A006 MSB Can be contacted via Teams Janet.Cooper.1@warwick.ac.uk
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Commented [AA1]: Who is GP/comm lead? What is my phone number

George Eliot Hospital Team

Associate Clinical Director	Dr Asok Venkataraman Consultant Cardiologist asok.venkataraman@geh.nhs.uk		
Deputy Associate Clinical Director & <u>Phase II Lead</u>	Dr Hadiza Gachi Consultant Physician Hadiza.Gachi@geh.nhs.uk		
Administra tion GEH NHS Trust	General Queries: Undergraduate.Admin@geh.nhs.uk Tel: 024 7686 5092, 024 7615 3817, 024 7615 3075 Mobile: 07932 361741	Louise Harmer Medical Education Lead Postgraduate/undergr aduate/ CEFs Tel: 024 7615 3461; 07717 450684 louise.harmer@geh.nhs.uk	Sam Cook Undergraduate Medical Education & TEL Manager Tel: 07768 481043 samantha.cook@geh.nhs.uk
Clinical Skills and Resuscitati on Team	ClinicalSkillsTeam@geh.nhs.uk		

South Warwickshire NHS Foundation Trust Team

Commented [AA2]: Charlie/Bethan leaving- need to sort

Core Clinical Education Lead	Dr Rakhi Kakad Consultant Diabetes & Endocrinology, SWFT Email: rakhi.kakad@swft.nhs.uk	
Associate Clinical Director	Dr Viviana Elliot Consultant Acute Medicine, SWFT viviana.Elliott@swft.nhs.uk	
Medical Education Manager	Judith Morris Email: Judith.Morris@swft.nhs.uk	
Administrative Contacts	Angie Jones Assistant Manager Angie.jones@swft.nhs.uk	Trudy Ashmore Admin Assistant Trudy.ashmore@swft.nhs.uk Kesia Hetman Admin Assistant Katarzyna.hetman@swft.nhs.uk
Clinical Skills & Resuscitation Team	Jo Jennings Resuscitation Team - Julie Lyons, Claire Pahal, Michelle Hughes, Clinical skills team - Katie Morrison, Sally Tilsley, Karen Hartley, Karen Thomas ClinicalSkills.Education@swft.nhs.uk 01926495321 extension 8224	

University Hospital Coventry and Warwickshire NHS Trust Team

CCE Co-Leads	Dr Cyprian Mendonca, Consultant Anaesthetist UHCW – Lead for CCE cyprian.mendonca@uhcw.nhs.uk	Dr Sarah Grieve Consultant Nephrologist UHCW– Deputy Lead for CCE Sarah.grieve@uhcw.nhs.uk
Head of Undergraduate Education	Dr Jacqueline Woodman Consultant Obstetrician and Gynaecologist UHCW jacqueline.woodman@uhcw.nhs.uk	
Administrative contact	Tara Woodbridge Medical School Administrator – Phase 1 & 2 Medical Education Department, UHCW Clinical Sciences Building Tel: 02476 968787 Email: tara.woodbridge@uhcw.nhs.uk OR Undergraduatemeded@uhcw.nhs.uk	
Clinical Skills Tutors	Linda Crinigan, Michelle Mahoney, Gracia Jones, Amy-Dawn Lees ClinicalSkills@uhcw.nhs.uk Phone: 02476 968311	

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How to use your learning logbook and ePortfolio in CCE

This logbook and your ePortfolio are the crucial ways in which you will be able to document and demonstrate your learning during CCE.

You can document the following in your **ePortfolio**:

- **Meetings:** You and your tutor (consultant educational supervisor or supervisory team) may possibly document the following meetings in the ePortfolio:
 - Start of block review
 - Mid-block review
 - End of block review
- **Supervised learning events:** You and your educational supervisor can document feedback for the following supervised learning events in the ePortfolio:
 - OSLERS
 - Case-Based Discussions
 - Mini-CEX
- **Reflective log:** This will help you to remember key learning events.
- **Feedback:** You have been asked to create two files in your personal library titled 'feedback from students' and 'feedback from staff'. You should regularly add any new feedback you receive to these documents. Feedback is a very powerful learning tool, so we advise you to actively seek and record as much feedback as you can during CCE. You may also wish to consider recording any feedback you receive from patients.

You can document the following in this logbook:

- A checklist of the CCE evidence of engagement requirements
- **Therapeutics log:** If you wish to, you can log any new therapies you encounter in this log (alternatively you can record these in your ePortfolio)
- **Clinical cases and Presentation log:** This checklist gives you an idea of the common conditions/cases you should be learning about and seeing during the block. Tick them off as you encounter them, and make sure to seek / learn about those cases that you might otherwise miss. You may not see all of the presentations by the end of CCE, but the list is a guide to common and important conditions.
- **T:DOCs log** will help you keep track of your practical skills development: once you have been signed off on these skills in simulation, you can record further development on the ePortfolio: see 'forms'.

By filling out your logbook/ePortfolio you will not only consolidate your learning and identify further learning needs, but you will also demonstrate your engagement with learning and with the clinical team. Your supervisors and facilitators may ask to see your logbook (and ePortfolio) as part of your discussions with them, so that they can fully assess your engagement and learning. A proportion chosen randomly may be audited by the medical school as part of CCE to monitor student engagement.

If you have any problems with any part of your learning logbook, please ask the Phase II admin team for help. (Contact details are above)

If you or a member of your clinical team (e.g. supervisor, tutor) have any problem with your ePortfolio, please consult your guide to the ePortfolio, and if this does not help, do contact Judy Purkis at Judith.Purkis@warwick.ac.uk or Anne Marie Chilton at A.Chilton.1@warwick.ac.uk. (See contact details above). Academic support is also available from Amy Attwater (CCE Lead) amy.attwater@warwick.ac.uk

Maintaining confidentiality and data security

As a medical student, you occupy a privileged position in the clinical team. You may be party to sensitive patient data during your learning, and you need to ensure that you respect your position by being scrupulously careful in maintaining the confidentiality of the patients you see. You should also protect the confidentiality of your colleagues when writing in your ePortfolio.

Keep your logbook safe and avoid writing anything in it that could identify a patient or colleague. When noting down any evidence in your ePortfolio, make sure not to use any identifying information. Imagine that your writing somehow became public: would anyone be able to identify any of the clinical cases you have written about? If you think in this way, you will find it easier to remove any identifiable details from your written logs. Use terms such as 'patient A, male', rather than '57-year-old doctor'. Write only enough detail to help you learn and remember key learning points about each case. Similarly, do not identify any colleague or other person in your written work.

When writing a reflection, it is safest to focus on general themes of the case and learning gained, rather than on specific details.

If you have any concerns about writing confidentially and safely, do speak with your clinical team, or contact Judy Purkis at Judith.Purkis@warwick.ac.uk or Anne-Marie Chilton at A.Chilton.1@warwick.ac.uk

Your 10-week CCE block: what to expect

During CCE you will be taking increased responsibility for your own learning, identifying, and monitoring your own learning needs with the help of your student colleagues and faculty team. You will have exposure to Medicine, Surgery and Specialties blocks (which includes Anaesthetics, Psychiatry, Child Health, Obstetrics & Gynaecology) and General Practice. **The emphasis is on developing core clinical skills in history taking, examination, investigations, and initial / basic patient management.**

While it is expected that every clinical case will involve discussion about history, examination, differential diagnosis, investigation, and management, each 10-week block will have a slightly different focus:

The following block structure will help you to identify goals and monitor your progress throughout the block.

- **At the start of the block:**

At the start of each block, you should think about what you hope to learn from the next 10 weeks, and record this as a reflection on your 'start of block agreement and learning needs reflection' in the e-portfolio in the 'forms' section which you should share with your supervisor and faculty team. Having clear goals at the start will really help you to maximise your learning.

During the block you should aim to fill out your learning logbook and ePortfolio as fully as possible, seeking out opportunities for clinical learning, reflection, and feedback.

- **Mid-block review and feedback:**

Around week 5 of the block, you should meet with your named consultant educational supervisor or supervisory team to conduct a mid-block review. Before this meeting, you should review your 'start of block agreement', and use this as a basis for reflecting on your progress so far so that you can begin to fill out the 'mid-block review & feedback form' on the ePortfolio in the 'forms' section. This review will help you identify any outstanding learning needs and will allow your faculty team to give you feedback on your academic and professional performance so far so that you can stay on track to receive a satisfactory grade by the end of each block.

- **End of block review and feedback:**

At the end of the block, you will have a final review meeting with the named member of your faculty team, and you will receive formative feedback on your professional development and academic performance. You will also meet with your GP tutor to receive feedback. You should have completed all the essential elements of the block by this time. The end of block review and feedback is recorded on the ePortfolio, under 'forms'. In order to evidence your engagement with the block we recommend that you complete the learning log (available on Moodle) on a daily basis whilst at the hospital to record your experiences and discuss with your named consultant.

Assessment in CCE and Evidence of Engagement Criteria for Phase II

The GMC require that all medical students must demonstrate evidence of engagement throughout their medical training. The following guidance defines the elements that Warwick Medical School uses to demonstrate sufficient engagement with Phase II MBChB. At the end of Year 2, the Course Progress Group (CPG) will carefully consider whether each student has demonstrated sufficient engagement to progress to Year 3 and will make a recommendation to the exam board. This decision will be based on the fulfilment of elements listed below, which include demonstration of both academic and professional development. The exam board may decide that students who fail to satisfy one or more of these requirements will need to remediate before being able to progress to Year 3.

	Each CCE Block Tasks	Achieved		
		Medicine	Surgery	Specialties
1.	Completion of the online written formative assessment by the deadline (usually near end of block)			
2.	Satisfactory attendance in clinical placement: 100% expected, 80% minimum			
3.	Submission of an end of block Hospital Trust form (No outstanding concerns identified)			
4.	Submission of an end of block GP form (No outstanding concerns identified)			
5.	Submission of 2 OSLEs (1 in GP, 1 in hospital)			
6.	Submission of 2 Mini-CEX (1 in GP, 1 in hospital)			
7.	Submission of 2 CBDs (1 in GP, 1 in hospital)			
	Across all Three Blocks			
8.	Overall satisfactory attendance at monitoring points (including academic day) as specified on Tabula: 100% expected, 80% minimum			
9.	Completion of a clinical audit in CCE 2 only	Graded as satisfactory		
10.	Completion of specified mandatory TDOCs			
11.	Completion of Student Selected Component 1	Graded as satisfactory		

OSLEs, mini-CEX and CBDs should be completed by a doctor at ST3 level or above. The forms for these can be self-entered (on eportfolio) in conjunction with your supervisor, but the End of Block form must be done by your supervisor via sending a ticket to them. Your GP will do at least one OSLE, Mini-CEX and CBD with you.

The end of block forms should be signed by the allocated consultant, GP or nominated deputy.

Your *professional* performance will be assessed by your faculty team and GP tutors according to the following FOUR elements:

Professional performance	How to achieve a satisfactory grade	Possible Grades
Satisfactory attendance	100% attendance expected at all sessions, including academic days and clinical skills sessions (minimum of 80% attendance) plus satisfactory attendance at clinical placements, as judged by your faculty team.	Commended
		No concern
		Concern
Engagement with learning	Demonstrate your engagement with learning by actively contributing during learning sessions, by engaging with the learning opportunities provided by your faculty team, and by demonstrating engagement with the learning portfolio.	Commended
		No concern
		Concern
Engagement with the clinical team	Demonstrate your engagement by showing respect for all members of the clinical team, by engaging with the learning experiences they provide, and by seeking to learn about the roles and skills of the different members.	Commended
		No concern
		Concern
Professional behaviour	Demonstrate your professionalism by showing through your behaviour that you understand and follow the guidance provided by the General Medical Council on professionalism.	Commended
		No concern
		Concern

Please note that at your mid and end block reviews you will need to use your e-portfolio and learning logbook (including your records of your weekly timetables and reflective logs) as evidence of attendance and engagement.

Assessment

Your course progress will be assessed in the following FOUR ways during each CCE Block (relevant forms for SLEs can be found in the ePortfolio under 'forms' and 'supervised learning events'):

1. TWO Objective structured long examination records (OSLERs); one in the hospital and one in the GP setting.
2. A minimum of TWO Case Based Discussions (CBD); one in the hospital and one in the GP setting.
3. A minimum of TWO Mini-Clinical Evaluation exercises (Mini-CEX); one in the hospital and one in the GP setting
4. Hybrid formative (MCQ/SAQ) at the end of each 10-week CCE block. These are completed online via the assessment Moodle page.

The above assessments are intended help you through the provision of constructive feedback on your performance and progress. Feedback on the written formative exams will be automated. Feedback on the OSLER, CBD and Mini-CEX elements (verbal and written) will be provided during your clinical placements. Further details on each of these supervised learning events are detailed next.

1. OSLER (Objective Structured Long Examination Record)

OSLER is similar to the final professional exam and includes observation of full history taking, appropriate clinical examination, problem solving, initial management and interaction with the patient. All students will be expected to go through a minimum of two OSLERs per 10-week block and the faculty should facilitate the opportunity for more where possible.

Year 2 OSLERs are not graded; however constructive feedback on clinical performance and recommendations for improvement on consultation competencies (history, examination, problem solving, relationship with patients and initial management) and learning objectives should be provided for each student to enhance performance.

2. Case Based Discussions

Students are able to choose their own cases for the case-based discussions based on their learning needs. However, faculty may offer guidance on appropriate patients they deem as having a particular history and / or examination signs that provide informative learning material. Case-based discussions should happen between an individual faculty and student with the aim of increasing depth in the students' knowledge regarding the case presented and relevant medical knowledge around the case. They should prepare the student for the same format of case-based discussion that they will be expected to have with their educational supervisors in their Foundation (F1/F2) and later training.

3. Mini-Clinical Evaluation Exercises (Mini-CEX)

The faculty member should locate patients for appropriate focused observation. This may not necessarily focus on clinical examination but is based upon an observed interaction with a patient e.g., an observation of history taking, observation of examination, observation of a procedure, or giving an explanation to a patient.

4. Formative exam

Near the end of each CCE block, there will be an online formative exam comprised of MCQs and SAQs on the presentations you have been learning about in your block. The exams will differ depending on which block you are in. There will be a deadline given to complete this exam each time. It is recommended that you do this as a closed book exam to evaluate your own knowledge and reflect on which learning areas need to be focused on. The university will only assess that the formative is done, not what the score is.

Guidance for students on the role of the faculty

- Each student in the faculty group will be assigned an educational supervisor, or supervisory team, to oversee progress and assessment.
- At the start of each 10-week rotation, each student will complete a 'start of block' form, in which they will reflect on their learning needs and goals for the coming weeks. There are also mid-block and end of block assessment forms that should be completed with their named educational supervisor as a means of monitoring their progress and providing feedback to help them learn. These and other forms should be completed online using the student NHS e-portfolio. The website address for the NHS ePortfolio is: <https://nhseportfolios.org>.
- Faculty groups are requested to familiarise themselves with the ePortfolio as soon as possible to ensure that students are supported in the use of this e-learning tool.
- Faculty group members are requested to respond promptly to students' emails and ePortfolio 'ticket requests' for feedback. **A standard of one to two weeks response time has been set.**
- **Each faculty member will be expected to provide two hours of face-to face teaching to the student group per week.** This includes reviewing their learning objectives, teaching on the ward rounds, case-based discussion, tutorials on investigations, applied science, discussion on patient management and giving feedback on their performance. Please note though, if your consultant is unavailable, please make use of their team to also complete these learning exercises.
- Faculty team members should work together to support teaching students within their faculty group. It is particularly important that this signposting occur when an educational supervisor is absent/unavailable. **It does not have to be your consultant who carries out teaching events or signs off your assessments, so please make use of their whole team.**
- Faculty groups will meet at the end of each block to discuss the progress of their students and make recommendations as necessary. This will include assessments of their academic and professional progress including attendance and engagement with the learning opportunities

Dealing with concerns about academic or professional progress during CCE

A single concern or failure to achieve the expected standard on any element will result in a *recommendation* to meet with your Clinical Personal Tutor (CPT). Multiple concerns may result in a *requirement* to meet with your CCE Lead or Phase Lead who may need to involve the Course Progress Group (CPG) and / or the Head of MBChB depending on the nature of the concern.

Even if no concerns are raised, students are expected to have had a minimum of four one-to-one meetings with their CPT by the end of the year. This includes the one in AC1 and 1 in each CCE block. If you are contacted by your CPT for a meeting, be sure to reply promptly, as this is an important factor in professionalism.

CCE Learning Tips from previous students

Before your placement....

- Email your consultant(s) and the other consultants in your faculty team before you start. If you don't get a response, find out from their secretaries where they are and track them down in person on your first day in the Trust.
- Organise studying of your presentation list ready to start.

When meeting your consultant for the first time.....

- Get to know the secretaries- they will know where/what your consultant is doing
- Arrange a date to do your MiniCEX, OSLE and CBD early on in the block
- Find out how your consultant prefers to be contacted
- Ask your consultant for opportunities early on
- Be honest about your weaknesses and how you'd like to improve
- Ask for a timetable of what goes on in the department/specialty to help structure learning.

How should I approach CCE?

- Be confident, persistent, and proactive; don't be afraid to ask for learning opportunities
- Seem eager and want to learn and be efficient and proactive
- Be comfortable with introducing yourself and asking for opportunities
- Don't just rely on your consultant for teaching: they have a whole team
- Try to gain experience outside of the wards- clinics, investigation, surgery, endoscopy
- Make use out of the bedside teaching slots - they are invaluable teaching.
- Get the sign-offs done in plenty of time, and make sure you turn up when scheduled to.
- Make the most of placements by setting goals for what you want to see/achieve each day
- Take responsibility for your own learning and put active effort into the way you come across.
- Ask the medical education team for names of consultants who are more available for teaching sessions.
- Always ask to do a consultation/take a history/examine if time permits (e.g., if there is a DNA) - all doctors have let me, and several commented I was the first student to ever ask.
- Ask questions, be engaged, even when observing think in your head why the doctor is asking those questions, what differentials do they have in mind, and what examinations / investigations would you do etc. and make the most of every opportunity – 'you get what you put into it'.
- You are given a large amount of freedom, and this is fantastic because it allows you to create and make the most of great learning opportunities. Get stuck in at the start and you'll start to get the hang of it, but it may take a few weeks.

Balancing clinical time and study.

- Balance time at hospital with making sure you do the presentation list /learning outcomes.
- Try to use time effectively. It is a tough course, and you need to make sure you are getting in the book hours.
- A lot of passive learning occurs during time on the wards, in clinics and in theatre, which is useful.
- Read up on every case you see afterwards to fill in any gaps/consolidate your knowledge
- Relate your learning on the wards to the presentation list.

Where to get the best teaching....

- If your allocated consultant isn't available – contact the rest of your faculty team, or there are always FY1s and FY2s up for teaching you, just introduce yourself – they will provide some of your best teaching. If you are really stuck- go to see the medical education team and they will find a learning opportunity for you.
- The registrars tend to be keener to teach in clinics and the FY1/FY2s have been the best on the wards in my experience.
- I emailed doctors I had never met but were in a specialty I was interested in and asked if I could observe. Many doctors are happy to have interested students with them. If you don't get a reply, it's likely you are not knowingly being ignored but that they are very busy.
- I recommend asking around on allocated wards about teaching opportunities. FY1s are great way to find out where and when things happen. I also recommend a group WhatsApp of 10 or so students on the same rotation so you can share news of teaching easily.
- If there's no one around or everyone is busy just go straight to the patients and ask if you can speak to them, 90% of the time they seem to appreciate the company and the interest e.g., patients on UHCW ward 10/11 awaiting cardiac surgery are great for listening to heart murmurs as many are waiting for a valve replacement.
- Go to the lunchtime teaching sessions put on by consultants at UHCW for example:
- If you want to practice clinical skills, the FY1/FY2s/most Registrars are very happy to demonstrate / facilitate once you have been signed off by the clinical skills team.
- Go to AMU, SAU and A&E; even better if after 5pm – ask the person in charge if you can shadow them – not always possible but the experience is unbeatable.

Your weekly CCE timetable

Add your weekly activities to this log and use it when meeting with your consultant to evidence your learning.

This page can be printed directly from Moodle.

Week Date.....

Monday	Tuesday	Wednesday	Thursday	Friday	Learning Priorities:
am	am	am	Am	am	
pm	pm	pm	Pm	pm	

Therapeutics log

CCE is an excellent opportunity for you to start to learn how to prescribe commonly used medications. You will be expected to have a basic knowledge of common drugs, their names, mechanisms of actions, and their side effects.

Please record any medications or therapies you encounter here. You can include information about non-drug therapies here also: information about psychoeducation, psychotherapy, etc. Remember to also include additional therapies such as oxygen therapy, intravenous fluids, etc.

This page can be printed from Moodle if you need more space.

Therapy	Indication(s)	Mechanism of action	Side effects/contraindications

Core Clinical Education 2022 Presentations

Below is a list of common and important presentations you should cover by block throughout the course of CCE. The presentations are not an exhaustive list; it is to give you an idea of the common conditions you are expected to come across in the clinical environment.

These presentations can and do overlap across Medicine, Surgery and Specialties blocks and you will come across them in various settings. The important thing is the learning from these areas during Year 2.

The key learning outcomes are:

- To take an adequate history and understand relevant differentials
- Carry out necessary examinations and investigations
- To understand initial management plans for such conditions

Medicine Block Presentations

<p>Cardiovascular</p> <ol style="list-style-type: none"> 1. Breathlessness (cardiac) 2. Chest pain 3. Heart murmurs 4. Hypertension 5. Painful swollen leg 6. Palpitations 7. Peripheral oedema and ankle swelling <p>Endocrine</p> <ol style="list-style-type: none"> 8. Abnormal blood sugar / Polydipsia 9. Fatigue 10. Weight gain / Weight loss <p>General medicine / Metabolic</p> <ol style="list-style-type: none"> 11. Acid-base abnormalities 12. Allergy / Anaphylaxis 13. Deteriorating patient / Sepsis 14. Fever 	<p>Neurological</p> <ol style="list-style-type: none"> 15. Dizziness 16. Headache 17. Fits / Seizures 18. Stroke <p>Renal and urinary</p> <ol style="list-style-type: none"> 19. Acute Kidney Injury / Renal failure 20. Chronic Renal Failure / Proteinuria 21. Fluid and electrolyte abnormalities <p>Respiratory</p> <ol style="list-style-type: none"> 22. Acute upper respiratory symptoms /sore throat 23. Breathlessness (non-cardiac) 24. Cough (+/- wheeze) 25. Haemoptysis 26. Pain on inspiration
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Surgery Block Presentations

<p>Breast</p> <p>1. Breast lump; breast tenderness / pain</p> <p>Ear, Nose and Throat</p> <p>2. Ear Pain</p> <p>3. Epistaxis / Nasal obstruction</p> <p>4. Hearing loss</p> <p>5. Hoarseness and voice change</p> <p>6. Vertigo</p> <p>Gastrointestinal / Colorectal</p> <p>7. Abdominal distension, mass, and ascites</p> <p>8. Acute abdominal pain</p> <p>9. Bleeding from the GI tract / Melaena</p> <p>10. Change in bowel habit / Diarrhoea and vomiting</p> <p>11. Chronic abdominal pain</p> <p>12. Jaundice</p> <p>13. Swallowing problems / Dysphagia</p> <p>General</p> <p>14. Lump in the neck</p> <p>15. Lymphadenopathy</p>	<p>Musculoskeletal</p> <p>16. Acute joint pain / swelling, bone pain / swelling</p> <p>17. Back pain and sciatica</p> <p>18. Lower limb disorders</p> <p>19. Upper limb disorders</p> <p>Ophthalmology</p> <p>20. Acute change in or loss of vision</p> <p>21. Red eye / eye pain</p> <p>Urology</p> <p>22. Groin / Scrotal swellings and pain</p> <p>23. Haematuria, Dysuria / Abnormal urinalysis</p> <p>24. Urinary symptoms / retention</p> <p>Vascular</p> <p>25. Limb claudication</p> <p>26. Shock</p>
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Specialties Block Presentations

<p>Child health</p> <ol style="list-style-type: none"> 1. Development in the healthy child / developmental delay 2. Fever in a child 3. Newborn screening / assessment <p>Care of the elderly</p> <ol style="list-style-type: none"> 4. Frailty / Impact of chronic disability 5. Falls <p>Dermatology</p> <ol style="list-style-type: none"> 6. Pruritus / Acute and chronic rashes 7. Skin infections and skin ulcers 8. Skin lesion / Skin lump <p>Haematology</p> <ol style="list-style-type: none"> 9. Anaemia / Pallor 10. Bruising and bleeding tendency / Hypercoagulability <p>Mental health</p> <ol style="list-style-type: none"> 11. Acute Confusion / Delirium 12. Anxiety, Phobias, OCD 13. Low mood / Elated mood / Hallucinations 14. Memory loss, chronic confusion 15. Substance misuse and addiction 	<p>Other</p> <ol style="list-style-type: none"> 16. Acute and chronic pain management <p>Rheumatology</p> <ol style="list-style-type: none"> 17. Chronic joint pain and stiffness <p>Women's health: Gynaecology</p> <ol style="list-style-type: none"> 18. Cervical screening / Cervical smear 19. Contraception request / advice 20. Genital discharge / Genital ulcers and warts 21. Menopausal problems 22. Menstrual problems <p>Women's health: Obstetrics</p> <ol style="list-style-type: none"> 23. Antenatal care, screening / risk assessment 24. Labour 25. Normal pregnancy / physiology of pregnancy 26. Puerperium and difficulty breast feeding
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Clinical cases / Presentations log

Note down any learning points relating to the presentations and cases you see here.
This page can be printed from Moodle.

Presentation	Learning points / Actions

Medical Imaging Phase II

Overview

In Phase II students are expected to revisit Phase I medical imaging objectives and thus be able to identify key anatomical structures on medical images. In Phases II and III students are expected to be able to identify major regional pathologies, predominantly on X-ray, and to describe the main types of imaging that are used across a range of common patient presentations.

Phase II Learning Objectives

Medical Imaging in Common Emergency Conditions

In Phase II, students are expected to be able to identify major anatomical structures and their vascular supply/drainage (with/without contrast) on X-ray, CT, and MRI. Students should be able to perform basic interpretation of chest (CXR), abdominal (AXR) and skeletal radiographs and be able to identify each of the following pathologies:

Radiograph (X-ray)	Common Emergency Condition
Chest	Simple/tension pneumothorax Pleural effusion Lung/lobar collapse Lung consolidation Heart failure Foreign body Pneumoperitoneum (on erect CXR)
Abdominal	Small bowel obstruction Large bowel obstruction Pneumoperitoneum Foreign body
Skeletal	Bone fractures Pelvis Femoral neck Wrist/carpus/scaphoid Long bones

For each of the following presentations, student should be able to:

- Describe the role of multi-modality imaging in the investigation of common clinical conditions (including common emergencies) and justify the choice of imaging modality.
- Recognise and describe common pathologies on basic imaging, and adequately appraise a radiological report to take the appropriate action including in the acute setting.

Region	Presentation
Chest and Cardiovascular	Cough Chest pain Breathlessness
Gastrointestinal	Abdominal pain Abdominal masses Bowel obstruction Bowel perforation
Renal and Urological	Urinary colic Urinary obstruction
Breast	Masses Abscesses
Neurological	Altered consciousness Stroke
Musculoskeletal	Bone pain Joint pain Bone and soft tissue trauma
Obstetrics and Gynaecological	Use of ultrasound in normal pregnancy Suspected or abnormal pregnancy

Diagnostic procedures at the trusts

Where possible (access will vary between Trusts) it will be extremely valuable to observe the following diagnostic tests and procedures so that you are able to explain to patients what will happen. Where feasible, try to ask for an opportunity to watch these investigations.

- Upper and lower GI endoscopy
- CT scan
- MRI scan
- Coronary angiography
- Bone marrow biopsy
- Echocardiography
- Lumbar puncture
- Doppler studies- lower limb
- Spirometry/lung function tests
- Mammogram
- Ultrasound guided biopsy

Investigations List

This is a list of the standard investigations performed in the NHS. The list has been broken down into initial, further/follow-up and specialist. The initial investigations are the commonest investigations carried out.

They are the investigations you will routinely order as FY1 doctors. You need to be able to explain:

1. Indications for use
2. Risks of the investigations
3. Parameters measured (NOT ranges- these are supplied in any assessments)
4. Identification of an abnormal value
5. How to respond appropriately. This response may include:
 - a. Urgent management
 - b. Long term management
 - c. Further/ follow-up investigations
 - d. A combination of the above

During Phase I you should have encountered all of the initial investigations.

The **follow-up/further investigations** are routinely used investigations, commonly in response to an abnormality detected in an initial investigation. This second category of investigations is used to further refine your differential diagnosis or possibly monitor response to treatment. You should aim to learn about these second-line investigations during Phase II.

The specialist investigations are investigations conducted by specialists, normally in response to abnormalities in one of the preceding categories. These investigations should be performed under the direction of a specialist or senior clinician (for example, a consultant or GP). As an FY1 doctor you would be expected to know the reasons for these tests and the implications of a positive test, however a detailed understanding of interpretation of results is not expected.

The subdivision of investigations is an idealised form. **As you progress through your training you will see clinicians using clinical judgement to order investigations from multiple categories at once and also situations in which further investigations can become initial e.g., in the Emergency Department.**

The investigations are broken down by the departments that perform the investigations, which does not always obviously correlate with the case e.g., CSF (cerebrospinal fluid) is sent to biochemistry as well as microbiology for analysis in suspected meningitis. It is also important to note that a positive initial result from one department e.g., haematology, might require a follow up investigation from another department e.g., radiology or cellular pathology.

If you are unsure what some of these investigations are for, it is recommended that you revise them before the start of CCE.

Blood Sciences- Investigations

1. Initial Investigations	2. Follow-up/ further investigations/ monitoring	3. Specialist Investigations
<u>Haematology</u>		
FBC (Full Blood Count) Haemoglobin ESR (Erythrocyte Sedimentation Rate) PV (Plasma Viscosity) INR (International Normalized Ratio) Blood film (malaria screen) D- Dimer	Blood Film Reticulocyte Count Haematinics Group and Save Cross Match	Bone Marrow Trepine and Aspirate Bleeding Time/PFA 100 Electrophoresis Sickle Cell Screen Serum protein electrophoresis Infectious Mononucleosis Screen Thrombophilia Screen Malaria Film HbA2 levels HbF Levels G6PD Screen Direct antiglobin test Factor Assays vWF (von Willebrand Factor) Antifactor Xa
<u>Immunology</u>		
1. Initial investigations	2. Follow-up investigations	3. Specialist investigations
Rheumatoid Screen Coeliac Screen (tTG) Autoimmune Screen	Protein Electrophoresis Immunoglobulins Anti-thyroid antibodies ASOT titres	HLA B27 Scleroderma antibodies (ANA, Scl-70)

Biochemistry and Metabolic Medicine

1. Initial investigations	2. Follow-up investigations	3. Specialist investigations
U & Es (Urea & Electrolytes) LFT (Liver Function Tests) Gamma GT Glucose ABG (Arterial Blood Gas) Serum Amylase CRP (C Reactive Protein) Beta- HCG (Human Chorionic Gonadotrophin): (Urine and Serum) Calcium Lipid Profile Paracetamol levels Salicylate levels TSH (Thyroid stimulating hormone) Troponin T and I	Free T3, Free T4, PTH HbA1c CSF (Cerebrospinal Fluid)- Spectrometry CSF (Cerebrospinal Fluid)- Glucose and Protein Cortisol PSA (Prostate Specific Antigen) FSH (Follicle Stimulating Hormone)	CEA (Carcinoembryonic antigen) Ca-125 Oestrogens Progesterone Ca15.3 Ca19.9 LH (Luteinising Hormone) Sweat Chloride Testosterone Ammonia Anti-TPO (Thyroid peroxidase antibody) Androstenedione DHEAs C1 Esterase inhibitor C3 C4 Immunoglobulins Synacthen Test Dexamethasone suppression test Urine Cortisol levels ACE (Angiotensin-converting enzyme) ACTH (Adrenocorticotropic hormone) Alpha-fetoprotein Aldosterone Alpha-1-antitrypsin Calcitonin Thyroglobulin Catecholamines Prolactin Urine Catecholamines Urine 5-HAA Vitamin D

Microbiology		
1. Initial Investigations	2. Follow-up/ further investigations	3. Specialist Investigations
Urine microscopy, culture, and sensitivities (MC & S) Blood MC & S CSF MC & S Sputum MC & S Tissue MC & S Fluid MC & S Faeces MC & S Faecal <i>Clostridium difficile</i> testing Genital MC & S Wound/ ulcer/ skin swab - MC & S MRSA screening swabs	Antibiotic Assays Legionella urinary antigen Faecal parasitology Blood/ CSF PCR for meningococcal disease. Sputum acid fast stain and culture for tuberculosis. Fungal culture of specimens.	Parasite serology. Chlamydia and Gonococcus PCR (urine, genital specimen). Cryptococcal antigen Detection. Sputum culture for <i>Legionella</i> , <i>Bordetella</i> . <i>Bordetella pertussis</i> PCR. Other bacterial serology (too numerous to list here). Syphilis serology. Fungal serology (e.g. <i>Histoplasma</i>). 16s PCR for culture negative specimens. Tuberculosis PCR and rapid resistance testing. Fastidious bacterial culture e.g., <i>Nocardia</i> , <i>Actinomyces</i> .

Virology

1. Initial Investigations	2. Follow-up/ further investigations	3. Specialist Investigations
Antenatal screening serology. HIV serology. Hepatitis serology (Hepatitis A, B and C viruses)	Respiratory virus swab (Including influenza). CSF PCR, for viruses (Enterovirus, herpes viruses, varicella, and mumps). EBV, CMV serology. Norovirus PCR.	Tropical virus serology and PCR. Eye swab PCR for adenovirus. Oral swab antibody detection for mumps, measles. HIV viral load, genotyping, and resistance testing. HBV resistance testing. HCV genotyping and resistance testing. Hepatitis D virus testing. VZV, Rubella, Measles immunity testing.

Cellular Pathology

1. Initial Investigations	2. Follow-up/ further investigations	3. Specialist Investigations
Cytology Histology Postmortems	Immunocytochemistry	FISH PCR Frozen Sections

Physiology

1. Initial Investigations	2. Follow-up/ further investigations	3. Specialist Investigations
ECG (Electrocardiograph)	Respiratory Function Tests (Spirometry). Peak Flow.	EEG. (Electroencephalogram) Neurophysiology- EMG Urodynamics.

Bedside Investigations

1. Initial Investigations	2. Follow-up/ further investigations	3. Specialist Investigations
Urinalysis (Dipstick) Blood Glucose VBG/ABG	Blood Ketones	

Patient Management in Medicine

When learning about patient management, it is tempting to jump straight to thinking about drug therapy, but to develop an effective management plan you need to consider the patient holistically. It is very helpful to get into the habit of structuring your management plan.

First, here are some basic principles that will help you.

1. **The patient is always at the heart of everything you do.**

Include the patient in all aspects of their care. You can do this even in an emergency (by taking the time to reassure the patient and let them know what is happening around them. It is even more vital as part of your approach to those with longer term conditions. Adopting a shared approach with your patients has positive effects on both medication adherence and on medical outcomes. Time spent building a therapeutic relationship with your patients and on answering their questions is never wasted. Once you have clearly elicited your patients' **ideas, concerns and expectations** in your history-taking, you are in a good position to work together to address the unique needs of each patient effectively.

2. **Use nationally recognised guidelines and interventions to shape your management plans**, so that you are using the best available evidence for each of your patients.

NICE Clinical Knowledge Summaries and BMJ best practice are usually helpful in addition to NICE guidelines. [Clinical Knowledge Summaries | Evidence and best practice resources | What we do | About | NICE](#)

You DO NOT need to learn every guideline for the examinations but should be aware of the red flag criteria associated with common presentations (e.g., low back pain, dyspepsia) and the principles of management (e.g., stepped care in asthma).

3. **Observe** clinicians developing management plans with patients. Do they tailor the approach to the individual patient? Do they have good ways of explaining things that you could try out? How do they include the patients views and check the patient understands the plan?

4. **Think about patient safety.** Errors happen when we stop thinking; either through over-confidence, lack of time, or a lack of insight into how common errors are.

- Think: 'what is the worst outcome that could happen here? What are the risks in this case? Have I thought of how to minimise the risks?'
- It is safest to think of every diagnosis as provisional, especially for complex or difficult-to-treat cases. Think: 'What new information could alter my diagnosis? Do the facts truly fit my diagnosis? When am I going to review this case to see if my original diagnosis and management plan are optimal?'
- Think: 'with whom shall I discuss this case with to ensure that I have thought of everything? How will I identify errors in my thinking?'

5. **Management and the multi-disciplinary team.** A further way to develop your thinking about management, particularly for chronic conditions, is to think of the multi-disciplinary team and all the people who could help the patient.

On the following pages, you will see some ideas to help you structure your thinking about management.

Think about organising your management in terms of...

TIME: Immediate, Short-term, and Longer-term management.

<p>Immediate Management: ‘What I will do in the seconds/minutes/hours after the patient presents to me’</p>	<p>Manage any life-threatening conditions (e.g., ABCDE approach, defibrillate a shockable rhythm, get IV access etc.)</p>
<p>Short-term management: ‘The care that I will organise in the hours/days/weeks following a patient’s presentation’</p>	<p>Consider both... <u>supportive</u> therapy (e.g., IV fluids to prevent pre-renal failure in a very ill patient, or pain relief after a fall) and... <u>definitive</u> therapy (e.g., antibiotics for an infection, or surgery for appendicitis)</p> <p>Examples:</p> <ul style="list-style-type: none"> • TED stockings and early mobilisation with physiotherapist after a period of immobility. • Further drug therapy following stabilisation. • Referral to a specific team • Referral to a psycho-education and rehabilitation group following an MI • Enhanced frequency of home visits post-discharge to monitor progress, etc.
<p>Longer-term management: ‘The longer-term care that I will help the patient to access, so that their condition (if chronic) can be managed effectively’</p>	<p>Examples:</p> <ul style="list-style-type: none"> • Collaboration with patients to agree a shared management plan. • Planning of future care needs, organisation of advance directive in the case of a new diagnosis of dementia. • Review of supports at home, involvement of multi-disciplinary team, coordination of further follow up, etc.

To check if your management plan is holistic, try reviewing your plan using the....

'BIO-PSYCHO-SOCIAL-LIFESTYLE APPROACH'

The table below gives some examples of management in each category (note that this is not an exhaustive list, but it is enough to get you thinking).
 Note: those students who use this approach develop better and more effective management plans.

Biological: The Body (Examples)	Psychological: The Mind (Examples)	Social: Their life (Examples)	Lifestyle choices and ongoing care
Drug therapy -route: oral / i.m./ i.v./ rectal / sub-lingual, etc. -long-term/short-term -preventative vs. 'treatment'	Education and support (teach patient about their illness and how to manage it effectively, including drug therapy. Offer individual or group support to help them cope with their illness).	Support and education for carers (an adequate support network at home can increase medication adherence and reduce relapse rates).	Healthy diet.
Other treatments: -nuclear medicine, surgery, radiotherapy, cardiac cath, etc.	Establish the wishes of the patient to guide your management (e.g., do they want palliative care or aggressive management of a cancer diagnosis?).	Aids/alterations to home environment to maximise quality of life and independence (occupational therapy).	Exercise, including both aerobic and strength training.
Preventive therapy - (e.g., Hep A vaccine before tropical travel, or ACE inhibitors in diabetes to preserve renal function)	Psychological therapies (chronic physical illness is commonly associated with depression: CBT may help).	Financial assistance when unwell (social workers can help with benefits, etc.)	No smoking, alcohol within recommended limits.
Oxygen therapy, IV Fluids.	Therapeutic relationship, continuity of care (for example, engagement with the patient and support can help with medication adherence and reduce relapse). Spiritual (chaplain service).	Voluntary groups (many illnesses have voluntary patient groups who offer advice and support).	Avoid precipitating factors of illness (e.g., dust in asthma).

Clinical Skills in CCE and T:DOCs

Introduction

Tomorrow's Doctors specifically lists the communication, clinical history, clinical examination, and practical skills in which medical students should be competent prior to qualification. Medical students should be competent and confident to carry out specific practical and procedural skills safely before qualifying as doctors. Core Clinical Education is where most of these skills will be taught and assessed so that you can build on these skills during the later years of teaching and clinical experience. You must be signed off in simulation before you can practice these skills under close supervision with patients. Your clinical and practical skills will be formally assessed in the OSCE examination at the end of Phase II. You will also complete the AIM or ALERT course during CCE. These are nationally-recognised courses for the assessment of the deteriorating patient.

Practical Procedures log (T:DOCs)

You are expected to perform the following practical procedures in simulation during Phase II, and to get each procedure observed and signed off at least once by a facilitator. Note down any further dates that you practice any of the skills below in the 'date(s)' column, to build your confidence and skill. Reflect also in the 'notes' section on how the procedure went in terms of completion, problems encountered and feedback from your supervisor.

	GMC procedure/ T:DOCs	When during course	Taught & Assessed (T:DOC) or Taught Only	Notes
AC1	Moving and Handling	AC1	TAUGHT ONLY	
	Venepunctures / Aseptic Non Touch Technique- ANTT	AC1	T:DOC assessed	
	Blood Cultures	AC1	T:DOC assessed	
	Peripheral IV Cannulation	AC1	T:DOC assessed	
	Surgical Scrub/Gown and Glove	AC1	T:DOC assessed	
	In hospital Resuscitation and Automated External Defibrillation	AC1	T:DOC assessed	
	Basic Airway Management	AC1	T:DOC assessed	
	Nutritional Assessment E-learning module	AC1	ELEARNING	

CORE CLINICAL EDUCATION				
1	Peak flow monitoring	CCE1	T:DOC assessed	
2	Arterial blood gas sampling	CCE1	T:DOC assessed	
3	Nebuliser therapy	CCE1	T:DOC assessed	
4	Oxygen therapy	CCE1	T:DOC assessed	
5	Inhaler therapy	CCE1	T:DOC assessed	
6	Intramuscular injection	CCE2	T:DOC assessed	
7	Subcutaneous injection	CCE2	T:DOC assessed	
8	Intradermal injection	CCE2	T:DOC assessed	
9	Blood glucose monitoring	CCE2	T:DOC assessed	
10	12 lead ECG recording	CCE2	T:DOC assessed	
11	Nasogastric tube insertion	CCE3	T:DOC assessed	
12	Male catheterisation	CCE3	T:DOC assessed	
13	Female catheterisation	CCE3	T:DOC assessed	
14	Pregnancy testing	CCE3	T:DOC assessed	
15	Mid-stream specimen of urine	CCE3	T:DOC assessed	
16	Urinalysis	CCE3	T:DOC assessed	
17	ABCDE assessment	CCE MEDICINE	T:DOC written but course assessment used	AIM course at UHCW & SWFT or ALERT at GEH
18	Skin Suturing: WORKSHOP	CCE SURGERY	TAUGHT ONLY	T:DOC written but not used in CCE
19	Introduction to Ophthalmoscopy Attendance at Workshop run by CEFs At GEH and SWFT and by Clinical Skills at UHCW	CCE SURGERY	TAUGHT ONLY	
20	Introduction to Otoscopy Workshop	CCE SURGERY	TAUGHT ONLY	

Objective Structured Long Examination Records (OSLER)

Use the list below as a guide to the competencies in the OSLER assessment:

HISTORY TAKING

- Introduces self to the patient and puts the patient at ease
- Enables the patient to elaborate presenting problem fully
- Listens attentively
- Seeks clarification of words used by the patient as appropriate
- Phrases questions simply and clearly
- Uses silence appropriately
- Recognises the patient's verbal and non-verbal cues
- Identifies the patient's ideas, concerns, and expectations
- Considers physical, social, and psychological factors as appropriate

EXAMINATION

- Performs examination and elicits signs correctly
- Uses diagnostic instruments competently
- Displays sensitivity to patient's needs during examination
- Washes hands competently and at an appropriate moment

PATIENT MANAGEMENT (more advanced)

- Reaches a shared understanding with the patient
- Collaborates with the patient in negotiating a mutually acceptable plan
- Provides appropriate advice on self-care
- Utilises drug therapy safely and rationally with regard to sound pharmacological principles
- Orders appropriate investigations and interprets results correctly
- Makes discriminating use of referral
- Is able to act on appropriate opportunities for health promotion
- Arranges appropriate follow-up
- Checks the patient's level of understanding

PROBLEM SOLVING

- Accesses relevant and specific information from the patient's record
- Seeks relevant and specific information to help distinguish between working diagnoses
- Generates appropriate working diagnoses or identifies the problem depending on circumstances
- Seeks relevant and discriminating signs to help confirm or refute working diagnoses
- Correctly interprets and applies information obtained from the patient's record, history, examination, and investigation
- Applies knowledge of the basic, behavioural, and clinical sciences to the identification of the patient's problem
- Identifies and applies knowledge to the management of the patient's problems
- Is capable of recognising limits of personal competence and acting accordingly
- Exhibits a well-organised approach to gathering and giving of information

RELATIONSHIP WITH PATIENTS

- Maintains friendly but professional relationship with the patient with due regard to the ethics of medical practice
- Uses empathy to encourage the patient to express feelings and thoughts
Supports the patient in coping with the situation
- Demonstrates awareness that the patient's attitude to the doctor (and vice versa) affects achievement of co-operation.

Reflection in the WMS curriculum: CCE

In Phase I you have written and shared a variety of reflections and received feedback on your work. In CCE, you should continue to reflect on your learning and development, and to demonstrate evidence of this in your ePortfolio as a core part of your clinical learning. You will not need to submit a further reflective piece to the medical school during CCE, but instead you are expected to regularly add to the reflective log in your ePortfolio and to make this available to your tutor for review as required. As mentioned previously, a portion of students' ePortfolios may be chosen at random for review by the medical school to assess engagement with this important eLearning tool. It is a good idea to include in your reflections your own thoughts on the professional criteria that you will be assessed against during CCE e.g., for attendance you could think in your reflections about issues such as time management, competing priorities, organisation skills, etc.

A reminder of how reflections can help you learn:

A good reflection involves the identification and exploration of an important clinical, ethical, or professional issue, drawing from different perspectives to the point where a new understanding is reached, and you can then plan a new way of handling that issue more helpfully in future.

The most helpful approach is to constantly think:

'What can I learn here that will make me a better doctor?'

Here are some indicators of reflective skills:

- a. Ability to identify useful topics to reflect on: e.g., experiences with patients, thinking about teamwork, thinking about difficult communication, etc.
- b. Ability to convey one's own emotions and personal reaction to a situation (not just giving a description of events)
- c. Ability to step back from a situation and look at it from a variety of perspectives
- d. Use of the personal pronoun; making it personal: e.g. 'I have always struggled with time-management, so in this block I plan to keep a diary...'
- e. Ability to include the perspectives of others, and to seek outside help and advice where appropriate
- f. Ability to produce realistic action plans: e.g. 'I plan to read up on clotting and present a revision session on it to my colleagues next week – I will get feedback from them on whether I have covered all the most important points'
- g. Ability to note down both positive and negative feedback, and to learn from both.
- h. Ability to apply what you have learned from an experience to future medical practice.

Some ideas for reflections:

- Interactions with patients, team members, relatives
- Organisational, prioritisation and time management skills
- Ethical dilemmas
- Showing initiative and resilience
- Dealing with feelings
- Self-directed learning skills

Specialty-Specific Checklists

General Practice (GP)

In your GP placements, we request you to complete at least three student-led consultations per day with the expectation of completing at least 18 per placement, (to allow some slippage). Please record in the student led consultation log.

As well as consulting with patients, and observing consultations, the following are other useful learning experiences that you can explore as part of your GP experience and would be valuable to reflect upon:

- Home visits (essential)
- Nursing home visits
- Nurse clinics
- Midwife and health visitor
- Family planning
- Chronic disease clinics (e.g., asthma, diabetes)
- Out of hours
- Minor surgery
- MDT / practice meetings

Use the CCE presentation checklists to tick off clinical symptoms and conditions as you go and talk to your GP if you feel you need increased exposure to particular cases or conditions.

In addition to previously mentioned requirements, the following are expected to be signed off during your GP experience:

- Two brief interventions for smoking/alcohol – signed off on ePortfolio

Furthermore, in CCE 1 and 3 you will need to do at least three extended patient encounters – one of which could be used as your CBD.

Suggested outline of an Extended Patient Encounter

1. Students talk to a patient in pairs: 60 mins (in surgery/patient's home)
2. Students debrief with a GP: 5-10 mins (GP present)
3. Students reflect on their encounter: 30 mins

Learning Outcomes of Extended Patient Encounters

In addition to the learning outcomes for Core Clinical Education (full list available on the website), the following learning outcomes apply specifically to the Extended Patient Encounters:

- Explain illness and health from a patient's perspective
- Reflect on the diagnostic process and management of patients
- Reflect on how a patient's health problems occur within the wider context of their life, and how this context interrelates with health
- Compare the roles of health professionals involved in a patient's care, and how each might contribute to a patient's health and wellbeing

If you are unsure about what you need to complete during GP, please contact the GP Lead.