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NOTE: All links in this book were correct at the time of printing.

An electronic version of this handbook is available from the Year 1 and 2 Community Blackboard sites.
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Welcome to the UQ MD Program!

Every year, a wonderfully diverse group of students commences their medical studies at UQ. In 2016, the intake included students from 14 different countries; around 40% were female, and while most students were between 20 and 29, we have had students under 20 and over 60 years of age. This diversity is one of the great strengths of the UQ program, as every student brings with them their own unique experiences.

The MD program at UQ is divided in two x two-year phases. Phase 1 consists of the pre-clinical years, and Phase 2 is comprised of the clinical rotations. Each semester of Phase 1 consists of four courses; Clinical Science, Clinical Practice, Health, Society and Research, and Ethics and Professional Practice. Each course is a separate entity with its own curriculum, assessment, and course coordinator. In between Years 1 and 2, there is an Observership conducted during the Summer Semester.
I’m sure no-one enters an MD program thinking it will be easy, and there are good reasons why studying medicine is often likened to “drinking from the fire hose”.

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.

There is a LOT of information to be processed, and the sooner that you discover an approach that works for you, the better off you will be. Once you start to fall behind, it can be very difficult to catch up.

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 find a way of building the pieces into something that makes sense, the big picture doesn’t seem so unreachable. The way that you 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’s best for you, but keep trying!

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 6 tips.

1. Read and understand the requirements of each course, which can be found in the electronic course profile (ECP). In particular, read the details of the assessment requirements. Behaviours such as non-attendance, lack of punctuality, and lack of engagement can have significant consequences.

2. Check your student email account, read the newsletters and the announcements on Blackboard, and subscribe to course discussion boards or you may miss important information.

3. Be an active participant in your own learning. Prepare for your CBL and Clinical Coaching sessions, and read your lab notes before attending practical classes. You will only get out of these sessions what you are prepared to put in.
4. Take the time to familiarise yourself with Blackboard. It may seem complex at first but the more you use it, the simpler it will become. All of the important content information for your courses is on these sites.

5. Use a medical dictionary or an on-line medical terminology website to build your medical vocabulary. Every time you encounter a word you don’t know, look it up. You will begin to notice similarities that will help you decipher an unfamiliar word. There are now free medical terminology apps as well.

6. **Address problems** before they become a hindrance to your learning. There is much support on offer; please take advantage of it. See also information provided in the ‘Where to go for help’ section on page 42. In particular, please take note of The Student Hub, which includes representatives from:
   - The Student Administration Team
   - UQ Student Support, including a Student Advisor and Learning Advisor
   - Student Help on Campus (SHOC)
   - The Office of Student Affairs

I hope you enjoy your time studying medicine at UQ.

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*Tammy Smith completed a B.Sc with Honours in Microbiology and a Ph.D in Immunology at The University of Queensland in the 1980s, and has been in medical education ever since, including 15 years as a Problem-based Learning facilitator, 8 years as a Module Coordinator and 5 years as a Course Coordinator for the Year 1 Clinical Science courses.*
Congratulations on being accepted to UQ’s MD Program! These four years will go fast and be incredibly rewarding, but may also be challenging and overwhelming at times, so here are a few tips to help you succeed.

From day one, you will be bombarded by the non-stop ‘fire hose’ of information. The information itself is not overly difficult (though each person will find some aspects tough), but the sheer volume will leave you out of breath and not knowing where to start. The first week or two may seem slower, but it picks up fast. Set a study strategy early, and expect to revamp and restructure repeatedly throughout the year. You will inevitably fall behind, but there is normal med-school-behind, and there is the terrifying you’re-REALLY-behind. The latter can be difficult to recover from.

It’s important to find the strategies that work for you. There is a tremendous variety of resources available, with endless lists of textbooks, videos, flashcards, online resources, etc. Choose one or two that work best for you and stick with them. Stay on top of course material; all lectures, CBL cases, VOPPs, practical sessions, and additional resources are examinable. Take advantage of the help offered by the Faculty of Medicine and UQ Medical Society, especially peer tutoring, UQSIG’s anatomy tutorials, and clinical and skills workshops offered throughout the year.

The biggest challenge you are likely to face is learning how to prioritise your time. This will be a useful lifelong skill, so you may like to consider this as part of the training for medical practice. Use travel time to review flash cards or watch videos on your phone. Use time at school wisely - actively participate in CBL so you recall material later even if you missed writing it down. You need to understand broad concepts and know details as both will show up on exams.

Go for the lowest hanging fruit first when studying. If lectures come easier to you, focus on those before moving to CBL cases. If pathology is your natural gift, start there. You eventually need to cover everything, but the various resources complement each other. A base of understanding from the easier ones will help you attack the more difficult. Medicine is a language, literally and figuratively. Understanding terminology and becoming comfortable with the way healthcare practitioners communicate will make learning more intuitive.

Your first set of exams will be exhilarating and terrifying. Use the mid-semester exams (MSEs) to check how your study strategy is working. A poor or failed first MSE does not mean you aren’t cut out for medicine; it means your approach and study strategy need revamping.

School/life balance is important, which means different things for different people. Some clubs recruit for positions prior to your first MSE, before you have a solid grasp on how you’re doing. You may want to avoid additional commitments at first, or you may be someone who thrives best by being in the thick of things right away. If you want to be involved with something, take it on, but be prepared that if you can’t manage additional commitments along with your studies, you may have to adjust the workload or give up the position until you can.

Take care of yourself. Eating and sleeping well, exercising, doing a hobby, or taking time to just sit outside and be, will provide a much-needed mental break and help balance all aspects of life, including academics. Cultivate friendships. Many med students are not from Brisbane and do not have a support system here. You will become each other’s support system, and that is crucial to getting through together. Develop a socializing strategy to manage time effectively. Perhaps you’re out one night on the weekend but not both. Maybe you limit yourself to two coffee dates weekly.
You may experience tough times, and feel overwhelmed and burnt out at times. Do not isolate yourself when this happens. Seek support: call your family or best friends, talk to friends from school, use the free, confidential counselling offered at UQ student services. Facebook will convince you that everyone is having fun while you’re studying. Not true; everyone is in the same situation trying to manage. There is no shame in having low moments. Everyone does. Take care of yourself and take care of each other.

Remember you chose to come here because you really want to be a doctor. It’s incredibly exciting to be here, in med school, in Australia. Take time to appreciate this tremendous opportunity. When it gets overwhelming, close your eyes, take a deep breath, and remember you love this stuff.

Mindy Eklove
Year 1 MD student, 2015

Mindy Eklove is currently studying medicine at The University of Queensland. Prior to medicine, Mindy worked in the international NGO and non-profit field, and has worked and volunteered in many underdeveloped communities throughout the world.
PROFESSIONALISM IN THE MD

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 professional attitudes and behaviours appropriate to the virtues and profession of medicine. 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 MD Program attendance rules
- Behave with academic integrity

These personal and professional attributes are applicable not only in clinical practice at the bedside but translate to the classroom through interactions with lecturers, tutors, administrative staff and peers. It’s also important to remember that inappropriate online behaviour can potentially damage 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 on page 9.

A critical component of professionalism for both medical students and doctors is monitoring and managing your own health. Please familiarise yourself with the MDANZ ‘Inherent requirements for studying medicine’.

In particular, please note Domain 4: Professionalism and Leadership which states that a medical student is expected to

1. Demonstrate sufficient behavioural stability in order to work constructively in a diverse and changing academic and clinical environment
2. Display the resilience and flexibility to satisfactorily deal with the demands of being a medical student
3. 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). 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 the UQ Disability advisors (http://www.uq.edu.au/student-services/disability) and the Director of Student Affairs (med.enquiries@uq.edu.au).
Practice professionalism every day!

For a productive, safe and happy learning environment,

- Be punctual to all scheduled 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.
- 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.
- 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 or access social media and text messages during your scheduled activities unless absolutely necessary.

Useful Links on Professionalism

UQ Student Charter
http://ppl.app.uq.edu.au/content/3.60.01-student-charter

MD Program Attendance Rules
https://medicine-program.uq.edu.au/current-students

UQ Academic Integrity Modules

MDANZ Inherent requirements for studying medicine

Preparing for Queensland Health Placements

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 a single integrated course.

The Clinical Science 1-3 courses are divided into modules as indicated in the table below. Clinical Science 4 has a different structure, where each week is based around a theme rather than a system, in order to further develop your clinical reasoning skills ahead of the clinical rotations.

Table 1: Module structure of Clinical Science 1-3

<table>
<thead>
<tr>
<th>Course Code</th>
<th>Module Title</th>
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<tbody>
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<td>MEDI7111</td>
<td>Preparation for System Modules</td>
</tr>
<tr>
<td>Clinical Science 1</td>
<td>Infection and Immunity</td>
</tr>
<tr>
<td></td>
<td>Cardiovascular System</td>
</tr>
<tr>
<td></td>
<td>Respiratory System</td>
</tr>
<tr>
<td></td>
<td>Renal System</td>
</tr>
<tr>
<td>MEDI7112</td>
<td>Musculoskeletal System</td>
</tr>
<tr>
<td>Clinical Science 2</td>
<td>Nervous System</td>
</tr>
<tr>
<td></td>
<td>Gastrointestinal System</td>
</tr>
<tr>
<td></td>
<td>Metabolism and Nutrition</td>
</tr>
<tr>
<td>MEDI7211</td>
<td>Eyes</td>
</tr>
<tr>
<td>Clinical Science 3</td>
<td>Endocrine</td>
</tr>
<tr>
<td></td>
<td>Male and Female Health and Development</td>
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<tr>
<td></td>
<td>Skin</td>
</tr>
<tr>
<td></td>
<td>Haematology</td>
</tr>
<tr>
<td></td>
<td>Mental Health</td>
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</tbody>
</table>

While the Course Coordinator has overall administrative responsibility for their course, the development and delivery of individual course modules is managed by other academics within the Clinical Science team. These Module Coordinators have the following duties:

- Writing and revising the CBL cases
- Defining the lecture program
- Liaising with lecturers and other content providers
- Maintaining the Blackboard site for their individual module
- Providing relevant resource material
- Providing formative assessment
- Answering discussion board posts

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 to three short cases designed to support the week’s key learning issues (KLIs). The following sections have been written to help you master the CBL process.
WHY USE CBL IN MEDICINE?

First developed in the 1960s, problem-based learning (PBL) and case-based learning (CBL) models were implemented widely in medical schools across the world in the 1990s. But for centuries medical students have accompanied doctors to hospital wards, seen patient “cases” and so learned medicine in a clinical context. CBL is about having patient encounters right from the first week of your first year, through realistic cases – thus grounding your learning in real world medical practice, even before you begin to visit clinics and wards.

There is a wealth of educational research and theory regarding the effectiveness of CBL for learning medicine and this model continues to be used at medical schools around the world. The points below provide some insight as to how the CBL program here at UQ has been carefully designed to provide the best possible learning experience.

CBL cases ground learning in real-world medical practice
CBL cases allow you to encounter the basic, social and clinical sciences in the context of real-world medicine. Theory is inextricably linked with practice. Adult learning theories suggest that we are most motivated to learn when the material is clearly relevant to our goal – to become practicing doctors. Right from year one, the CBL cases demonstrate the clinical relevance of the key learning issues.

CBL cases encourage integrated learning
Traditional courses generally scheduled separate programs for anatomy, physiology, pathology etc. The result being that the anatomy of the lung might be covered in semester one, and the corresponding physiology months later. The CBL cases and accompanying lectures, practicals and resources within each module are carefully chosen so that learning across disciplines is integrated wherever possible.

Learning from memorable, “real” patients
Although generally you will only “meet” your CBL patients through written text, rest assured they are based on very real cases. Each case is carefully written and reviewed by clinicians. You will get to know your CBL patients by name as you read their stories (though real names are changed for privacy of course). You will be given the background to their social and family situation. The CBL patients you will meet are of varying age, gender, cultural and social backgrounds, reflecting the population diversity in Australia. We learn best when we can put a “face” to a clinical condition, and CBL aims to provide this experience. Many a graduate has commented that they still remember their CBL “patients” by name years later!

You will also notice that very often the patient’s own words are used in the CBL case. As in real life, patients will use lay terminology, and won’t always give you information in a logical sequence! This will help to develop your skills of history taking, identifying key information and formulating a clinical summary.

Why include rare cases?
Remember that in CBL, the process of considering the presentation and the possible diagnoses is far more important than actually coming up with the precise “answer”. And while you will learn about common conditions, there are also times when a very rare condition provides an ideal case from which to learn. In medicine and research, our understanding of normal physiology has often been deduced by observing those rare cases when a patient has a localised defect in a very specific function. Equally, clinicians always need to be alert for the rare, but serious, diseases that must not be missed. It is worth noting “approximately 8% of the Australian population live with any one of about 10,000 known rare diseases. This is similar to the proportion of people living with diabetes or asthma”

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Collaborative learning in small groups
Learning theories emphasise that working in groups allows us to stretch our understanding far further than we would by learning alone. Through bouncing ideas off one another, the final understanding we generate is greater than simply the sum of each individual’s knowledge. Your CBL groups will be enriched through having members with differing educational and personal backgrounds. We appreciate that learning in a group may be new for many students. It may take some getting used to, but it will be worth it. The more you put in to the group learning process, the more you will get out of it. In addition to this learning benefit, CBL groups reflect clinical practice – in which you will regularly work in multi-disciplinary teams. Consider, for example, the team that works in an operating theatre. Workplace teams rely on each member bringing their own expertise and performing their share of the work competently to ensure safety and excellence in patient outcomes. See also the later section, “Working in Groups”.

CBL is learner-centred and “inquiry-based”
Students are at the heart of the CBL model of learning. The CBL tutor is there to guide and support the process, and content experts provide input through lectures, practicals and resources. But CBL tutorials are not about receiving information passively from a tutor. They are about actively engaging and directing your own learning as a group. CBL cases prompt students to want to know more to “solve” the case, and to identify the gaps in their current knowledge. This then directs each student’s learning for the week. When groups reconvene for the second tutorial of the week, students share the answers they’ve now discovered to their earlier questions. This is termed “inquiry-based” learning in educational theory.

CBL develops clinical reasoning skills
The CBL cases are designed to closely reflect the decision-making processes used by medical practitioners. Working through CBL cases not only assists to learn content, but to learn clinical reasoning skills – how to think and make decisions like a doctor. You can read more about this process in the later section on this topic. Many students and graduates have commented that once in Phase 2 and then the workplace, they began to appreciate more and more just how useful the CBL process had been. “It taught me to think like a doctor,” a new graduate commented recently.

This style of learning – collaborative, integrated, self-directed, and inquiry-based – may be quite new to you. It may be very different to the teaching methods you experienced in your undergraduate studies, and it may take a little while to get used to. But stick at it and we are confident that you too will find it truly is an excellent way to develop both the knowledge and the skills you will use every day when you graduate as a doctor.

Further reading & References

CBL THE UQ WAY

CBL in the UQ MD Program is student-centred small group learning. Cases are derived from real patient scenarios and regularly reviewed by clinical specialists. All CBL tutors are qualified doctors.

Throughout Phase 1, you will participate in two CBL tutorials each week. CBL tutorials provide a framework for learning and are compulsory in the UQ MD Program.

In year 1, each CBL tutorial is 2.5 hours long. It is essential to commence CBL tutorials on time, to be able to work through the case material thoroughly, engage in relevant group discussions and develop your clinical reasoning skills. In Semesters 1-3, CBL tutorials follow a systems module structure, as per the format described below. In Semester 4, the format of CBL tutorials varies in preparation for clinical rotations.

Guide to Roles in CBL Tutorials
In the first session of CBL for the year, groups are encouraged to discuss roles and create a rotating roster so each student experiences the different roles. Tutors will support each group member in their role to facilitate an active learning environment, provide guidance, facilitate effective group CBL processes and be a professional role model.

The roles in CBL include

- **Chairperson** - leads the group’s discussions that week
- **Scribe** - records visible “chart” notes during the tutorials that week
- **Computer** - logs on and opens case promptly, looks up anything needed during CBL
- **Group-Identified Focus Tasks (GIFTs)** - 2-4 students allocated per week to present
- **Short Cases** - 2-3 students allocated per week to prepare and present
- **Case Summary** - usually allocated to the week’s Chairperson to prepare and present

Roles of Chairperson or “Chair”
The role of Chair provides the opportunity for each student to develop leadership skills which will be useful throughout their professional life. The Chair:

- Leads the group through the CBL process
- Leads the group to consider and discuss hypotheses and mechanisms after each Trigger
- Leads the group to consider and discuss what else they wish to know (e.g. further history) or do (e.g. specific examinations, investigations or management and why) before next Trigger
- May use the ‘Discussion Starters’ in the Chair Copy to guide these discussions or the group may discuss other issues as relevant
- Encourages participation of all group members and maintains good group dynamics
- Starts punctually, keeps group on time and focussed on task at hand, whilst also encouraging adequate exploration of each trigger (not rushing to finish)
- Checks that the scribe adequately records the points raised in discussion
- Encourages scribe to record the learning needs identified by the group during the tutorial then leads group discussion about which of these will be developed as GIFTs that week
- Checks that GIFTs and short cases are allocated at end of tutorial 1 and delivered in next tutorial
- Summarises the Main Case and presents this Case Summary in Tutorial 2

Roles of Scribe
The role of Scribe provides the opportunity to practise the essential skills of identifying cues from patient information and recording medical notes. The Scribe:

- Prepares the whiteboard for each tutorial. The suggested whiteboard layout for CBL Discussion (Cues, Hypotheses, Mechanisms, NTK (Need to Know) and GIFTs) is outlined in Table 2 below.
- Records the cues (key information) that the group identifies in each Trigger during Tutorial 1 (and some parts of Tutorial 2) on the screen or whiteboard.
- Records hypotheses generated by group with notes about mechanisms.
- Helps the group organise and order their thoughts and reorder/reprioritise their hypotheses as more information is revealed with each Trigger.
- Participates in the group discussions.
- Leads the group in articulating, prioritising and ranking differential diagnoses – an opportunity to practise developing and demonstrating clinical reasoning skills (in preparation for OSCEs).

Roles of all Group Members
- Read essential reading prior to CBL
- Rotate through each role and learn from the experience
- Follow the CBL process and actively participate in discussions
- Respect each other, the tutor, the leadership role of the chair and the role of scribe
- Ask questions, discuss openly, share knowledge and create a safe environment in the groups where genuine learning is valued
- Prepare and deliver GIFTs, short cases and any other learning activities as agreed

Table 2: Whiteboard Layout for CBL Discussion

<table>
<thead>
<tr>
<th>Cues</th>
<th>Hypotheses</th>
<th>Mechanisms</th>
<th>NTK (Need to Know)</th>
<th>GIFTs (Group-Identified Focus Tasks)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Record key information identified in the trigger</td>
<td>Record the group's thoughts, ideas, discussions</td>
<td>Record proposed mechanisms for each hypothesis</td>
<td>Record what the group wants to know or do next in the case to work things out</td>
<td>Identify knowledge gaps or learning needs, choose which to present</td>
</tr>
<tr>
<td>e.g. Jane, 55yo, brought in by ambulance with chest pain, started 1 hr ago, getting worse</td>
<td>e.g. Myocardial Infarction, Angina, Broken ribs, Pneumonia, PE, Lung cancer</td>
<td>e.g. Blockage in coronary artery, Hypertension, Trauma, Infection, Clotting problem, Smoker?</td>
<td>e.g. Cholesterol level, Diet, smoking, Family history, Medications, Has she been hurt, Blood pressure, Fevers Other blood clots, Past history</td>
<td>e.g. What senses pain in the chest? What blocks coronary arteries? What is the difference between angina and infarction?</td>
</tr>
</tbody>
</table>
SCHEDULE FOR CBL EACH WEEK

Before CBL Tutorial 1
- Review the Resources list for the week and read the essential resources (and extension resources if you wish to understand a topic more deeply)
- Attend scheduled lectures and laboratory classes.

CBL Tutorial 1
- Commence on time - student on computer duty logs in and opens the case.
- In first 5 minutes
  - Discuss any issues regarding the weekly resources
  - Intermittently reflect on the group process and discuss any group adaptations needed
- Next 1 hour 40 mins:
  - Chair to lead group through case
  - Scribe to document key information (cues) as the group identifies them
  - Group to think about, discuss and suggest a number of hypotheses (plus mechanisms)
  - Scribe to document hypothesis list and mechanisms
  - Chair to use the discussion starters as a guide to facilitate group discussions, as required. (NB: Some groups will have lively and comprehensive discussions without referring to all or any of the discussion starters, other groups find them very helpful.)
  - Group to consider physiology, anatomy, pathological mechanisms, develop hypotheses, work out what more you need to know (e.g. further history, examination, investigations)
  - Tutor will guide group discussions, assist the Chair, identify opportunities to integrate basic sciences with clinical application and help you to develop clinical reasoning skills.
  - As the group works through each Trigger (led by Chair), the scribe continues to document key cues and updates the hypothesis list (recording the group’s reasoning e.g. putting “up” or “down” arrows if a hypothesis becomes more or less likely, and adding or crossing out some).
  - As the group works through the case, it will become apparent that there are gaps in the group’s knowledge. The scribe jots down these learning needs for later discussion.
- Last 5-10 mins: Reflection and Planning (RAP)
  - The group decides which of the identified learning needs are most relevant to the week, then defines some GIFTs (see below) to be presented in CBL Tutorial 2
  - The group plans for CBL Tutorial 2 – allocating:
    - 1 student to present each GIFT (usually 2-4, see below for examples)
    - 1 student to present each of the CBL Tutorial 2 Short Cases (usually 2-3)
    - 1 student to present a Case Summary of Main Case (see section on Case Summaries)
  - Note: It is not necessary for all students to have a task between Tutorial 1 and Tutorial 2

Before CBL Tutorial 2
- Chair (or other allocated student) prepares a Case Summary to present in Tutorial 2
- Students allocated to GIFTs prepare their topic to present in CBL Tutorial 2
- Students allocated to Short Cases work through their Short Case, understand the issues and come to CBL Tutorial 2 ready to lead their colleagues to work through the case
CBL Tutorial 2

- First 5 minutes: 1 student to present a Case Summary of the Main Case
- Next 1 hour: Short Cases (usually 2-3 per week)
  - Each allocated student leads group through the short case they have prepared.
  - That student is responsible for reading up on the case before Tutorial 2, preparing to respond to discussion starter questions and leading the group to think and discuss.
  - Tutor facilitates
- Next 45-50 minutes: GIFTs (usually 2-4 per week)
  - Each allocated student presents the GIFT they have prepared (ensuring effective)

Group Identified Focus Tasks (GIFTs)

An effective GIFT can take many forms. Key features include

- **Succinct** - a single flowchart, a 5-minute presentation, a short quiz
- **Engaging** - interactivity, visual/auditory cues, mnemonics, role-plays etc.
- **Relevant** - key information
- **Reliable** - students to reference their sources

Examples of GIFTs, include but are not limited to,

- Short presentations about the topic (e.g. 7-8 PPT slides max)
- Links to audio or visual clips of signs (e.g. heart sounds, motor signs, embryology animations, etc.) plus a discussion or quiz etc.
- Images with quizzes
  - For example, anatomy, histology, pathology (e.g. labels covered, extrapolate to surface anatomy or clinical signs, etc.)
- Flowcharts or diagrams with labels, arrows and/or explanations: build up together in group, or cover labels with quiz, etc. (e.g. Homeostasis of sodium/calcium/blood pressure; coagulation cascade; complications of diabetes; hypothalamic-pituitary-end organ axis).
  - See the example flow chart outlining the Renin-Angiotensin-Aldosterone System in Figure 2 on page 17.
- Role-plays
  - Students may design a role-play situation to demonstrate GIFT
  - For example, write a short script for another student and play the other role.
- Create a mini-case to demonstrate GIFT and take group through
- Present and analyse a paper on recent research on the topic area (begin regularly in Semester 2, by Semester 4 include every week)
- Group quiz
  - For example, several students prepare GIFTs and upload 24hrs before Tut 2 for all to read, send 2-3 quiz questions to 1 Quizmaster to compile and adds 1-2 more from each GIFT, then Quizmaster conducts quiz in Tutorial 2 to cover all GIFTs. GIFTs aren’t presented, but students prepared to answer questions about their GIFT as group works through quiz.
- Concept Maps (approx. 10 mins)
  - Suits many weeks as a learning tool
  - For example, a concept map of how the main case illustrated the KLIs, or how the physiology and pathophysiology link to the clinical presentation or management, complications, etc.
- Others as determined by individual groups
Figure 2: Example of a flow chart outlining the Renin-Angiotensin-Aldosterone System

Decreased renal blood flow

Renin (from JGA cells in kidney)

Angiotensinogen
(from liver)

Angiotensin I
(in plasma)

Angiotensin-converting enzyme
(ACE; from lungs)

Angiotensin II
(in plasma)

Adrenal cortex

Hypothalamus

Blood vessels

Aldosterone

Anti-diuretic hormone
(ADH; Vasopressin) (from posterior pituitary)

Thirst

Vasoconstriction

Kidney

Sodium and water retention

Restoration of blood pressure
TOOLS & TIPS FOR HYPOTHESESING

In CBL, while the destination is important, the journey to get there is arguably more so. Being able to generate plausible hypotheses and explain underlying mechanisms is what develops understanding and clinical reasoning skills, far more than leaping to a diagnosis.

There are several methods students and doctors use to generate hypotheses. One of these methods is the mnemonic VINDICATES combined with Systems to create a grid, as illustrated in Table 3 below:

- In the ROWS, we can use the VINDICATES tool to consider common causes of disease or disease processes (or commonly missed ‘systems’ such as endocrine).
- In the COLUMNS, we can consider the most likely systems to be involved, including both anatomical systems, e.g. CVS, and functional, e.g. haematopoietic.
- Then we can quickly consider likely scenarios in each cell. We do not need to complete all cells, only consider them – e.g. in the example below, chest pain is unlikely to be a cardiovascular neoplasm so we don’t fill in that cell).

This technique can be useful to broaden your hypothesising. Even very experienced clinicians will use tools to ensure that they have not missed anything, particularly if a patient is not responding to treatment as expected. In situations like that the doctor may review the patient’s history, examination and investigations anew and will liaise with colleagues in their teams and use techniques to broaden their thinking.

Table 3: Hypothesising on the possible causes of chest pain in a 55-year-old woman who is previously well and afebrile

<table>
<thead>
<tr>
<th></th>
<th>CVS</th>
<th>Resp</th>
<th>MSK</th>
<th>GIT</th>
<th>Neuro</th>
</tr>
</thead>
<tbody>
<tr>
<td>V - vascular</td>
<td>Myocardial infarction</td>
<td>Pulmonary embolism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I - infection, inflammation</td>
<td>Pericarditis</td>
<td>Pneumonia, Pleurisy</td>
<td></td>
<td></td>
<td>Shingles</td>
</tr>
<tr>
<td>N - neoplastic</td>
<td>Lung Cancer</td>
<td>Bony metastases</td>
<td>Upper GIT cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D - degenerative</td>
<td>Aortic stenosis</td>
<td>Vertebral crush fracture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I - iatrogenic</td>
<td>Drugs affecting heart</td>
<td></td>
<td>Gastritis from NSAIDS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C - congenital</td>
<td>Bicuspid aorta</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A - autoimmune, allergy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>T - trauma</td>
<td></td>
<td>Pneumothorax</td>
<td>Fractured ribs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E - endocrine</td>
<td>Hypermetabolic state affecting heart</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S - pSych</td>
<td>Anxiety causing tachycardia</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
MAKING THE MOST OF CBL

- From the previous sections, you will be aware of why CBL is used and how it is done at UQ. So how can YOU make the most of this process? The following practical tips have been put together to help start you on the best possible footing.

- **Foster the development of professionalism** within the group from day one by developing **ground rules** and revisiting them regularly. These may cover behaviours such as punctuality, showing respect at all times for tutors and peers and their cultures, lifestyles and beliefs, being aware of body language etc.

- **CBL time is short.** Be READY to start each session on the hour. That means arriving early, having the computer on, first trigger up, roles assigned and ready to commence the tutorial.

- **Actively engage** in each session. CBL is a compulsory part of the program, and sessions are short for the material to be covered, so make a conscious decision to give your full attention and invest in the process – it will pay off.

- **Establish and maintain a safe learning environment.** A safe environment is a productive environment. From the start of the year encourage all members of the group to openly speak and be heard without fear of ridicule; encourage a ‘No question is a stupid question’ mentality and an environment where every member of the group feels valued for their unique experiences, knowledge and ideas.

- **Be prepared for tutorials.** Do the essential reading for the first session as you will get far more out of the case if you can keep up with discussion points that utilise the expected prior knowledge. Also, spend an adequate amount of time preparing GIFTs/summaries/short cases for the second tutorial to the standard expected of the group. By putting in effort one week, you will benefit from the effort of others in subsequent weeks and ultimately, a shared bank of quality learning resources / revision tools.

- **Work in collaboration.** Being a doctor means working as part of a much larger multidisciplinary healthcare team. Start refining the process of collaborative working from the start - take turns, share roles, contribute to discussion (but be aware of ‘taking over’), actively listen and encourage quieter members of the group to participate. Use the diversity of the group to your favour by including everyone and utilising each individual’s knowledge base and skill set.

- **Ask questions!** Questions lead to a higher level of understanding, both for those listening to the explanation, and for those providing the explanation. Don’t be afraid to ask something you feel you should already know; everybody comes from a different educational/learning/work background. Some will be very comfortable where as others may need more support and this dynamic changes from tutorial to tutorial.

- **Ensure identification of areas for further learning** every week; as a group AND as an individual.

- **Note down any queries** you have from your studying for the week or from the CBL cases for the next session, so that they can be discussed within the group and any misconceptions cleared up.

- **Encourage the precise use of medical language.** Medicine can be like a completely different language at times; if you don’t understand the meaning of a word, look it up! CBL is an ideal place to practice the use of correct medical terminology in discussions rather than using ‘layman’ terms.
- **Reflect on the process frequently** with your group, and your own performance within it. Your tutor will help with this reflection and help the group to make improvements if any areas are identified as needing change.

- **Don't get left behind: ACT.** Medicine is an intense course and once behind it can be exceptionally difficult to catch up. While most students will feel overwhelmed at times, if you feel that you are increasingly struggling to cope with the workload, or personal circumstances, it is OK to ask for help – doctors need it too! You can approach your tutor or any of the many support services on offer to you. Don't struggle alone.

- **Don't create isolated silos of information** and fill them unevenly. It is not helpful to know everything about one area to the detriment of others. Revisit the cases to **build links** between these areas of knowledge. Similarly, be sure you have a clear understanding of the basics before attempting to master higher order concepts.

- At the end of each week, **generate your own summary** of the material you have covered. Concept maps or mind maps work for some people; others have different ways of making links. Experience shows that it is the process of creating your own summary that is important. Try not to rely on summaries prepared by other students, or on commercial mind maps, although these may provide helpful examples on which to base your own summaries.

- **Review material regularly!** This is a much more effective approach to retaining information than just cramming intensely close to exam time.
BIOMEDICAL SCIENCE DISCIPLINES IN THE CLINICAL SCIENCE COURSES

While closely integrated and centred on case-based learning, it is important to recognise that a number of distinct disciplines in biomedicine contribute to 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

Individual disciplines will typically contribute to more than one of these domains, but tend to be more centred within one of them. 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>
</thead>
<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>Histology, Physiology</td>
</tr>
<tr>
<td>Diagnostic and therapeutic sciences</td>
<td>Pharmacology; Radiographic Anatomy, Immunology</td>
<td>Pathology, Biochemistry, Gross Anatomy, Neuroanatomy, Genetics, Microbiology,</td>
</tr>
</tbody>
</table>

Many of the academics who will be teaching you in these disciplines are from the School of Biomedical Sciences (SBMS) or the School of Chemistry and Molecular Biosciences (SCMB). SBMS is part of the Faculty of Medicine and includes the disciplines of gross anatomy, embryology, histology, radiographic anatomy, physiology and pharmacology. From 2017, the Pathology teaching team will also become part of the School of Biomedical Sciences, although staff will be physically based at Herston. SCMB is part of the Faculty of Science, and includes the disciplines of cell biology, immunology, microbiology, biochemistry and genetics. Certain areas of the biomedical sciences; particularly the diagnostic and therapeutic science domains, may also be covered by your clinical lecturers.

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.

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. This is an important task, as you will need to access and apply that knowledge to manage the myriad problems of medicine and health care that you will encounter in your future careers. Often discipline knowledge will be tested using specific assessment tools, such as anatomy spotter exams, or image-based exams that focus on histology, pathology and radiographic anatomy.

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 medical students with an important foundation, upon which they must develop their clinical reasoning, clinical skills and professional behaviour. Both course suites cover large areas of medical knowledge, which are 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, and 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 for students to 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 to develop a level of expertise relevant to your professional duties.
YEARS 1

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 simulations, 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, who will cover both history and examination skills, as well as 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, however, be required to complete a single DVD recording, outside of your CC tutorials, which will then be marked by your Clinical Coach. In Semester 2, students will further apply their skills from Semester 1 with a standardised patient actor and will receive assessment and feedback from tutors of the Discipline of Psychiatry.

3. **Procedural Skills Workshops (PSW)** – Students will learn and be assessed in their competency to perform Hand Hygiene, Basic Life Support (BLS) and apply Personal Protective Equipment (PPE). These three (3) workshops will be completed by all students, once only per year, in groups of 10 students. It is supervised by a team of experienced clinical nurses, who support gold standards in principles of infection control. It is expected that students perform important online pre-readings for the 3 PSWs, are dressed appropriately for a clinical environment (closed-in shoes, no dangling clothing) and arrive at least 10 minutes in advance of their session for sign-in and completion of forms.

4. **Nutrition Master Class** – This single class 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 Master Class has a specific emphasis on nutrition skills, such as how to perform a nutrition assessment and how to 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. Students 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
- 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) 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, with an aim to develop competency for an Observed Structured Clinical Examination (OSCE). This examination is run in semester 2 (MEDI7222).

2. **Self-guided patient history-taking and examination skills** – Small groups of students (minimum recommended 2) are encouraged to speak to patients and practise 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 in students’ portfolios, which are 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 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, Pap smears, 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.
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”.

- **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.

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.4

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/1Wl9qogPw1E

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.
REMEMBER

ISBAR

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

I — Introduction
“I am................ (name and role)”
“I am calling from ..................”
“I am calling because..............”

S — Situation
“| 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 patients’ 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 ..........”

The four Health, Society and Research (HSR) courses offer a complementary perspective to the understanding of health and illness that you gain in the clinical courses. Rather than examining health or illness at an individual level, the HSR courses take a population perspective, exploring how health works in whole populations. Or how it affects specific sub-populations such as Aboriginal and Torres Strait Islander peoples, or adolescents, or migrants, or people with diabetes, or particular employment categories. The HSR courses address health where the bulk of the burden of disease confronts you: in the community, both locally and globally. And they give you some insight into how the health system impacts on you at a personal and professional level, and how you can, in turn, act on it. They explain how global policies set a frame for national and state policies, and find themselves translated into action in your own practice, and how your advocacy and practice can feedback into changing the system.

But most importantly, the HSR courses teach you the scientific basis of medical knowledge. If the clinical courses teach you how medicine reasons, the HSR courses show you how medicine knows. They unpack how the evidence is established to confidently diagnose and treat, determine prognoses and track outcomes. They tell you what shapes health in whole communities, what groups are at risk and why, how population interventions change outcomes for specific sub-populations. They give you a deep understanding of how medical knowledge has been developed and how evidence guides clinical practice and public health. They complement clinical reasoning—clearly outlined in this handbook—bringing a research base to the analytic and non-analytic processes that you use in your clinical context.

So it’s clear why these courses are around Health, Society and Research: you cannot understand health without a complex understanding of society, and research skills are the tools that you need to unpack that knowledge.

An overview of the HSR courses
There is a logical progression for the four HSR courses.

**HSR 1** begins with the basic concepts of health and how these are culturally embedded in the lived experience of Indigenous and culturally diverse Australians. The course will explore the health system’s response to the challenges of illness and disability, and the contributions of Commonwealth and State, civil society and Aboriginal and Torres Strait Health Services. HSR1 will equip you with the critical concepts and essential search skills for applying evidence-based medicine in your clinical and public health practice.

**HSR 2** gives you the practical clinical epidemiological skills to analyse data in clinical populations across a series of case studies. HSR2 will teach you to recognize where the diagnoses you make in clinical practice might signal significant problems for the community—and not only individual patients. It will give you the skills to quantify risk in population groups—migrants, Indigenous Australians, infants, adolescents, the aged, risk-exposed workers. The course will give you confidence in using the common statistical analyses that underpin your practice, evaluating the statistical significance for diagnosis and treatment outcomes. HSR2 will teach you to critically evaluate studies and interpret their treatment findings, letting you weigh up the evidence for new drugs independent of the claims of the pharmaceutical companies promoting them.
HSR 3 takes you into the place where the bulk of morbidity is encountered and treated: the community. Across the life-span, you will examine interventions for prevention of disease, promotion of health, maintenance of that healthy status through rehabilitation and chronic disease management. The course will give you a chance to build on your previous research capacity, developing a research protocol that would allow you to examine these issues in depth and engage in health and disease at different stages of life: pregnancy and childbirth, childhood, adolescence and early adulthood, in maturity and aging.

HSR 4 relocates you as a global citizen, making you aware of the extent to which medicine is subject to global health policy but also the pressures of global economics and geo-politics. It will expose you to the global factors that will shape your experience over your professional lifespan, and orientate you towards responding through advocacy and global engagement. The course examines the globalization of health and disease, Australian and international responses to these challenges and the key global policy agreements that in turn, influence Australian health policy and practice. HSR4 will deepen your research skills by introducing the discipline of systematic literature review, develop your skills in analysis of global health analysis, and build your confidence in writing for publication—a skill with broad application across your professional career.
**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 medicine 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. Our purpose in the Ethics, Law and Professionalism Discipline is to help you develop the skills and attitudes you need to be the type of Doctor our community demands and respects. Ethics is a branch of philosophy. It is about doing the “right” thing at the “right” time. Medicine can be uncertain, with multiple “rights” and few “wrongs” to guide decision making. The best course of action is not always clear. 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. You will also cultivate the virtues inherent in the “good” doctor the community expects and defines through the rule of law.

**What skills will I develop?**

In Phase 1 we establish the foundations that provide you with the skills necessary to be the type of Doctor our community respects: a thoroughly professional, compassionate, humanitarian, problem solver in the field of medicine. Over the course of Phase 1, your ethical and legal reasoning abilities develop as your clinical reasoning skills increase. These skills will be tested and developed further in Phase 2.

**How can I succeed?**

Be prepared to be challenged on your thoughts and attitudes and the way you learn. Your CBL class is the venue to talk openly and respectfully. Lectures, on-line learning resources and readings support these discussions. Your assessment will involve critical analysis and writing tasks as well as factual recall. If you have not studied the humanities previously and need assistance UQ provides a number of workshops to assist. See: http://www.uq.edu.au/student-services/learning/workshops

**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.
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 an 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.
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 and 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 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 school, 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 content, and is based on first-hand experience. Please remember that a real person will be reading your on-line 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.

YEAR 1 OBSERVERSHIP

The MD Observership takes place at the end of year 1. It allows students to gain exposure to the practice of medicine in a clinical healthcare, research or community setting prior to the Clinical Rotations phase of the program in years 3 and 4.

The Observership offers students the opportunity to further their 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.

Domestic and onshore international students may complete the elective placement anywhere within Australia or Overseas. The elective placement must be a minimum duration of 4 weeks.

The Ochsner cohort must complete an 8-week clinical placement in Australia to meet the accreditation requirements of the Australian Medical Council, and this may include a Clinical Research placement.

Students are able to split the Observership into 2 blocks. Domestic and International are eligible to complete 2 x 2-week blocks, and Ochsner students can split placements into either 2 x 4-week blocks or a 2 & 6-week block.

The learning objectives will depend on your 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

You will receive briefing sessions and further information during Year 1.
About the UQ-Ochsner MD program
In 2009, UQ partnered with the Ochsner Health Care System to create a unique medical program. Students enrolled in this program complete their Phase 1 studies in Brisbane before returning to the US to complete their final two years of clinical training in the Ochsner Health Care System in New Orleans. Students graduate with a UQ medical degree but are also able to register for practice throughout the US. From an initial intake of 16 students in 2009, the program now has an annual intake of around 120 students.

UQ-Ochsner students and the USMLE
In order to be licensed in the United States, physicians must pass the US Medical Licensing Exam (USMLE). The exam is divided into three parts: Step 1, Step 2 and Step 3. **For US students, Step 1 is the single most important factor in getting into their preferred residency program.** It is an 8-hour multiple choice exam that is focused on the clinical application of basic sciences. Evidence shows that in order to proceed successfully toward residency match, the Step 1 Exam is best taken after the first two years of medical school and before starting clinical rotations. Students who delay taking the Step 1 Exam experience:

- high risk for worse performance on exam than those who took it at the recommended time
- poor clinical performance due to time needed to focus on studying
- loss of opportunities such as research, away rotations and other residency application-building experiences
- ongoing anxiety

For this reason, UQ-Ochsner program rules require all UQ-Ochsner students to attempt the United States Medical Licensing Examination Step 1 examination before commencing Phase 2 of the program. Successful completion of the Step 1 Exam requires careful planning; it is impossible to do well by delaying preparation until one or two months before the test. However, passing the UQ Phase 1 courses is also important and preparation for Step 1 should be undertaken in concert with the UQ curriculum. Attaining good results in the Clinical Science courses has been demonstrated to correlate with performance on the Step 1 exam.

Ochsner students can access full details on Year 1 and Year 2 preparation for Step 1 Exam on the Ochsner Phase 1 site. [https://medicine-program.uq.edu.au/ochsner-students](https://medicine-program.uq.edu.au/ochsner-students)
RESEARCH OPTIONS IN THE MD

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

The Health Society and Research course 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 Research Higher Degree (RHD), 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 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** incorporates a Masters of Public Health (MPH) into the MD degree.

- **Summer Research Scholarships** are available to all students and provide excellent opportunities to get 'hands on' research experience concentrated 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.
- Medical students do not get any time out of the MD curriculum to spend on research - you must organise your research around the MD requirements.
- Research is an option - the MD is your priority!

The following websites have all the information and relevant links regarding anything to do with student research. If you are interested in research at any time during your MD please refer to these sites in the first instance:

- Medical Student Research Portal: [http://research-portal.medicine.uq.edu.au](http://research-portal.medicine.uq.edu.au) and
- Research in your medical degree: [https://medicine-program.uq.edu.au/research/research-your-medical-degree](https://medicine-program.uq.edu.au/research/research-your-medical-degree)

Finally – please use the [Medical Student Research Portal](http://research-portal.medicine.uq.edu.au) as your ‘go to’ website where you can find projects, get ideas for research, and keep up to date with research events, student scholarships and prizes, and most important – to get **officially acknowledged** for the research you do.

If you don’t report it on the Portal we can’t acknowledge your research achievements when you graduate.
Phase 1 Academic Lead (Tammy Smith)
The role of Academic Lead, Phase 1 ("Phase 1 Lead") is based within the Office of Medical Education (OME), and is focussed on students and courses within phase 1 (years 1 and 2) of the MD Program. It is a student-facing role, which serves as a central point of effective communication between students and academics involved in the phase.

The role is also important in coordinating and integrating teaching and learning activities within individual courses, through interaction with Course Coordinators, and as Chair of the Phase 1 Committee.

Head, St Lucia Clinical Unit (Matt Brandt)
The Clinical Unit Head is responsible for all academic staff involved in the delivery of the medicine program at that site. The role is to champion, manage and review the delivery by these staff of teaching and learning experiences in the medicine program at the St Lucia Unit.

Director, Office of Student Affairs (Jennifer Schafer)
The Director of the Office of Student Affairs (OSA) provides leadership in ensuring that UQ medical students have a supportive learning environment and one that is conducive to them maximizing their potential and wellness as they progress through their program. The Director has a student-focussed role, and serves as an advocate for students, but importantly occupies a position that is clearly separate to the usual academic decision making processes around student progression. Based predominantly at the St Lucia Clinical site, they engage with the student body to enhance student experience, develop innovative solutions to issues and concerns, and provide counselling and guidance to individual students regarding academic performance and progression. The Director also works with other leaders in the Medical Program and across the university to ensure that the extracurricular needs of students are met and that relevant policies and procedures to support that goal are developed or clarified as needed

Director, Office of Medical Education (Nick Hawkins)
The OME Director has primary responsibility for the development and implementation of the Doctor of Medicine/MBBS program. They provide academic leadership, foster innovative teaching approaches, and work to facilitate exceptional student outcomes.

Course Coordinators
The 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 may be able to help with certain student issues.
ADMINISTRATIVE SUPPORT FOR PHASE 1

Role of the Student and Academic Administration teams
Academic Administration involves provision of support for teaching and learning at UQ through services that enable effective academic decision-making, governance and information provision. Academic Administration also covers aspects of students’ engagement with policy and procedures as they pertain to the code of conduct, appeals and grievance resolution. Responsibilities include:

- supporting the formulation and management of academic policies;
- administration and coordination of program design, development and review;
- management and monitoring of academic timetables.

Student Administration provides administrative support and information through all stages of student life from admission to graduation. Student Administration works collaboratively with academic and professional staff to deliver accurate and timely student focused administrative advice and service, and contributes to the development of student related policy.

For all enquiries, email med.enquiries@uq.edu.au

Role of the Curriculum Support and Innovation (CSI) team
The CSI team brings together professional support and expertise in the areas of curriculum design, eLearning support, and project management for innovative Faculty-wide teaching and learning projects.
WHERE TO GO FOR HELP

IMPORTANT WEBSITES

The Medicine Program website (https://medicine-program.uq.edu.au/current-students) is your “go to” site for general program information, such as attendance guidelines, academic calendars, program rules, and information about the Observership program.

MyAdvisor (http://www.uq.edu.au/myadvisor) provides you with information about managing your program, enrolment, assessment, class timetables, rights and responsibilities, policies, financial matters and graduation.

SI-net (https://sinet.uq.edu.au/ps/uqsinetsignin.html) is The University of Queensland’s online Student Administration system. You can use mySI-net to view your course profiles, view your timetable, pay your fees, apply for financial assistance and view your results.

From the Learn.UQ Welcome page (https://learn.uq.edu.au), you can access the Community sites as well as your course Blackboard sites.

Information Technology Services (ITS) (https://www.its.uq.edu.au/). ITS is UQ’s primary division for providing IT services. Help guides to services provided by ITS can be found on this site.

Every course offered at The University of Queensland has a course profile developed and delivered through the Electronic Course Profile (ECP) system https://www.courses.uq.edu.au/ and linked from the relevant Blackboard Course site. Each ECP consists of six major sections (General Course Information; Aims, Objectives and Graduate Attributes; Learning Resources; Learning and Teaching Activities and Modes; Assessment Tasks and Policies; Policies and Guidelines) and a learning summary.

UQ Library provides information and services such as computer access, research skills, software training and 24/7 study spaces. (https://web.library.uq.edu.au/library-services/services-students%20) The UQ Library Medicine guide (http://guides.library.uq.edu.au/medicine) will take you directly to the general resources of most use to medical students.

The University of Queensland Medical Society (UQMS) offers peer tutoring which many students find helpful. http://uqms.org/

For non-MD specific help, including general study techniques, please note that UQ has a number of services that may be able to help. See the Student Services website. http://www.uq.edu.au/student-services/

For health issues please see your own health care provider or the UQ Health Service http://www.uq.edu.au/healthservice/
APPS OF INTEREST

**UQnav** is a free mobile application that contains searchable maps of UQ’s campuses. Enter your destination and UQnav will show you where it’s located. [http://www.uq.edu.au/appcentral/detail/3/](http://www.uq.edu.au/appcentral/detail/3/)

**UQ SafeZone** is an easy-to-use, location-based application for mobile devices that connects staff and students directly with UQ security officers or emergency services during any type of first aid or emergency situation on UQ campuses and sites. [https://www.pf.uq.edu.au/unisafe/uqsafezone/](https://www.pf.uq.edu.au/unisafe/uqsafezone/)

**MyTransLink** makes planning your trip to, from, and between UQ campuses by bus, train, or ferry much easier. In particular, be aware of bus route 66 which connects the St Lucia campus to PA, Mater and RBWH hospitals. [https://translink.com.au/plan-your-journey/mytranslink](https://translink.com.au/plan-your-journey/mytranslink)

**Medscape** is a web resource for physicians and health professionals. All content in Medscape is available free of charge for professionals and consumers alike, but registration is required. [http://www.medscape.com/public/medscapeapp](http://www.medscape.com/public/medscapeapp)

THE STUDENT HUB

Still have a problem or question? Not sure who to contact? Contact the Student Hub!

What is the Student Hub? The Student Hub is a ‘one-stop shop’ manned by an enthusiastic group of people who will help to connect you with the best person to assist.

The Student Hub includes representatives from:

- Student Administration Team
- UQ Student Support, including a Student Advisor and Learning Advisor
- Student Help on Campus (SHOC)
- Office of Student Affairs

**Walk-in:**

- Level 4, Building 69, St Lucia Campus (once refurbishment is complete in early 2017)
- Level 5, Oral Health Centre, Herston Campus

**Telephone:** +61 07 3346 4922

**Email:** med.enquiries@uq.edu.au

Dr Jennifer Schafer, Director, Office of Student Affairs can provide advice, assistance with grievance resolution and pastoral care for students which is completely independent from decisions about assessment and academic progression.

OUTSIDE HELP

**Beyond Blue** [https://www.beyondblue.org.au/](https://www.beyondblue.org.au/)

**Lifeline** [https://www.lifeline.org.au](https://www.lifeline.org.au); telephone 131114 provide out of hours support for those in urgent need.

**Black Dog Institute** has My Compass which can be downloaded as an app. [https://www.myc ompass.org.au/](https://www.myc ompass.org.au/)

**MoodGym** is a free on-line cognitive program developed by ANU to help prevent and manage depression. [https://moodgym.anu.edu.au/welcome](https://moodgym.anu.edu.au/welcome)

**Keeping the Doctor Alive** is a self-care manual developed by the Royal Australian College of General Practitioners. [https://www.ranzcp.org/Files/Branches/Victoria/Keeping_the_Doctor_Alive-pdf.aspx](https://www.ranzcp.org/Files/Branches/Victoria/Keeping_the_Doctor_Alive-pdf.aspx)