WELCOME TO THE UQ MD PROGRAM

Every year, a wonderfully diverse group of students begin their medical studies at UQ.

Last year’s intake for the Doctor of Medicine (MD) was made up of students born in 43 different countries and speaking 29 different languages. Students born in Australia, United States and Canada account for 69% of the 2019 intake, with students from China, India, New Zealand, Singapore, Taiwan and many more making up the remaining 13%.

The age of students entering the 2019 MD Program ranged from 19 to 43, with the majority of the cohort age range from 20 to 25.

The 2020 cohort has 280 Australian students and 90 international students who will be based in Queensland for all four years of study and around 110 students enrolled in the UQ-Ochsner MD program who will complete Years 1 and 2 in Brisbane before returning to the US to complete their final two years of clinical placements in New Orleans, Louisiana. This successful partnership is now in its twelfth year.

The diversity of our student cohort is one of the great strengths of the UQ MD program, adding a truly global dimension to our medical education.

The MD program at UQ is divided in two x two-year phases. Phase 1 focuses on gaining a firm foundation in the basics of clinical practice, ethics law and professionalism, public health, research and clinical sciences. These courses are designed to best prepare students for the clinical placements in Year 3 and 4 (Phase 2).

Each of the first three semesters of Phase 1 consists of four courses;

- Clinical Science (3 units, graded)
- Clinical Practice (2 units, pass/fail)
- Health, Society and Research (2 units, graded), and
- Ethics & Professional Practice (1 unit, pass/fail).

Semester 4 (Semester 2 of Year 2) has a different structure. All students will continue to take Clinical Practice and Ethics & Professional Practice. Students will also take Integrated Clinical Studies which combines clinical sciences, public health, and research. Students will also choose from a number of 2-unit selective courses related to health as a complement to the standard studies. Students enrolled in the MD-Ochsner program are required to take the USMLE Step 1 Preparation selective.

In between Years 1 and 2, there is an Observership requirement which gives students the opportunity to spend time with doctors in practice during the summer semester.

The calendar and requirements for the MD Program differ in a number of ways from those of general UQ undergraduate degrees and it is very important that students know where to get reliable information about what is expected and when. For example, we have 16-week rather than 13-week semesters for most MD courses. You can find the 2020 MD Calendar here. The timing of deferred and supplementary exams is also different to the standard university schedule. Please refer to information provided in the calendar, the Assessment Guidelines and via Blackboard and newsletters. Be mindful to avoid making travel plans during supplementary assessment weeks.

Timetables may also vary from week to week because many of our teachers are active clinicians, so please also refer to the Enrolment and Timetable section of the Medicine Program website.

Medicine is an exciting, fulfilling profession but it is also a demanding one. The MD Program is similarly demanding and it is important that all students take a steady approach to their studies throughout the year and seek support early if experiencing challenges. The Medical Student Support section of this document provides information about the support available.

In any given week, you will attend two Case-Based Learning (CBL) tutorials, a Clinical Coaching session, several live lectures, a variety of practical classes and other small group activities and have access to a wide...
range of electronic resources and reading material. Some students initially feel there is a vast array of information or feel an increase in workload compared to their previous studies. It may seem a little daunting or overwhelming at first, however, we know that students who do take on board our advice about how to approach their MD studies, who make adjustments to their approaches and who seek support, do create effective habits to manage the workload and do succeed in their studies.

Think of studying medicine as a newly opened jigsaw puzzle. If you try to memorise each individual piece, the task seems impossible. However, once you learn a way of combining the pieces into something that makes sense, the content does not seem so overwhelming. This is why much of the program is interactive with plenty of opportunity to discuss material with your peers and your teachers. Through this discussion and reflection on how the content of the courses integrate you gain deeper understanding of what you are learning. The process that you use to put the picture together may be different to the approach of another student, and it may take you a little while to work out what process is best for you; keep working at it and ask for help.

As well as providing you with an overview of the four courses you will study each semester, this handbook contains key information to help you succeed in the MD, beginning with these tips:

- Become familiar with the Current Students section of the Medicine Program website; in particular the Medical Program Participation Requirements and the Assessment Guidelines.
- Read and ensure that you understand the requirements of each course. Detailed descriptions are given in the electronic course profile (ECP). Please note that these evolve from year to year due to developments in medicine or in response to student or tutor feedback. Ensure that you consult the ECP for the year you are enrolled in that course.
- Take the time to familiarise yourself with UQ’s learning management system, Blackboard. Training in Blackboard and other Digital Essentials is available via the UQ Library website. Important content and information for your courses and program is posted to your Blackboard sites. Please make it a habit to review regularly.
- Regularly check your UQ student email account, read the newsletters and the announcements on Blackboard, and subscribe to course discussion boards to ensure you are across important information.
- Download your individual timetable every week so that you are prepared to for your learning and assessment activities.
- Be an active participant in your own learning. Prepare for your learning activities. You will only get out of these sessions what you are prepared to put in.
- Address problems before they become a hindrance to your learning. Developing skills in help-seeking behaviour is essential to becoming a clinician, and in fact is part of professional behaviour. There amount and range of support available is tremendous. You can read more about the support available in this Handbook and you will learn more about it during Orientation and in the regular newsletters.

We wish you all the best for your studies and hope you enjoy your time studying medicine at UQ!
PROFESSIONALISM IN THE MD

The Medical Board of Australia provides guidance for medical practitioners in the publication of “Good Medical Practice: a code of conduct for doctors in Australia”. In this document the Board describes professionalism:

“Doctors have a duty to make the care of patients their first concern and to practise medicine safely and effectively. They must be ethical and trustworthy. Patients trust their doctors because they believe that, in addition to being competent, their doctor will not take advantage of them and will display qualities such as integrity, truthfulness, dependability and compassion. Patients also rely on their doctors to protect their confidentiality.

Doctors have a responsibility to protect and promote the health of individuals and the community.

Good medical practice is patient-centred. It involves understanding that each patient is unique, and working in partnership with their patients, adapting what they do to address the needs and reasonable expectations of each patient. This includes cultural awareness: being aware of their own culture and beliefs and respectful of the beliefs and cultures of others, recognising that these cultural differences may impact on the doctor–patient relationship and on the delivery of health services.

Good communication underpins every aspect of good medical practice.

Professionalism embodies all the qualities described here, and includes self-awareness and self-reflection. Doctors are expected to reflect regularly on whether they are practising effectively, on what is happening in their relationships with patients and colleagues, and on their own health and wellbeing. They have a duty to keep their skills and knowledge up to date, refine and develop their clinical judgement as they gain experience, and contribute to their profession.”

When you graduate from the UQ MD program, you are expected to demonstrate that you are fit to practise in a manner that reflects community expectations and standards. This means that in addition to technical competence, you must demonstrate appropriate professional attitudes and behaviours which align with the Code above. This includes overt recognition that the MD program and medical professionalism are full time commitments. To promote professionalism, the Faculty fosters specific personal and professional attributes in its students. Students must also develop insights into their own strengths and weaknesses, and work consistently to become the professional doctors that the community and your medical colleagues expect.

By making the commitment to professionalism on commencing the MD program, you agree to:

- Abide by the UQ Student Charter
- Abide by the Medical Program Participation Requirements
- Behave with academic integrity

These personal and professional attributes are applicable not only in clinical practice with patients but in all of your interactions with lecturers, tutors, professional staff and peers. It is also important to remember that appropriate, professional online behaviour is important to avoid potential damage to personal integrity, doctor-patient and doctor-colleague relationships, and future employment opportunities. Details of each of these attributes can be found in the list of Useful Links on Professionalism.
A critical component of professionalism for both medical students and doctors is monitoring and managing your own health. Please familiarise yourself with the Medical Deans Australia and New Zealand (MDANZ) ‘Inherent requirements for studying medicine’.

The Australian Medical Council Standards for Medical Education set specific expectations for medical graduate outcomes grouped into 4 domains. Domain 4: Professionalism and Leadership which states that a medical student is expected to:

- Demonstrate sufficient behavioural stability in order to work constructively in a diverse and changing academic and clinical environment.
- Display the resilience and flexibility to satisfactorily deal with the demands of being a medical student.
- Monitor their own health and behaviour and to seek help when required.

For the safety of the public, medical students are registered with the Australian Health Practitioner Regulation Agency (AHPRA) throughout their medical degree studies. The Board’s role is focused on registering students and managing notifications about students:

- whose health is impaired to such a degree that there may be substantial risk of harm to the public, or
- who have been found guilty of an offence punishable by 12 months’ imprisonment or more, or
- who have a conviction of, or are the subject of, a finding of guilt for an offence punishable by imprisonment, or
- who have contravened an existing condition or undertaking.

If you have any concerns about your ability to participate in the program, please consult with a UQ Diversity, Disability and Inclusion Adviser and the Medical Student Support Team.

How you can demonstrate your commitment to professionalism every day…

For a productive, safe and harmonious learning environment:

**DO:**

- Engage actively in all learning activities.
- Comply with all occupational health and safety (OH&S) and other requirements associated with laboratory classes.
- Maintain a professional environment in your group activities. This includes respecting others of differing cultures, religions, gender, and sexuality.
- Prepare assigned tasks to the best of your ability and in a timely manner.
- Realise that academic and administrative staff are people too. Express concerns in a constructive and respectful manner, as you would wish to be treated yourself.
- Be open to the idea that others may have opinions that are different to, but as valid as, your own.
- Remember that non-verbal behaviour and body language are just as important as verbal communication.
- Tell someone (e.g., your CBL tutor, your course coordinator) if you are feeling uncomfortable in a learning environment or are struggling with your studies.
Don’t:
- Wander in late to lectures or leave before the end. If you need a coffee, buy it before or between lectures, not during.
- Use vulgar or inappropriate language, this includes non-verbal behaviour and body language.
- Talk over the top of another person; whether in a group environment or a lecture.
- Invade others’ personal space or put your feet up on desks.
- Come to sessions unprepared or underprepared, and then expect others to make up for your lack of preparation.
- Cut and paste your presentations from Wikipedia or another student's work.
- Answer phone calls, texts or access social media during your scheduled activities unless absolutely necessary.

Useful Links on Professionalism
- UQ Student Charter
- Medical Program Participation Requirements
- UQ Academic Integrity Module
- UQ Fitness to Practise
- MDANZ Inherent requirements for studying medicine
- Preparing for Queensland Health Placements

Use of Images in the MD Program

Use of student ID image
In accordance with PPL3.40.08 Access to Students Images, the Faculty of Medicine will use your ID image for identification purposes directly related to your student enrolment. These purposes may include, but are not limited to:
- for specific identification purposes directly related to your enrolment (for example, placements, hospital identification cards)
- for reasons of student and patient safety
- for the purpose of pastoral care and enhancing the learning and teaching experience, for example, through the production of reference sheets that allow academic staff to more effectively identify and provide assistance to students
- for other reasonable purposes where the signed consent of the students concerned has been obtained.

Your image may be accessed by Faculty staff, staff of hospital departments, and other clinical placement sites. All images will be kept private, and will not be published in a public setting. Where there is a specific requirement from a placement organisation that student images be on display in a public area, you will be asked to agree to that use of your images as part of accepting the placement.
All images provided for the above purposes will be deleted upon graduation or exit from the program. If you wish to lodge an appeal regarding the use of your image, you can do so in accordance with PPL 3.60.02 Student Grievance Resolution and PPL 1.60.02a Privacy Management—Policy.

**Taking photographs as a medical student**

Mobile phones and other smart devices make taking photographs very easy. However there are strict UQ guidelines which cover when and how you can take photographs in certain environments; for example, photography is *strictly prohibited* in the Gross Anatomy Facility (GAF).

As a medical student, you should also be professional in your use of social media and be aware of your responsibilities around the use of clinical images. The Australian Medical Association (AMA) has two useful guides covering these topics.

AMA Guide — [Social Media and the Medical Profession](#)

AMA Guide — [Clinical Images and the use of Personal Mobile Devices](#)
THE CLINICAL SCIENCE COURSES

Unlike most courses that you have studied, the Clinical Science courses combine many different disciplines, such as anatomy, physiology, biochemistry, microbiology and pathology, into single integrated courses.

The Clinical Science 1-3 courses are divided into system-based modules. While the Course Coordinator has overall administrative responsibility for their course, the development and delivery of individual course modules is managed by other academics (known as Module Coordinators) within the Clinical Science team.

Each module is run using a case-based learning (CBL) model facilitated by a clinician tutor. Each week, you will work through one main case and two short cases designed to support the week’s key learning issues (KLIs). CBL tutorials integrate learning across a number of your courses (not limited to clinical science topics). Given this, more information about CBL is provided below, with detailed information available on your Course Blackboard sites.

Biomedical Science Disciplines in the Clinical Science Courses

While closely integrated and centred on CBL, in order to fully understand and appreciate the cases, it is important to have a solid grounding in a number of distinct disciplines in biomedicine. This is directly reflected in the teaching program in the Clinical Science courses. Disciplines are communities of practice; groups of academics or other professionals who share a common interest in a particular area of knowledge.

In general, discipline-based content can be considered in terms of three closely related domains;

- The science of normal human structure and function
- The science of disease and disordered function
- The diagnostic and therapeutic sciences

While these are presented as separate domains, in reality they are closely inter-related. For example, normal structure (anatomy) and function (physiology) are aligned and disease (pathology) will impact on both of these, while all three inform effective pharmacological interventions. Therapeutic approaches will thus exploit knowledge of the disciplines in order to try and correct the disorder. Individual disciplines will typically contribute to more than one of these domains, but tend to be more centred within one of them. The biomedical science teaching will emphasise the overlaps between disciplines and the clinical relevance of the understanding of the discipline. The table below shows some of the key biomedical disciplines you will come across and their relationship to these three domains.

<table>
<thead>
<tr>
<th>Domains</th>
<th>Primary Disciplines</th>
<th>Secondary disciplines</th>
</tr>
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<tbody>
<tr>
<td>Human structure and function</td>
<td>Gross Anatomy, Histology, Physiology, Biochemistry, Cell Biology</td>
<td>Embryology, Neuroanatomy</td>
</tr>
<tr>
<td>Disease and disordered function</td>
<td>Pathology, Microbiology, Immunology, Genetics</td>
<td>Gross Anatomy, Histology, Physiology</td>
</tr>
<tr>
<td>Diagnostic and therapeutic sciences</td>
<td>Pharmacology; Radiographic Anatomy, Immunology, Pathology</td>
<td>Biochemistry, Gross Anatomy, Neuroanatomy, Genetics, Microbiology</td>
</tr>
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Biomedical science lectures for each module are generally planned to cover anatomy, physiology, pathology and pharmacology in sequence, such that the healthy system, disease, and treatment are layered sequentially to facilitate your understanding and integration of information.
Disciplines will typically have a recommended textbook, which can provide you with an overview of the way that the discipline views issues in biomedicine. Access to a textbook (purchased or online) is important in helping you structure your learning in the various disciplines you will encounter. Online multimedia resources through the library will further aid your learning.

You will gain knowledge in each of these disciplines as you work through your CBL cases. You will also receive formal teaching, either in the form of lectures or through tutorials and practical classes. These discipline-oriented teaching and learning activities will help you build a scaffold of knowledge in biomedicine which will serve you and your patients through your careers. You will need to access and apply that knowledge to manage the myriad of problems of medicine and health care that you will encounter in your future careers. As the future clinical leaders, it will also prepare you to identify areas of deficient knowledge in order to further develop medical science through research and improve patient care.

Discipline knowledge will be assessed using tools, such as an integrated multi-disciplinary practical examination, and image-based questions.

It is important to remember that while some disciplines have a heavy weighting in the Clinical Science course and others less so, they all contribute to your learning in the Clinical Science courses, and more generally in the medicine program.
THE CLINICAL PRACTICE COURSES

Correlating Clinical Science with Clinical Practice

Within Phase 1 of the UQ MD Program, the Clinical Science and Clinical Practice courses provide you with an important foundation upon which you will develop your clinical reasoning, clinical skills and professional behaviour. Both courses cover large areas of medical knowledge, grouped by bodily systems, and are intended to foster an integrated approach to medical decision-making.

A few general principles in the correlation between the two courses are as follows:

- Clinical Science teaches core scientific knowledge pertinent to the understanding of the human body, in both normal and disease states, and uses case-based learning (CBL) to apply this knowledge to clinical scenarios.
- Clinical Practice teaches practical skills, both verbal and physical, which will be employed in the delivery of patient-centred care. This course involves history-taking, examination skills, procedural skills and how to perform these skills in a professional manner.
- It is unsatisfactory for a doctor to examine a patient without having a foundation of scientific knowledge to their decision-making process, just as it is unsatisfactory for a doctor to understand a disease process but not be able to engage with patients in a clinical setting: the courses are complementary.
- It is intended that you draw parallels between the two courses, even if the delivery of systems-based teaching is not always synchronous.
- To achieve a fully-integrated understanding of clinical science and clinical practice requires many years of study and practice, so please utilise the expertise of the many academic and clinical members of staff to assist you in this endeavour.

It is important to understand that the body of medical knowledge is too vast to cover in any one course and is continuously expanding due to new medical discoveries and challenges. As a future health professional, you will be required to build on your foundation knowledge, seek answers when they are needed and develop a level of expertise relevant to your professional duties.
Year 1

The Clinical Practice courses aim to equip junior medical students with a set of skills relevant to patient interactions, many of which will be employed and developed over the entire career of a medical professional. In Year 1, the teaching of Clinical Practice largely constitutes simulation, utilising peers or standardised patient actors as model patients. The following broad categories of skills will be covered in Year 1:

- History-taking skills
- Peer-physical examination skills
- Procedural skills
- Nutrition counselling
- Demonstrating professional behaviour

Year 1 Clinical Practice courses consist of several learning activities in which the above skills are taught and assessed:

1. **Clinical Coaching (CC) Tutorials** – These are two-hour tutorials, hosted at your Clinical Unit, once per week. They are led by a Clinical Coach, who is an experienced clinician. They will cover both history and examination skills, and assist with the integration of core knowledge into clinical contexts. Your Clinical Coach is your regular contact in Clinical Practice, with whom you can discuss many topics ranging from curriculum to assessment and beyond.

2. **Clinical Communication Skills (CCS)** – In Semester 1, the majority of CCS components will be included within your Clinical Coaching (CC) tutorials. You will also be required to complete a single recording of a peer medical interview outside of your CC tutorials, which will be marked by your Clinical Coach. In Semester 2, students will further apply their skills from Semester 1 with a standardised patient actor.

3. **Procedural Skills Workshops (PSW)** – Students will learn to perform Hand Hygiene, Basic Life Support (BLS) and apply Personal Protective Equipment (PPE). These workshops will be completed by all students, once only per year, in groups of 10 students. They are supervised by a team of experienced clinical nurses who demonstrate principles of infection control. It is expected that students complete important online pre-readings for these PSWs, are dressed appropriately for a clinical environment (including closed-in shoes) and arrive at least 10 minutes in advance of their session for sign-in and completion of forms.

4. **Nutrition Masterclass** – This single practical workshop is offered for all students in Semester 2. It correlates with the Gastrointestinal System and Nutrition and Metabolism modules in the Clinical Science course. The Masterclass has a specific emphasis on nutrition skills, including how to perform a nutrition assessment and provide appropriate nutrition advice to patients.

5. **Professional Behaviour** – It is important that all medical students develop a sense of professional identity and are cognisant of their interpersonal and professional interactions with peers, patients, health professionals and members of the community. Feedback and assessment of students regarding professional behaviour is provided within assessment items and also in the Clinical Participation Assessment (CPA).
Year 2

In Year 2, students in Clinical Practice courses will evolve their history-taking and examination skills, from tutorial-based peer-physical skills to bed-side patient interactions in the wards and departments of major hospitals. You will be expected to revise all systems-based examinations from Year 1 Clinical Practice, under the direction of hospital-based clinicians (Clinical Coaches), as well as develop new history-taking skills, examination skills and procedural skills. The following broad categories of skills will be covered in Year 2:

- Bed-side and simulated patient history-taking skills
- Bed-side physical examination skills
- Intimate examination skills
- Introduction to specialty skills
- Procedural skills
- Clinical communication skills
- Demonstrating professional behaviour

Year 2 Clinical Practice courses consist of several learning activities in which the above skills are taught and assessed:

1. **Clinical Coaching (CC) Tutorials** – These 1.5-hour tutorials will be run as 2 rotations of approximately 6 weeks each, per semester and are supervised by Clinical Coaches at Mater Clinical Unit, PA Southside Clinical Unit (Princess Alexandra Hospital, Greenslopes Private Hospital, Sunnybank Private Hospital, Queen Elizabeth II Jubilee Hospital, Redland Hospital) and Royal Brisbane Clinical Unit (Royal Brisbane and Women’s Hospital, Prince Charles Hospital). Clinical Coaches will guide students to develop confidence and finesse in their history-taking and examination skills.

2. **Self-guided patient history-taking and examination skills** – Small groups of students (minimum recommended 2) are encouraged to speak to patients and practise history taking and examination skills, within clinical settings, in their own time. Students can utilise this experience to gain confidence, practice existing skills, build professionalism and better understand the patient experience. Questions regarding individual cases should be directed to the student’s regular Clinical Coach. Self-guided patient history-taking and examination experiences will be recorded as a patient case log, which will be submitted for assessment.

3. **Procedural Skills Workshops (PSW)** – These will be familiar to students from Year 1 of the MD program and specifically cover Venepuncture and Peripheral Intra-Venous Cannulation skills.

4. **Women’s and Men’s Health Teaching Associates (WMHTA) program** – This full-day program is hosted at the Mater Clinical Unit (Whitty Building) and teaches students how to perform the gold-standard of intimate examinations for both male and female patients. Skills taught include appropriate communication skills, cervical screening, breast examinations, testicular examinations and digital rectal examinations. Student competence is assessed as part of their tutorial.

5. **Endocrine Examination Workshop** – This workshop teaches students core knowledge and skills necessary to perform specific endocrine examinations, including thyroid and diabetic leg and foot examinations. The workshop is led by clinicians with specialist knowledge in this area.

6. **Clinical Ophthalmology Workshop (COW)** – This workshop is hosted by the outpatient Eye Clinics at Mater Hospital Brisbane, the Princess Alexandra Hospital and Royal Brisbane and Women’s Hospital. Students will learn the basics of eye assessments, practise fundoscopy on dilated pupils, be introduced to the slit-lamp and receive teaching from specialist Ophthalmologists.
7. **Advanced Life Support (ALS)** – This introduction to ALS offers students the opportunity to practice and extend BLS skills with simulations. Students will learn new content about the management of airways and arrhythmias (defibrillation and pharmacotherapy based upon ALS algorithms).

8. **Suturing Master Class** – This workshop introduces students to basic suturing skills, including instrument handling, tissue handling, interrupted simple suture and vertical mattress suture placement.

9. **Clinical Communication Skills** – Six Clinical Communication Skills (CCS) modules are delivered throughout the year through a program of interactive tutorials. Tutors will facilitate the learning of essential communication skills such as those required in breaking bad news, taking a sexual history, performing a mental health history and examination, facilitating behavioural change through motivational interviewing and communicating in a palliative care setting.
TOOLS FOR CLINICAL SCIENCE AND CLINICAL PRACTICE

Clinical Reasoning

The process of clinical reasoning is undertaken by all clinicians, often automatically, and is the cognitive process that underlies diagnosis and management of a patient’s presenting problem. The literature further defines clinical reasoning as follows.

- **Clinical reasoning is the ability to** “...sort through a cluster of features presented by a patient and accurately assign a diagnostic label, with the development of an appropriate treatment strategy as the end goal”¹

- **Clinical reasoning** is fundamental to all forms of health-care practice, but is difficult to teach because it is complex, situation-specific, built up through experience and frequently based on tacit, automatic processes of pattern-recognition. It involves gathering and analysing information (diagnostic reasoning) as well as deciding on therapeutic actions specific to a patient’s circumstances and wishes (therapeutic reasoning). It combines cognitive strategies such as analysis and problem solving with situated reasoning about patient needs in their broader clinical context.²

The Dual Model of Clinical Reasoning

There are a number of models of clinical reasoning, but the most widely discussed and the most helpful from a practical point of view is referred to as the Dual Model. The Dual Model proposes that the clinical reasoning process is made up of both analytic and non-analytic processes. Neuro-imaging studies show that these processes are both anatomically and physiologically distinct. The differences between the two processes will be discussed in more detail below, but can be highlighted here by giving some of the commonly associated words and concepts,

- **Analytical**: conscious, slow, controlled, deductive; hypothetico-deductive; used especially in more difficult or uncertain cases, or when there is no obvious ‘illness script.’

- **Non-analytical**: fast, intuitive, pattern-recognition, spot diagnosis; ‘expert’ method; retrieval of illness scripts; used especially for ‘classical’ or routine cases.

It is important to realise that these two processes are not mutually exclusive or separate. Their relationship is dynamic. Expert clinicians move freely between the two, depending on the particular context, as no one diagnostic strategy is appropriate for every case. The concept of expertise in any field includes an element of flexibility in the ways in which solutions to problems can be derived.

Research has demonstrated that over-reliance on either Analytical or Non-Analytical processes alone can lead to an increased rate of diagnostic error. Both processes are subject to bias, hence the importance of incorporating a metacognitive strategy.

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Analytical Thinking

This is most commonly allied with the hypothetico-deductive approach. It is based on a degree of underlying knowledge of the situation or problem which then informs the data collection process. Accurate data collection is crucial for accurate diagnosis and management.

It is important to understand that this is an active process, because without attention and careful observation, subtle clues in the patient’s history or demeanour may be missed.

“The eye does not see what the mind does not seek.”

“More things are missed in medicine by not looking than by not knowing.”

Non-Analytical Thinking

Pattern recognition is part of this mode of thinking. It is relevant even at the very beginning of your CBL tutorials because exposure to clinical material can happen through personal experience, the experiences of family and friends, and via books, television, movies, social media etc. The only difference between students and clinicians in this situation is that the latter have had more exposure to medical scenarios.

‘Illness scripts’ are more personal than the classical clinical vignettes outlined in medical textbooks. They are based on real patient experiences but are relatively lacking in pathophysiological information. As with other single elements of the clinical reasoning process they are prone to bias, and if used alone and without a metacognitive strategy in place, they may increase diagnostic error.

Metacognition

Metacognition is “thinking about thinking.” It is a process of reflection and analysis of the decision-making process. Use of a metacognitive strategy as part of clinical reasoning has been shown to reduce the chance of errors in the process (such as premature closure,) which may in turn increase the risk of diagnostic and management mistakes.

Clinical Reasoning and GIFTS

‘Group Identified Focus Tasks’ (GIFTs) are an integral part of your CBL tutorials. Use of a wide range of different types of GIFTs is encouraged, as each strategy can assist the development of one or other aspect of the clinical reasoning process.

In Summary

Clinical reasoning is fundamental to all forms of medical practice. It is without doubt the most important skill you need to develop in order to become a confident, efficient, and safe practitioner. Two key elements in the development of good clinical reasoning are interacting with as many patients as possible (both virtual and real), and becoming thoroughly involved with the process of CBL.
Clinical Case Summaries

The preparation and presentation of case summaries are skills you will use every day in clinical work, especially when requesting advice about your patients and when you “handover” your patient to a colleague to continue their care. Proper clinical handover is vital for patient safety. Poor handover has been identified as a major preventable contributor to patient harm, and to medical malpractice claims.³

Case summaries are given in many different situations. A doctor who admits a patient to hospital will give a case presentation to the treating team. When assessing a patient in the emergency department, junior staff (or medical students) will present a summary of their patient to senior staff. Written summaries are used in referrals and discharge letters. A brief verbal summary is given when phoning a doctor on-call.

The appropriate form and length of the summary will depend on the situation. You may also find that each doctor you work with, and likewise each CBL tutor, has a slightly different preference for how a summary is given. Rather than let this confuse you, see this as an opportunity to learn a range of different techniques. Two standard techniques, ISBAR and Standard Case Presentation, are outlined here to guide you.

The Standard Case Presentation

As you progress through CBL cases and your Clinical Practice courses this year, you will become very familiar with an ordered approach to seeing a patient. Practicing doctors are all familiar with the same structured approach – history, then examination, then investigations, etc. Your case presentations should also follow this structure. The “Standard Case Presentation” on the next page lists all the topics to include in the appropriate order, with further details outlined in your Clinical Practice Handbook. Ultimately, the amount of detail included under each heading will vary according to the situation. On many occasions, it will suffice to say, “There was no significant past history” or “all other examinations were normal”.

You will notice that CBL cases are written just as a real consultation with a real patient would unfold. Patients rarely give you their information in this exact sequence! So, when preparing a case summary, you need to reorder the information into this logical format which your colleagues are expecting to hear.

Likewise, patients will use their own words to describe their symptoms and history. At times using the patient’s own words is appropriate, such as the presenting complaint “my heart was skipping beats”. After stating this however, you should then use the medical term “palpitations” during the rest of the presentation. Similarly, if a patient tells you they have “sugar diabetes”, you should simply translate this to “diabetes mellitus” in your summary.

Standard Case Presentation

History
Basic Demographics (Name, Age, Gender)
Mode of Presentation if relevant
(e.g. “brought in by ambulance”)
Presenting Complaint
History of Presenting Complaint
Systems Review
Past Medical History
Past Surgical History
Medications/Allergies/Immunisations
Family History
Social History (including Substance Use)
Occupational History
Menstrual/ Obstetric/ Sexual/ Travel History if relevant

On examination
General (including vital signs, GCS where relevant)
Relevant systems examinations

Provisional Diagnosis + Differential Diagnoses

Actions
Investigations
Initial Management

Confirmed Diagnosis

Further Management Plan
Ongoing management and duration
Follow-up arrangements
ISBAR (Introduction – Situation – Background – Assessment – Recommendation)

In many scenarios, a clinical summary needs to provide adequate information in a format that is even more concise than that described above. “ISBAR” is one tool that is widely used. Figure 3 provides the framework and the videos below give excellent examples of using ISBAR.

ISBAR Case Study 1
https://youtu.be/1Wf9qgPw1E

ISBAR Case Study 2
https://youtu.be/AmZKJ3JAPsE

How do I know which details to include and which to leave out?

This will become easier with experience. Most students err on the side of including too much detail initially. In CBL you will learn to develop hypotheses about what is causing the patient’s presentation. When you present a case summary, remember that your listener is going through precisely the same process. For example, if an infection is a likely hypothesis in the case, the listener will be waiting for you to tell them whether fever was present (a significant positive) or absent (a significant negative) – to test their hypothesis. With time, you will learn more about potential diagnoses, and so become more confident about which information to include and what can be safely left out.

Always imagine the scenario in which the summary is being given (ask your tutor to suggest a scenario). This will then guide you as to what to include. For example, when you are sending a patient back to their GP after several weeks in hospital, their exact blood pressure on the day of admission is probably of little relevance. Consider what your listener needs to hear to safely take over care of the patient. Begin by mastering the two methods described here, then consider other styles or scenarios you can practice e.g. writing a referral letter or discharge summary.

Remember, your tutors are available to guide you and give you feedback. Make good use of the opportunities that CBL gives you to practice case summaries and you will rapidly become competent in this important clinical skill.
ISBAR

Clinical conversations should be clear, focussed and the information relevant. Poor communication risks patient safety and contributes to adverse outcomes.

I — Introduction
“[My name] (name and role)
“I am calling from [organization name].”
“I am calling because…”

S — Situation
“I have a patient (age and gender) who is
a) stable but I have concerns
b) unstable with rapid/slow deterioration
“The presenting symptoms are…”

B — Background
“This is on a background of…”
(give pertinent information which may include:
Date of admission/ presenting symptoms/ medications/
recent vital signs/test results/status changes)

A — Assessment
“On the basis of the above:
□ The patient’s condition is ...
□ And they are at risk of ...
□ And in need of ……”

R — Recommendation
Be clear about what you are requesting.
e.g. “This patient needs transfer to/review ……”
Under the care of….
In the following timeframe ……”

Figure 3: ISBAR Clinical Summary tool from Hunter New England Area Health Service (2008). ISBAR revisited: Identifying and Solving Barriers to Effective Handover in Interhospital Transfer. Used with Permission.
THE HEALTH, SOCIETY & RESEARCH COURSES

Health, Society and Research (HSR) is a suite of three courses delivered by the School of Public Health.

The aim of these courses is to ensure graduates of UQ’s MD Program are able to: conceptualise health and aware of ways to measure it; find, appraise and implement evidence-based practices; and be an active and informed member of workplaces and communities that promote and protect health for all.

Many HSR concepts are complex and multi-faceted so we provide tutorial sessions with activities to promote discussion, application and reflection. Your attendance at lectures and tutorials will contribute to your understanding of these concepts and your ability to complete assessment tasks successfully.

In HSR1 we:
- compare health systems and models of healthcare provision
- define, conceptualise and reflect on determinants of health
- introduce research ethics
- identify relevant literature and/or sources of quality evidence

In HSR2 we:
- assess population health
- introduce quantitative study designs used to inform evidence-based practice
- appraise quality and clinical application of evidence

In HSR3 we:
- explore strategies to promote and protect health across the life course
- introduce purpose of qualitative and mixed methods study designs, along with quantitative studies, to apply evidence-based practice in context
- systematically identify literature/evidence, extract relevant data and summarise findings in relation to a research question
THE ETHICS & PROFESSIONAL PRACTICE COURSES

Why do we need to know this?

Medicine is a moral practice as well as a science. It is a healing relationship that involves another human being at times of vulnerability, illness or uncertainty. There is a universality about the experience of illness as Sontag notes:

*Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.*

This universality cements medicine as a highly visible public “good”. It is expected and funded by a community that scrutinises, judges, valorises or punishes medical conduct. The “doing” of medicine, both in terms of our demeanour and our actions is framed by codes of ethics and professional behaviour, and the rule of law. This occurs in major medical decisions as well as the multiple daily interactions where we demonstrate respect for patients and colleagues of all backgrounds.

Will I find this challenging?

You bring to this course a mix of individual and culturally diverse values, expectations, beliefs and training. These may be affirmed, questioned, or debated by you and others during your time in the Faculty of Medicine. Openness to other perspectives is one of the key virtues we aim to cultivate in our program. Some students find it challenging that ethics doesn't have a “right” answer. This is exactly why it is included in the curriculum - medicine can be uncertain, with multiple “rights” and few “wrongs” to guide decision making. Tolerating uncertainty and being able to think through the best course of action is one of the attributes we expect from our graduates. You will learn how to approach ethically and legally challenging situations using a variety of processes that will ensure your decisions are systematic and defensible.

What skills will I develop?

Actively listening to others and understanding their point of view is a skill that you will develop as part of ethics and professional practice. In Phase 1 we establish the knowledge foundations necessary to be the type of doctor our community respects: a thoroughly professional, compassionate, humanitarian, problem solver in the field of medicine. Each semester we focus on a theme, illustrated in the diagram below. This lays the foundation for further development in the clinical environment in Phase 2.

Semester 1: Professionalism and Law

Semester 2: Clinical Ethics

Semester 3: Philosophical Ethics

Semester 4: Patient Safety and Health Law

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How can I succeed?
Be prepared to be challenged on your thoughts and attitudes and the way you learn. Ethics and professional practice is assessed through assignments, examinations and through your discussions in CBL group. Lectures, on-line learning resources and readings support these discussions.

Can I do more?
Yes! We supervise a variety of students to attain their Doctor of Philosophy, Masters of Philosophy or in publishing academic journal articles in areas of the student’s interest.
YEAR 1 OBSERVERSHIP

The Year 1 Observership is a placement undertaken during summer semester between years 1 and 2. It provides opportunities for you to gain exposure to the practice of medicine in a clinical healthcare, research or community setting.

During your Observership, you will further your personal and professional development, gain insight into health service provision, participate in research activities, access leading researchers and/or medical specialists from both health and community agencies, and develop lasting friendships, mentorships and networks.

If you are a domestic or onshore international student, you are required to complete a minimum of 4 weeks anywhere within Australia or overseas. This can be split into 2 x 2-week blocks.

If you are an MD Ochsner student, you are required to complete an 8-week placement within the Australian Healthcare environment to satisfy the program accreditation requirements stipulated by the Australian Medical Council (AMC). You may split your Observership into 2 x 4-week blocks, or 1 x 2-week and 1 x 6-week block.

The learning objectives will depend on your placement choice but should include one of the following:

- develop a knowledge of health systems
- develop an understanding of the professional roles of a range of health care professionals
- develop an understanding of health care team dynamics, team management, and patient roles
- gain an insight into ‘the life of a doctor’
- experience the practice of medicine in other environments
- experience clinical and non-clinical research
- develop appropriate communication skills with patients and colleagues

Briefing sessions will be held during the year, and further information can also be found here.
INTEGRATED CLINICAL STUDIES

In semester 4, your clinical science study is integrated with key public health and research topics to form Integrated Clinical Studies (ICS). This course builds upon the biomedical science, public health and clinical principles covered in previous semesters of the Medical Program, and allows the opportunity to revise and expand this knowledge by applying it to commonly-encountered clinical scenarios. The development of clinical reasoning skills in preparation for progression to the clinical rotations in Phase 2 is a significant focus of this course. Each week is based around a theme rather than a system and multiple long and short cases are explored each week within small–group CBL tutorials, facilitated by a medically trained tutor.

SEMESTER 4 SELECTIVES

As outlined in the Welcome section, semesters 1-3 of Phase 1 consist of four courses; Clinical Science (3 units), Clinical Practice (2 units), Health, Society and Research (2 units), and Ethics and Professional Practice (1 unit).

Goal 2 of UQ’s Student Strategy is to provide student-centred flexibility; “To provide our students with flexible options that support and service their priorities, meet their expectations and personalise their learning experience.”

In order to better meet the individual interests and goals of our students, from 2019 we are introducing a range of 2 unit pass/fail “selectives” which you will take alongside your set courses. The selectives on offer to non-Ochsner Year 2 MD students in 2019 can be found on the MD course list. Students enrolled in the MD-Ochsner Program will be required to take the USMLE Preparation course. All other students are not required to make a choice about the selectives until the start of Year 2.
WORKING IN GROUPS

Love it or loathe them we can’t escape groups! Whether family, fellow students or (we hope!) a multidisciplinary team when we finally graduate. It’s worthwhile to take a few minutes to think about groups and start with some core knowledge and skills so that you get the best out of them and contribute as well as you can.

Being part of a group means that you can achieve more than as an individual. A group can develop a core identity which helps members feel good about themselves. This can lead to increased productivity and even a competitive edge. Members can learn from each other, feel supported, commiserate when things don’t go well, and brainstorm ways to handle challenges. Apart from all of that, groups can be fun – sharing stories and talking about common interests, learning interesting and new things about people – all good stuff.

There can be a downside to groups. Individuals have different personalities - some are quiet, others more outgoing. It can happen that you find yourself in a group where you feel that one person “takes over” and it is hard to say anything. Depending on your own personality and background it can be very challenging to be assertive in this case, and it is easy to withdraw and feel anxious. Another issue might be that members get slack and don’t always pull their weight – that can lead to frustration and resentment. A more extreme issue is bullying – this can range from subtle issues like excluding a person to harassment, open hostility or even abuse.

Some Suggestions

- Discuss the “rules” when you first establish your group. Basic things like only one person talking at a time, everyone gets a chance to speak etc. Then everyone knows where they stand.
- Be courteous – think about your own attitudes and behaviour and how that could affect others. What you see as your great sense of humour and aptitude for telling risqué jokes might be highly offensive to someone else.
- Think carefully about communication- sometimes we expect others to know what we mean but it isn’t always clear. Make sure that when dividing tasks, for example, that everyone is clear about the expectations rather than leaving it “hanging in the air”.
- Be generous – when someone does a good job tell them so.
- Look out for each other – if you know that someone is having a tough time, for example a family member is sick, ask if you can give a hand with notes etc.
- Build in a regular time to discuss how things are working in the group – set a time and use it. Then everyone can talk. It can feel very scary to raise a concern “out of the blue” but if you have a set time to talk you can work things out more easily. If something is bugging you, try to offer a practical solution. For example, rather than “Jack dominates the group and it is getting me down” maybe say “I think that we all need to work on our presentation skills and I was wondering if we could maybe take turns to present something each session”.

The bottom line – what a great course you have started. What a great future you have ahead of you. Some of the people you meet now will be your friends for the rest of your life. Enjoy them. Learn to be a team player. It will be great.
CASE-BASED LEARNING

Case-based Learning (CBL) tutorials are a core aspect of Phase 1. They are one of the opportunities you will have to learn and work in a small group setting. You will stay in the same CBL group for all of year 1, and then another group for all of year 2. You will spend two tutorials a week together in CBL (five hours per week in year 1, and four hours in year 2), plus you will also work in this same small group in Clinical Practice and other courses. All of the suggestions above for working in groups are very applicable to CBL. Each semester you will have a new CBL tutor who will help to facilitate your learning and your group dynamics to help ensure you get the most out of CBL.

CBL tutorials will appear in your timetable as an activity of Clinical Science or Integrated Clinical Studies, however, by their very nature, they provide an opportunity to integrate your learning from each of your courses. For example, each CBL case will contain elements for discussion relating to ethics, professional practice, clinical practice, public health and research, allowing you to bring together your learning from different courses and apply this to an authentic patient scenario. While for some courses, this integration is more informal, CBL sessions in year 1 are specifically a learning activity for (and assessed in) both Clinical Science and Ethics and Professional Practice. Full details about how CBL works and why is provided for you in the Course Blackboard site for each associated course.

ASSESSMENT IN THE MD PROGRAM

As you progress through Phase 1 of the MD program, you will encounter a range of assessment types, including theory exams with multiple-choice and short-answer questions, multi-station “spotter” exams, individual and group assignments, and other forms of assessment to develop your clinical competence. You will also be assessed on your participation and engagement in your small group activities such as Case Based Learning (CBL) tutorials and clinical coaching sessions.

Many of your courses will provide you with opportunities to hone your assessment skills without contributing to your overall marks. This is called formative assessment and it is wise to take advantage of these opportunities when they arise.

The General Assessment Guidelines – MD/MBBS Program provides guidelines for staff and students in relation to those aspects of assessment that are common across all courses in Phase 1 and/or Phase 2 of the MD/MBBS program, and which are not specifically described in the my.UQ website.

Many of your exams in Phase 1 will be conducted electronically on your own device (or one borrowed from the Faculty of Medicine) on a platform called ExamSoft. This platform allows your course coordinators to provide timely and detailed individualised feedback on your exam performance.

ExamSoft consists of two main components; a web-based portal which is mainly used by staff to create your assessments (although you will, at times, also log in to access results), and an exam taker app, Examplify, which runs on Windows, Mac laptops and iPads.

You can read more about ExamSoft and Examplify here.

The Faculty of Medicine has developed “Bring your own device” (BYOD) guidelines to assist you with decisions about choosing a device to support your studies.
GIVING AND RECEIVING FEEDBACK

Feedback may be defined as “… information provided by an agent (e.g., teacher, peer, book, parent, self, experience) regarding aspects of one’s performance or understanding … [it] is one of the most powerful influences on learning and achievement …”\(^5\)

As you work your way through the MD program, you will encounter many opportunities to give and receive feedback, both formally and informally. Giving constructive, professional feedback and receiving feedback from peers and supervisors is part of your continuing professional development and is an expected component of assessment in many courses, especially Clinical Science and Clinical Practice.

Receiving feedback

In both Year 1 and 2, you will be given formal feedback by your CBL tutors and by your clinical coaches. When your assignments are returned to you, when you view your exams and are supplied with model answers, this is also feedback.

Not only are tutors an important source of feedback; you have a rich and often untapped source of feedback in your peers – this becomes increasingly important in Postgraduate Clinical Practice.

We encourage you to actively seek feedback from your teachers (and peers) at any time when you feel it would be helpful or reassuring, and to ask for clarification or assistance if necessary.

Giving feedback

During CBL tutorials your peers will present cases and other group identified focus tasks (GIFTS), and these present an opportunity for you to develop your own skills in providing good feedback to others. If asked to give feedback, consider what information the recipient would be likely to find most valuable and communicate this as clearly as possible. Be prepared to provide clarification if asked.

A common model for giving feedback in clinical education settings was developed by Pendleton (1984)\(^6\).

Pendleton’s rules

1. Check the learner wants and is ready for feedback.
2. Let the learner give comments/background to the material that is being assessed.
3. The learner states what was done well.
4. The observer(s) state what was done well.
5. The learner states what could be improved.
6. The observer(s) state how it could be improved.
7. An action plan for improvement is made.

You can find additional information and guidelines on giving and receiving feedback in the Clinical Practice Handbook, Chapter 4: Clinical Communication Skills.

Staff in the MD program are always appreciative of constructive student feedback, whether via formal Student Evaluation of Course and Teaching (SECaTs) or other avenues. We can assure you that every piece of feedback is considered and discussed as part of our ongoing review process, and it is also a major aspect of the professional development process for CBL tutors. Every year the course is modified in response to feedback (although that is not to say that every wish is ultimately granted!)

When giving feedback to teachers and the Faculty, remember that the key elements of effective feedback are that it is respectful, professional and constructive, is delivered in a timely manner, is specific in its

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content, and is based on first-hand experience. Please remember that a real person will be reading your online feedback, and be sure that it is reflective of the quality of feedback that you would like to receive yourself. It is also important to consider that your opinion may not be reflective of your cohort as a whole, or even of the majority.

Sometimes in the heat of the moment we can say something critical or frankly rude. It is easy to quickly write an email or text and click “send” without really thinking. Later we might think “Mmm, maybe not such a good idea”. You will have experiences in this program and in your future clinical roles which frustrate and sometimes even enrage you. Now is the time to master the art of reflection before making any written comment – ever! This applies in student evaluations, notes in medical charts, emails to colleagues i.e. the rest of your professional life!

Effective communication is also more likely to achieve the desired outcome. Compare “These resources were rubbish” with “I would find it easier to learn if the resources were briefer (no more than 20 minutes) and available in mp4 as well as VOPP”.

**Self-feedback**

An often untapped source of feedback comes from self-reflection. Learn to generate your own feedback by reflecting on what you have achieved and where there may be areas for improvement. This is a valuable task to undertake prior to receiving feedback from your CBL tutor at the two formalised times each semester and will help develop your feedback as a two-way dialogue.
RESEARCH OPTIONS IN THE MD

UQ Medicine is committed to enhancing the research training and experience for students in the MD Program. Active participation in the research process gives students the skills to develop independent critical-thinking, propose theoretical concepts, and critically analyse their findings.

Phase 1 provides you with a foundation of evidence-based practice and research skills relevant to clinicians. Additionally, there are a number of ways students can incorporate research training and experience into their medical degree.

- **The Clinician Scientist Track (CST)** allows eligible students to combine a Higher Degree by Research (HDR), either an MPhil or PhD, with the medical program. There are three ways to incorporate a PhD or an MPhil into the MD; the Intercalated MD-PhD or MD-MPhil, and the Concurrent MD-MPhil.

- **Extended Research** refers to a wide variety of extra-curricular research options for all medical students with an interest in doing some ‘hands on’ research during their medical program. These will be casual/voluntary research projects, flexible enough to work on alongside your full-time MD during free time, weekends or holidays.

- **MD-MPH** allows eligible students to enrol in a course-work Masters of Public Health (MPH) alongside the medical degree.

- **The Summer Research Program** provides scholarships for students to undertake research over the summer break.

Points to remember:

- While there are a variety of research options available – not all students will be eligible for each option.

- The MD is your priority! You must organise your research around the MD requirements. Some options also require you to maintain a particular grade point average (GPA).

The **Student Research Portal** has all the information and guidelines regarding anything to do with medical student research. If you are interested in research at any time during your medical degree, please refer to these pages in the first instance. Sections include:

- **Research in your Medical Degree**: Details, guidelines, timelines and criteria for all your research options.

- **Find a Project**: An interactive database of available research projects, supervisors and contact details. Also a great place to get ideas.

- **For Students**: 'Register your Research' and 'Report your Research Achievements’ during your medical program and you will receive official recognition at graduation.
MEDICAL STUDENT SUPPORT

The University of Queensland Medical Program seeks to deliver impactful student support, which is fully aligned with program delivery. The support available ranges from administrative and academic through to pastoral, health and well-being as well as crisis and counselling support.

It is recognised that targeted, high impact and quality support is a critical factor underpinning student success and satisfaction.

For medical students at UQ to reach their full potential, the Medical Program acknowledges the importance of supporting students throughout their studies. This support facilitates students to achieve their best, enjoy their medical program experience, and compliments their academic journey to becoming a medical practitioner.

The Medical Student Support Strategy 2018-2020 is the governing document for medical student support, and reflects the medical student support vision, mission, and guiding conceptual frameworks.

Further information is available on the Medical Student Support webpage. A summary of some key sources of support is provided in this section.

Administrative Support

Student and Academic Administration Team

The Student Administration team provides program administrative support and information through all stages of the student lifecycle, from admission to graduation. They oversee activities such as enrolment, timetabling, annual program requirements (e.g. Blue Cards, first aid, and immunisation), processing applications (e.g. deferred exam, my.UQ application requests), placements (including allocations and away placements) and so much more.

The team provides timely and accurate advice in relation to University policies and procedures, program rules, and faculty guidelines. If you are unsure who to contact, please call or email the team and they will find the answers for you.

The team is located in the Student Hub on Level 5 Oral Health Building at the Herston campus and at Enquiries Counter, Sir William Macgregor Building at the St Lucia Campus.

If you are unable to visit the Student Administration team in person you may telephone +61 7 3346 4922 or email med.enquiries@uq.edu.au.

Clinical Units

The Clinical Units serve as the base for students during their studies and are staffed by a team of academic and professional staff from the Faculty of Medicine.

St Lucia Clinical Unit is the primary base for Year 1 students. You may contact team via email on med.stlucia@uq.edu.au.

Depending on your timetable during Year 1 and 2, you may also spend time at the Royal Brisbane Clinical Unit, the PA-Southside Clinical Unit and the Mater Clinical Unit.
Personal Advisor Network (PAN)

At the beginning of Year 1, you will be allocated a clinician, researcher or academic as a Personal Advisor. Your Personal Advisor stays connected with you across all four years of your degree and will provide you with a guidance, support and encouragement; a listening ear and anchor even as you move across years and sites. You will be advised of your Personal Advisor’s details and have your first scheduled contact in the first few weeks of semester. You can read more about the Personal Advisor Network here. If you have any queries please contact med.enquiries@uq.edu.au.

Medical Student Support Team

In addition to Student Services available to all students at UQ, the Medical Student Support Team (MSST) provides dedicated support to medical students for all wellbeing needs, and refers to other services as required. The MSST can assist medical students with:

- Mental health support, strategies and resources
- Navigating University policies and procedures and liaising with the Faculty
- Maximising performance
- Overcoming unique challenges of studying in a foreign country or interstate
- Referral to specialist support services e.g. counselling, disability support, accommodation and learning support.

Visit the website to learn more or contact the MSST via med.mss@uq.edu.au. All contact is confidential.

UQ Counselling and Crisis

The UQ Counselling Service offers counselling and crisis support to listen without judgement, offer new perspectives and work with you on strategies that are right for you. This is a confidential service. All current UQ students can access 10 free counselling sessions each year. Visit the website or call the UQ Counselling and Crisis Line on 1300 851 998 anytime of the night and day for crisis counselling and support.

Academic Support

Course Coordinators

Your Course Coordinators have overall responsibility for their courses, including the relevant Electronic Course Profile (ECP), most aspects of the assessment process, communication with students, and liaising with staff teaching into their courses. Your Course Coordinators should be your first contact point with course-related enquiries. You can find the contact details for your Course Coordinators in the ECP and on the course Blackboard site.

Student Academic Support

If you require more specialised academic advice or support regarding academic progression, you may contact Student Academic Support Lead (Year 1 & 2), Angela Brandenburg at med.acsupport1@uq.edu.au. Please note that Angela’s support role does not extend to detailed reviews of student work, and Course Coordinators continue to be the first point of contact for students who have queries regarding the course’s content, learning activities and assessment.

Medical Careers Advice

Medical Careers Lead, Dr Rachele Quested, sits within the Office of Medical Education, and is available to provide careers advice to medical students. Rachele can be contacted on med.careers@uq.edu.au.
NOTE: All links in this document were correct at the time of production however key information may be updated during the year.

The most current version of this handbook can be found at:

https://medicine-program.uq.edu.au/current-students

Please report any broken links to med.enquiries@uq.edu.au