

# **Quality Assurance of Basic Medical Education**

Report on Oxford Medical School,  
University of Oxford

November 2009

**General  
Medical  
Council**

Regulating doctors  
Ensuring good medical practice

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# The GMC's role in medical education

1. The General Medical Council (GMC) sets and monitors standards in medical education. The standards for undergraduate medical education are set out in the publication *Tomorrow's Doctors*.
2. In order to ensure that UK medical schools maintain these standards the GMC runs a quality assurance programme, which involves regular assessments and visits to schools. This programme is called Quality Assurance of Basic Medical Education (QABME) and is carried out on behalf of the GMC by a team of medical and educational professionals, student representatives and lay members.
3. The team makes determinations as to whether these schools are meeting the standards in *Tomorrow's Doctors* after analysing school documentation and completing a range of quality assurance activities at the School and partner institutions. The determinations in this report have been scrutinised by the GMC's Undergraduate Board.

# Introduction

4. This is the 2008/09 quality assurance report to the GMC on the established medical school at the University of Oxford (the School).
5. The last GMC review of the School was in 2001, prior to the establishment of the QABME programme. Areas identified for further consideration at that time included:
  - a. Simplification of supervisory structures.
  - b. Further vertical integration of clinical teaching and basic sciences.
  - c. Ensuring that public health remains a strong curricular theme.
  - d. Evaluation of assessment methods.
  - e. Ensuring the final year of the undergraduate course adequately prepares students for the PRHO year (now Foundation Year One, F1).
  - f. Consideration of a shadowing period in Year 6.
  - g. Creating the curriculum which the School considers most appropriate for its own students while being aware of the different needs of students transferring to or from other medical schools.
6. The School offers two courses in medicine, both leading to a Bachelor of Medicine and Bachelor of Surgery qualification (BM BCh):
  - a. A six year course for those with the necessary A-level qualifications. Graduates may complete this course in five years by omitting the Final Honour School (FHS) in Year 3:
    - i. The pre-clinical course (the first three years of the six year course) is taught in two main parts: the First BM and the FHS, which leads to a BA degree. The course consists of a series of lectures, practicals, seminars, and college tutorials to provide an understanding of science and scientific method.
    - ii. The final three years comprise the clinical component of the course with most teaching in hospitals and general practices. There is an emphasis on self-directed learning and evaluation of medical literature underpinning the clinical training.
  - b. A four year Graduate Entry Course (GEC) for graduates with a biomedical or physical sciences degree:
    - i. The first two years cover basic medical science and clinical skills; the first year concentrates on science taught within a clinical

context and an introduction to clinical practice, while the second year concentrates on clinical teaching with a smaller science component. The final two years are shared with the six year course, and students are fully integrated into the clinical course at this stage.

7. The School currently has approximately 850 undergraduate students, with an average of 150 and 130 students in each cohort in the pre-clinical and clinical years respectively. In addition there are just over 100 graduate entry students, 30 in each cohort.

8. Unless the report refers to a specific cohort of students, our findings apply to both entry routes into the BM BCh programme.

9. The main clinical teaching site is the Oxford Radcliffe Hospitals NHS Trust which comprises the John Radcliffe Hospital, the Churchill Hospital, and the Horton General Hospital. In addition to hospitals and general practices in Oxford, the district general hospitals in Northampton, Reading and Swindon are major partners in teaching delivery. Milton Keynes Hospital is used for the graduate entry course, and all students also rotate to district general hospitals in High Wycombe and Stoke Mandeville.

### The QABME team

10. The visiting team members appointed by the GMC Undergraduate Board to undertake the quality assurance visits were:

Professor Sam Leinster (Team Leader)

Dr Martin Talbot (Deputy)

Dr Nick Bishop

Dr Roger Bloor

Professor Lindsey Davies

Professor Christopher Fowler

Mrs Susan Hobbs

Dr Johann Malawana (stood down as of 1 January 2009, see paragraph 11)

Dr Martin Rowan-Robinson

Dr Maria Slade

11. Following his appointment to the GMC on 1 January 2009, Dr Johann Malawana stood down from the visiting team because of the conflict of interest that his appointment to the GMC presented. Prior to standing down, Dr Malawana attended the quality assurance visit on 28 October 2008 (see paragraph 13).

12. Ms Louise Wheaton (GMC Education Quality Officer) supported the QABME team.

## **Our programme of visits in 2008/09**

13. The team conducted five quality assurance visits on: 28 October 2008, 28-30 January 2009, 24-25 February 2009, 29 April 2009 and 22 July 2009.

14. The findings of the team have been reached by reviewing documentary evidence submitted by the School and undertaking the following activities:

- a. Meetings with members of the School responsible for curriculum development, assessment, student support, student conduct, student selection, widening participation and quality management.
- b. Observation of teaching sessions in both the main university teaching hospitals and district general hospitals and a session in one general practice.
- c. Site visits to various NHS Trusts.
- d. Site visit to one general practice.
- e. Discussions with students.
- f. Discussions with teachers, including general practitioners (GPs) and clinical consultants.
- g. Discussions with Foundation Year One (F1) doctors and their educational supervisors.
- h. Observation of the fifth and final year examinations of clinical skills.
- i. Observation of the final examination board.

# The report

## Summary of our key findings

15. Subject to the requirements in paragraph 18, the School's BM BCh programmes meet the requirements of *Tomorrow's Doctors* in accordance with Section 5(3) of the Medical Act 1983.

16. Although we have recommended some areas for improvement by the School, these should be read in the context of our overall findings.

17. Where there are requirements, the School is requested to respond to the requirement with the timelines for action within the 28 day right of reply to the report.

## Requirements

18. The School is required to:

a. Review the assessment strategy and its implementation across departments with regard to current best practice in assessment. The School must enhance the central governance and oversight of clinical assessments (see paragraphs 52 and 85). As part of this, the School must:

i. Improve the reliability of the clinical assessments; particularly in the Year 5 specialty examinations (see paragraphs 86, 90 and 92).

ii. Ensure the clinical re-sit arrangements in the Year 5 specialty examinations are comparable to the original examination method (see paragraphs 86 and 91).

iii. Review its current standard setting procedures to ensure they conform to current best practice, and continue its efforts to improve consistency in standard setting between departments (see paragraph 87).

iv. Continue its effort to develop and implement blueprinting to ensure a consistent approach between departments (see paragraphs 21 and 89).

## Recommendations

19. To enhance the quality of the School's programme, we have identified the following recommendations. The School should:

a. Increase the integration and coherence of the teaching of social and behavioural sciences, public health and diversity issues throughout the curriculum (see paragraphs 26, 42-45, 50 and 67).

- b. Ensure basic sciences are integrated into the clinical years of the course (see paragraphs 25 and 64).
- c. Enhance the signposting of fitness to practise and whistle blowing policies and procedures to students (see paragraph 104).

#### Areas of innovation and good practice

20. We commend the School on the following areas of innovation and good practice:

- a. The Year 4 Laboratory Medicine course as good preparation for the clinical years of the programme (see paragraph 27).
- b. The student selected component (SSC) in methods of medical education for introducing students to the principles of medical education and the opportunities for peer teaching (see paragraph 37).
- c. The teacher of the month scheme as a mechanism to recognise excellent teachers (see paragraph 54).
- d. The Patient-Doctor course as an effective way of introducing clinical relevance and patient contact to the pre-clinical years of the course (see paragraph 61-62).
- e. The student support systems and the links between the School and collegiate system (see paragraph 75).
- f. The Year 5 appraisal for students to reflect on skills and look towards future careers (see paragraph 98).
- g. The use of an independent investigator in the School's fitness to practise procedures (see paragraph 103).

### **Curricular outcomes, content, structure and delivery**

#### Outcomes

21. We are satisfied that the School's learning outcomes are based on the outcomes set in *Tomorrow's Doctors*. We reviewed a sample of learning objectives, which are set at departmental level and confirmed by the School centrally. The School must continue to develop blueprinting to improve the mapping of assessments to learning outcomes.

22. The F1 doctors we met who graduated from Oxford felt well prepared for their foundation training. The educational supervisors we met confirmed that graduates from Oxford were well prepared to begin F1.

## Content

23. We are satisfied that the curricula for both the six year programme and GEC are sufficiently challenging and place greater demands on students as they progress. This was confirmed by reviewing a sample of examination papers and interviewing students.

24. We found adequate time for reflection in both courses. Students, pre-clinical and clinical teachers were satisfied with the time available. We reviewed portfolios which encourage reflection and students are provided with mentored reflection within their college tutorials. The course encourages self-directed learning, particularly in the clinical years. Clinical teachers reported that students are generally proactive in identifying any gaps in their knowledge and organising experiential learning.

### *The scientific basis of practice*

25. The pre-clinical years of the course provide students with a high level of basic science knowledge. Students and F1s were positive about receiving a scientific grounding which enables progression to the clinical years. The teaching in Years 1 and 2 is given clinical relevance and clinicians are invited to teach students. The School should do more to integrate basic sciences into the clinical years of the course.

26. We found that social and behavioural sciences could be better integrated into the course (see paragraph 44).

27. The Laboratory Medicine course in Year 4 is well received by students, who reported that it was well organised and useful in preparation for the clinical years of the programme. The course enables students to build on their prior knowledge and understanding of disease processes to apply this to planning, undertaking and interpreting laboratory-based investigation of patients in the diagnosis and treatment of disease. We commend this course as an area of good practice.

28. The three week anatomy course at the end of Year 3 is well received. The course builds on Year 1 learning with an emphasis on the clinical relevance of anatomy, physical examination and procedures. In the GEC, the majority of anatomy learning is self-directed from textbooks and students do not attend the Year 3 Principles of Clinical Anatomy course. The School reported that anatomical models are available for student use and GEC student knowledge is comparable to those on the six year course.

29. Students have a strong understanding of scientific method as a result of practical sessions and project work, including the research project in the FHS year.

### *Treatment*

30. The School reported some concerns among graduating students about their knowledge of therapeutics and prescribing. We are satisfied that the School

responded appropriately to these concerns and has taken action to address them. The F1s we met valued the Safe Prescribing course before the start of F1 and clinical teachers reported that F1s from Oxford are well prepared for prescribing.

31. We are satisfied that recognising and managing acute illness is covered in simulation as part of the Preparing for Practice as a Doctor (PPD) course. Students are assessed on basic life support (BLS); complete an advanced life support (ALS) course and acute life-threatening events – recognition and training (ALERT) course. Students work with qualified nurses in the ALS and ALERT courses.

32. We are satisfied that students learn about chronic illness in primary care and other relevant clinical placements.

33. The role of lifestyle is appropriately covered in the Year 5 Primary Care block. A student selected component (SSC) in complementary and alternative therapies is available and students have a timetabled teaching session in Year 4. We are satisfied that students have an awareness of alternative and complementary therapies.

#### *Clinical and practical skills*

34. We are satisfied that the clinical and practical skills listed in *Tomorrow's Doctors* are covered in both courses. Students reported sufficient opportunities to practise clinical skills and F1s felt well prepared for this aspect of their foundation training. This was confirmed by the educational supervisors and clinical teachers we met.

35. A sample of practical skills is assessed in the Year 4 objective structured clinical examination (OSCE). Students must be signed-off for practical skills in the Year 6 PPD course. We support the School's plans to reintroduce the formal assessment of practical procedures into the Second BM clinical examination in the academic year 2009/10.

#### *Communication Skills*

36. We are satisfied that communication skills are adequately represented within the curriculum and assessment. The Patient Doctor course in Years 1 and 2 introduces students to communication skills. Communication skills are primarily taught in Year 4 and the communication skills course is well received by students. The F1 doctors we met found the teaching with simulated patients in Year 4 useful preparation for their foundation training. The School offers an SSC in British sign language. History taking is assessed in Year 4 and Year 6 and challenging communication is covered in the Year 5 specialty clinical assessments.

### *Teaching skills*

37. The School offers an SSC in methods of medical education to Year 5 students, in which they identify learning outcomes, plan teaching sessions and evaluate teaching performance. This course has a 90 per cent uptake and once students have been trained they have the opportunity in Year 6 to act as tutors for two weeks of the Patient Doctor 2 course at the beginning of Year 4. The Year 4 students we met spoke positively about the peer teaching. The *Oxford Course Experience Questionnaire* consistently rates the opportunity to train in and practise teaching as a valuable aspect of the course. The F1 doctors we met found the course useful in preparation for teaching students as F1s. We commend the SSC for introducing students to the principles of medical education and the opportunities for peer teaching.

### *General skills*

38. We are satisfied that graduates are competent in skills such as reflecting on practice and using research skills to develop their practice. This was confirmed by F1s and their educational supervisors.

### *The working environment*

39. Students are introduced to the health service as a system in the pre-clinical years of the course as part of the public health strand. We consider that there would be benefit from distributing the teaching of this topic throughout the curriculum.

### *Medico-legal and ethical issues*

40. We are satisfied that the Year 1 GEC ethics thread, the Year 4 ethics course and the thread through the clinical years adequately cover medico-legal and ethical issues. The F1 doctors we met spoke positively about their ethics teaching.

### *Disability and rehabilitation*

41. We found disability and rehabilitation are taught in geratology (care of the elderly) and within the expert patient workshops. However, students reported that the teaching they received was limited. We encourage the School to consider strengthening this when further integrating behavioural and social sciences.

### *The health of the public*

42. Public health is taught in medical sociology, statistics and pathology in the pre-clinical years of the course. However, there appears to be a lack of central direction and coordination of this teaching. In the clinical years, public health is covered in the Year 5 Primary Care block.

43. We support the School's vision to develop and integrate the population perspective throughout the curriculum and its associated assessments. We recommend that the School increases the integration and coherence of public health within the curriculum.

### *The individual in society*

44. The School reported that behavioural science teaching is linked to basic science, psychiatry and public health. We found that social and behavioural sciences are not well integrated into the course and the students we met did not consider it integral. We support the School's plans to extend early behavioural science teaching and better link it into later years of the course. We recommend that the School increases the integration of social and behavioural sciences through the curriculum.

45. We note that students encounter issues of diversity within the clinical placements and have opportunities to go overseas for the elective programme and some Year 5 specialty attachments. The college tutorial system encourages students to reflect on and challenge beliefs. However, formal diversity teaching should be enhanced and integrated as the students we met had a limited understanding of diversity issues and their potential impact on health care.

## Structure

46. The balance of core curriculum and SSCs is appropriate and meets the requirement in *Tomorrow's Doctors*. Students spoke positively about SSCs, particularly the opportunities to organise SSCs independently, including overseas. In addition to SSCs, the curriculum is clearly divided into core and extension material and the college tutorial system allows students to follow up areas of interest.

47. The FHS provides opportunities for laboratory or library based research projects in which students study a selected topic in depth. Students also complete an extended essay on an unrelated topic during the FHS. The F1s we met found the FHS useful to develop research skills.

48. The School demonstrated appropriate mechanisms to monitor student choice and ensure an appropriate balance of SSCs is taken. We are satisfied that the opportunities available allow students to study topics of interest outside the core curriculum in depth and to consider potential career paths.

## Delivering the curriculum

### Supervisory structures

49. There are clear systems in place for governance of the course and curriculum design. The central academic management team is highly committed.

50. The teaching committees during the pre-clinical years include representation from clinicians, the Director of Pre-Clinical Studies (DPS) and relevant departments. The Director of Clinical Studies (DCS) sits on The Medical and Physiological Sciences Education Committee and the DPS and DCS meet informally on a regular basis. The formal links between the pre-clinical and clinical courses should be strengthened to enhance vertical integration of basic science studies into the clinical years of the course.

51. Students have appropriate involvement in the committee structures and spoke positively about the multiple layers of communication with the students.

52. The School sets a central assessment strategy from which the Course Leads develop an individual assessment strategy. The operational responsibility is held by the departments who set a code of practice based on the strategy and construct the examination papers. These are agreed by the relevant teaching committee and audited by the DCS. We found that the School's assessment strategy is implemented inconsistently across departments. We have concerns about the governance of assessment and we require that the School has more central control of assessments, particularly in the clinical years of the course. This will help to address our concerns detailed in paragraphs 89-92.

53. We are satisfied with the communication between the School and the Postgraduate Deanery. At a formal level, the Postgraduate Dean sits on the School's Clinical Education Committee and Educational Policy and Standards Committee and the DCS sits on the Foundation Board. Informally, the Foundation School Director and DCS meet regularly and there is evidence of joint working on projects.

#### Teaching and learning

54. The teachers we met provided good role models for students and were committed to education. Students are able to nominate staff as 'teacher of the month'. The aim of the teacher of the month scheme is to give formal recognition to individuals who display particular commitment to medical student teaching in the clinical years of the course. The scheme is well received by students and teachers. We commend the teacher of the month scheme as an area of good practice.

55. We are satisfied with the training opportunities provided to NHS and University staff, and their uptake. The courses include UNICON, a Diploma in Teaching and Learning in Higher Education, Medical Science Seminars in Learning and Teaching and the Medical Educators Forum. The staff we met spoke positively about the opportunities for personal and professional development.

56. The School has multiple layers for student evaluation of the pre-clinical years. Written evaluation is collected on all course components and this is monitored by the relevant teaching committee. The DPS also conducts face to face meetings every term with students representing each college. The termly and annual course reports provided to the Medical and Physiological Sciences Education Committee show the response to student evaluation. The School provided examples of closing the feedback loop.

57. The School reported that the *Oxford Course Experience Questionnaire*, completed at the end of the course, suggested that variation in the quality of clinical placements was a concern of the student body. The students we met commented on variability, but considered that it balanced out overall and by the end of the course students generally receive equivalent experiences.

58. In the clinical years student evaluation data is collected at all clinical teaching sites and students and clinical teachers reported changes as a result of this. The GP teachers we met receive a summary report of student evaluation from the School at the end of each attachment comparing them with other practices. The School requests evaluation from staff and students and has a clear awareness of activities on the ground. The School also visits sites on an annual basis and demonstrated a formal committee structure to support this process. We are satisfied with the quality management systems in place.

59. We are satisfied with the balance of teaching methods within the curriculum. We reviewed student timetables which show that students have a balance of lectures, tutorials, practical classes, and opportunities for self-directed learning. Students were happy with the teaching methods in use and particularly value the college tutorial system. The GEC allows students a high proportion of time for self-directed learning and students reported that this is complemented by problem based learning sessions, case based seminars and tutorials.

60. Students are required to work with other health and social care professionals during the course. Students undertake a shift with nursing staff and F1s reported interactions with pharmacists, physiotherapists and attendance at multi-disciplinary meetings during their undergraduate training. Students also work with occupational therapists and join paramedics for an ambulance shift.

61. The six year course is divided into pre-clinical and clinical study, however the basic science in the first two years is taught with an emphasis on its clinical relevance. Students confirmed this and appreciate the grounding in basic science before progressing to the clinical years. The School has made progress in increasing integration of clinical teaching into the pre-clinical years since the last GMC visit by implementing the Patient Doctor course and the Principles of Clinical Anatomy course.

62. The Patient Doctor course in Years 1 and 2 enables students to attend general practice to meet patients linked with current teaching, and to discuss aspects of the case with a clinical teacher. Students and GP teachers were very positive about the course. We commend the Patient Doctor course as an area of good practice.

63. The School has no plans to extend clinical contact in the early years of the course. We encourage the School to consider developing the Patient Doctor course into Year 3 of the course as the GPs we met thought this could work well.

64. We support the School's plans to increase the integration of basic sciences into the clinical years of the course and recommend that the School implements these plans.

65. The GEC is more highly integrated than the six year course and the early patient contact is well received by students. GEC students reported that this works effectively as they have basic science knowledge from their previous degree.

66. We are satisfied that students have opportunities to gain experience in a variety of environments including hospitals, general practices and community medical services. The School is content with the relatively low representation of primary care in the curriculum. The GPs we met spoke highly of their links with the School and their contribution to the curriculum.

67. The School recognises that students have limited opportunities to interact with people from a range of social, cultural and ethnic backgrounds. We recommend that the formal diversity teaching is enhanced and further integrated into the curriculum.

68. The PPD course is effective in preparing students for their foundation training. This includes seminars and a two week clinical shadowing attachment. The F1s we met confirmed this and found the logbooks provided in the shadowing period to be useful. These include a section on the top 10 drugs prescribed by the current F1s with dosage, routine investigations and procedures.

69. Students, F1s and clinical teachers are positive about the experience gained in the interval between final examinations and the start of F1 as the time on the wards is considered good preparation for foundation training.

#### Learning resources and facilities

70. We are satisfied with the facilities available for teaching at all sites visited including libraries, IT facilities, lecture theatres, seminar rooms, and clinical skills laboratories. The George Pickering Education Centre is a good resource and the Medical Sciences Teaching Centre is very well designed. Students were happy with the resources available and reported involvement in the review of facilities.

71. The facilities used during clinical examinations were adequate, including the use of an outpatients department for the Second BM final clinical examination.

72. The learning resources on Weblearn, the School's virtual learning environment, are adequate and students were satisfied with these.

#### Student selection

73. We are satisfied that the School's selection procedures are valid, open, objective and fair. The School publishes information about the admissions system on the website and the University works to a common framework and equal opportunities policy. The staff responsible for selecting students are trained to apply guidelines and include academics and clinicians.

74. The School is actively working to widen access to medicine to areas from which it does not receive many applications. The admissions coordinator visits

secondary schools to speak to students and to engage with teachers. The School also runs a summer Sutton Trust scheme to give potential students without a University education or from disadvantaged areas an insight into studying medicine.

#### Student support, guidance and feedback

75. The collegiate system works very well and the links between the colleges and the School are effective. Some variability exists in the support provided between colleges; however this does not disadvantage students. All students spoke positively about the collegiate system and felt well supported, both academically and pastorally. We commend the School's student support systems as an area of good practice.

76. During the first three years, the college tutor has a direct responsibility for supervising academic understanding and monitoring student attendance. The tutors meet with students at least once per week. The tutors allocated to pre-clinical students are often basic scientists but clinicians are available to advise students.

77. Some students found the transition from the pre-clinical to clinical years difficult due to the change in learning styles and structure. The School provides additional support to these students, including a structured interview with senior staff if necessary.

78. The Occupational Health service is accessible in the University and the Directors of Studies meet with Occupational Health every term. Students are encouraged to register with a college GP. The collegiate system also provides access to senior tutors, counsellors and other health care support.

79. We are satisfied with the guidance provided to students about the core curriculum, SSCs and assessment. Students reported that the handbooks and information on Weblearn are clear and accessible. In the clinical years of the course, students found the logbooks useful. During clinical examination observations, we found that students were clear on what was expected of them. College tutors are available for academic advice and guidance. The cheating and plagiarism policies are satisfactory and can be accessed on Weblearn and in handbooks. The School provided evidence of how cheating and plagiarism cases have been dealt with.

80. College tutors provide students with regular feedback throughout the course and following assessments. Students have informal formative assessments on a weekly basis in college in Years 1 to 3. In the clinical years, students have a feedback folder which is completed by their clinical supervisor and enables students to identify objectives and record when they have been met. Students receive feedback at the end of each attachment. Students spoke positively about the feedback received.

81. Students complete a reflective portfolio in Year 6 which is assessed comprehensively. The portfolios reviewed by the team showed reflection, maturity, clinical application of knowledge, and ethics.

## Assessing student performance and competence

### The principles of assessment

82. The assessment schemes support the curriculum and individual examinations map to the core syllabus. We reviewed a sample of examination papers and are satisfied that students are tested on the breadth and depth of their knowledge.

83. We are satisfied that professional attitudes and behaviour are appropriately assessed in formal examinations. There are good mechanisms for picking up students with mental health or attitudinal/ behavioural issues during the course.

84. Students are assessed on the core curriculum and SSCs. The FHS contributes to a student's BA degree classification. The School reported that SSCs can impact on progression; however there have been no examples of this happening.

85. The School introduced an assessment strategy to address the challenges associated with departmental led assessments. We recognise the progress the School has made to improve consistency, such as introducing common scoring systems. However, more must be done to ensure that the strategy is applied consistently across all departments and that individual examinations are valid, reliable and developed in line with current best practice. This will help to address our concerns detailed in paragraphs 89-92.

86. The School uses a range of assessment techniques including a variety of written question types to test knowledge. A wide variety of formats are used for clinical examinations, these include short and long cases, OSCEs and modified objective structured long examination records (OSLERs). We have concerns about the reliability of the Year 5 clinical examinations (see paragraphs 90-92). The School must take action to improve reliability and ensure that re-sit methods are comparable to the original examination format.

87. Standard setting is used in the majority of departments. However, there is unacceptable variability in how standards are set. In the assessment strategy for the pre-clinical years there is a clear commitment to criterion referenced assessments. The School reported that a modified Angoff method was used to establish the standard, however in practice the number of judges used was sometimes small. In the clinical years, a standardised four point global marking system is used based on whether the candidate achieves the competency expected of an F1 doctor. Each examiner makes a global assessment against a series of anchor statements but we are concerned about the potential for considerable inter-examiner variability. The School must review its current standard setting procedures to ensure they conform to current best practice and continue its efforts to improve consistency in standard setting across departments.

88. We observed the seven-station final clinical examination and found that the range of stations and patients was adequate, although the range and complexity of

competencies tested was limited. We are satisfied that only students who are competent in the basic assessment of patients would pass this examination. There are other competencies, such as practical procedures and advanced communication skills, which are required of an F1 doctor and are not assessed in this examination. We encourage the School to test a wider range of competencies relevant to F1 level in the final clinical examination. We support the School's plans to increase the number of stations and test practical skills within the final clinical examination.

#### Assessment procedures

89. We found variability between departments in the quality and format of blueprints. We recognise that items in assessments are derived from curricular outcomes. However, we are concerned that there is not a consistent, structured method of sampling. The School must continue its effort to ensure a consistent approach to blueprinting across departments with central monitoring and control.

90. We reviewed a sample of cases used in the Year 5 clinical examinations, which were set at an appropriate level. Each clinical examination at the end of a specialty block in Year 5 is small and departmentally driven. This is the final assessment of these specialties prior to graduation. There is variability in the format of each examination and the School must take action to ensure greater consistency and comparability across departments.

91. The re-sit methods vary significantly between departments and often the re-sit method is significantly different to the original examination and sometimes of questionable reliability and validity. For example, in some departments a student can fail a station in the Year 5 specialty examination, receive feedback on where they went wrong and re-sit the same station on the same day and pass. We strongly discourage examining students on the same material on the same day. The School must take action to ensure that the re-sit methods are comparable to the original examination and in line with current best practice in assessment.

92. The School reported that during and at the end of Year 5, the DCS individually reviews the position of all students who have not passed all the Year 5 rotations. However, we have concerns that students could theoretically be borderline in a number or all of the Year 5 specialty examinations and pass the year overall. We encourage the School to consider combining marks across Year 5. The School must improve the reliability of the clinical examinations, particularly in Year 5.

93. Students receive clear guidance about examinations in handbooks and on Weblearn. During the clinical examination observations, we found that students were clear about what was expected of them.

94. In the pre-clinical years teachers are involved in marking formative assessments for three years before they can become involved in summative examining, for which there are clear university guidelines. Examiners in the clinical years are invited to seminars on learning and teaching, which include training on written and clinical examinations. Examiners have a clear briefing, two of which we observed, prior to each clinical examination. In the final clinical examination briefing

there were opportunities to review results from the previous academic year and discuss significant marking discrepancies between examiner pairs to help in the calibration of examiners.

95. The guidance provided to examiners is adequate and the anchor statements are clear. The School uses a common marking scheme with a global score of one to four (clear fail, borderline fail, clear pass and high pass) across the clinical examinations. During our examination observations, we saw that examiners followed the guidelines provided.

96. In the final clinical examination all students were examined by an external examiner in at least one station. External examiners visit the Year 5 specialty examinations at least once per year. The external examiner reports provided evidence of effective interaction between the School and the external examiners.

### Appraisal

97. Students receive regular, structured and constructive appraisal from their college tutors and clinical teachers. All students have an end-of-year appraisal with their college tutor to review progress. During clinical teaching, students are encouraged to ask clinical teachers to focus on areas they find challenging.

98. All students meet the Deputy DCS for a semi-structured 30-minute appraisal in Year 5. The Deputy DCS has devised her own form of psychometric testing and students assess their skills and preference for importance of generic job factors prior to the meeting. The appraisal reflects on this and looks to potential future careers. The Year 5 appraisal is well received by students, and we commend this as an area of good practice.

### Student progress

99. An exit degree is available to students after three years of study and students are able to transfer onto other courses.

100. We are satisfied with the provision of careers advice. The careers website is a useful resource and college tutors are available for advice. Alumni from the colleges also provide advice to students on particular specialties.

101. In the pre-clinical years, the college holds the primary responsibility for reporting concerns about a student. During the clinical years the relationship switches and the School often informs the college of a student in difficulty.

102. The School reported that in the past some college staff failed to grasp the significance of fitness to practise concerns, and the different responsibilities of medical students to those on other courses. The School took effective action to inform college tutors via seminars and training sessions.

103. We commend the use of an independent investigator in the School's fitness to practise process and we note the value of this. We are pleased to note that the School's policies and procedures are already closely aligned to the GMC and Medical Schools' Council guidance: *Medical students: professional values and fitness to practise*. We encourage the School to develop its plans to ensure students are aware of the declaration they are required to make to the GMC at the point of graduation. The School provided examples of the policies and procedures in action and they work well in practice.

#### Student health and conduct

104. We identified variability in the level of student awareness of fitness to practise policies. Students in the pre-clinical years showed limited awareness, however students in the clinical years demonstrated knowledge of reporting routes to raise concerns about colleagues or teachers. We recommend that the School better signposts policies and procedures to ensure they are accessible to students.

105. We note the innovative approach to raising concerns in Year 6, in which a Medical Director at the John Radcliffe Hospital shows students an interactive DVD of an imaginary day in the life of an F1. This demonstrates issues of patient safety, which is the focus of discussion.

106. Clinical teachers reported that fitness to practise expectations are clear and that communication channels to and from the School work well in practice.

107. We are satisfied with the School's processes for transferring information to other medical schools, foundation schools and deaneries. The School provided examples to support this. Students are made aware that information may be passed on where necessary to support their transition to F1.

#### **Acknowledgement**

108. The GMC would like to thank Oxford Medical School and all those they met during the visits for their co-operation and willingness to share their learning and experiences.

# University of Oxford

Medical Sciences Office  
The John Radcliffe, Headington, Oxford OX3 9DU



From the Director of Clinical Studies  
Dr Tim Lancaster

30<sup>th</sup> September 2009

Professor Jim McKillop,  
General Medical Council,  
2<sup>nd</sup> Floor, Regent's Place,  
350, Euston Road,  
London NW1 3JN

Dear Professor McKillop,

## **Final report of QABME visits to Oxford Medical School 2008-9**

Thank you for your letter of 16<sup>th</sup> September, 2009 and for sending the final QABME report. The Oxford Medical School considers this to be a fair and accurate report.

With reference to the requirements, we believe that our assessment processes are robust and reliable, but we agree with the visitors that there is room for improvement. In response, we are planning the following steps:

1. Review of school assessment strategy to be completed by 31<sup>st</sup> January 2010;
2. Awayday with leads for clinical assessments to review assessment processes in the light of the revised assessment strategy, to be completed by 31<sup>st</sup> March 2010;
3. Plan for changes to clinical examinations, especially in year 5, to be completed by 30th April 2010;
4. New assessment arrangements to be in place for academic year 2010-11 (July 2010).

With reference to the recommendations, we plan the following action:

- a. Review of the curriculum in this area, to be completed by July 2010;
- b. Review of integration of science into the clinical years, to be completed by July 2010;
- c. This recommendation will be implemented by December 2009.

Yours sincerely,

Tim Lancaster