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**Have a question?**

Contact [med.enquiries@uq.edu.au](mailto:med.enquiries@uq.edu.au)
NOTE: All links in this book were correct at the time of printing.

If you find any broken links please report them to phase1@ome.uq.edu.au.
Every year, a wonderfully diverse group of students commences their medical studies at UQ.

The 2018 intake for the Doctor of Medicine (MD) is made up of students born in 39 different countries and speaking 24 different languages. Students born in Australia, United States and Canada account for 72.5% of the 2018 intake, with students from Singapore, China, India, UK and South Korea making up a further 12.7%.

The age of students entering the 2018 MD Program ranges from 19 to 47, with the average age around 23.

Of the domestic students coming into the program this year, 29% are from a rural or remote location, and 2.1% have an Aboriginal or Torres Strait Islander background.

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.

The timetable for the MD program differs in a number of ways from the general UQ calendar; for example we have 16-week rather than 13-week semesters, and all of your exams will be in week 1 of UQ’s assessment block. You can find the 2018 MD Calendar here.

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 weekly 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. In particular, please note of The Student Hub, which includes representatives from:
   • The Student Administration Team
   • UQ Student Support, including a Student Adviser and Learning Adviser
   • Student Help on Campus (SHOC)
   • The Medical Student Support Team

I hope you enjoy your time studying medicine at UQ.

Dr Tammy Smith
Academic Lead: Phase 1
Office of Medical Education
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 is 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 Adviser (http://www.uq.edu.au/student-services/disability) and the Medical Student Support Team.med.mss@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 Guidelines

UQ Academic Integrity Module
https://www.uq.edu.au/integrity/Login.aspx

MDANZ Inherent requirements for studying medicine

Preparing for Queensland Health Placements
Use of Images in the MD Program

Use of student ID image

In accordance with PPL3.40.08 Access to Students Images, the Faculty of Medicine will use your ID image for identification purposes directly related to your student enrolment. These purposes may include, but are not limited to:

- for specific identification purposed directly related to your enrolment (for example, placements, hospital identification cards)
- for reasons of student and patient safety
- for the purpose of pastoral care and enhancing the learning and teaching experience, for example, through the production of reference sheets that allow academic staff to more effectively identify and provide assistance to students
- for other reasonable purposes where the signed consent of the students concerned has been obtained.

Your image may be accessed by Faculty staff, staff of hospital departments, and other clinical placement sites. All images will be kept private, and will not be published in a public setting. Where there is a specific requirement from a placement organisation that student images be on display in a public area, you will be asked to agree to that use of your images as part of accepting the placement.

All images provided for the above purposes will be deleted upon graduation or exit from the program.

If you wish to lodge an appeal regarding the use of your image, you can do so in accordance with PPL 3.60.02 Student Grievance Resolution.

Taking photographs as a medical student

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

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

- AMA Guide – Social Media and the Medical Profession

- AMA Guide – Clinical Images and the use of Personal Mobile Devices
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 system-based modules. 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.

While the Course Coordinator has overall administrative responsibility for their course, the development and delivery of individual course modules is managed by other academics (known as Module Coordinators) within the Clinical Science team.

Each module is run using a case-based learning (CBL) model facilitated by a clinician tutor. Each week, you will work through one main case and two 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"1

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 on CBL and being a team player


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 hours 20 minutes 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, all CBL tutorials follow a similar structure, as per the format described below. In Semester 4, in preparation for clinical rotations, the format of CBL tutorials is more varied coinciding with the move from systems-based modules to weekly themes.

Guide to Roles in CBL Tutorials

In the first CBL session of the year, groups will discuss the CBL process and the individual roles required on a weekly basis, creating a roster to ensure equal exposure of every member of the group to these different roles.

The specific roles of the CBL group are:
1. Chairperson
2. Board Scribe
3. Computer Person
4. Short Case Presenters
5. Group-Identified Focus Task (GIFTs) Presenters

More detail on each of these specific roles is outlined on subsequent pages.

Role of all Group Members

Graduate doctors need skills for working well in a team and being part of the CBL group is important preparation for this. For the team to succeed – that is, for everyone to maximise their learning – each member needs to play their role adequately. Therefore,

- Come prepared – read the essential resources which are indicated as being required prior to the first CBL tutorial; come ready to engage and learn
- Follow the CBL process and actively participate in discussions
- Respect each other, the tutor, the leadership role of the chair and other presenters, and the role of scribe
- Ask questions, discuss openly, share knowledge and create a safe environment in the group where genuine learning is valued
- Prepare and deliver GIFTs, short cases and any other learning activities as agreed
- Rotate through each specific role and learn from these experiences

Role of the CBL Tutor

All CBL tutors are medically trained and they come from a wide variety of specialities and backgrounds. While they bring a broad range of skills and experiences, their role is not to be content experts, but rather to:
• Enhance learning by facilitating and guiding group processes
• Highlight misconceptions and clarify difficult or confusing concepts (but not to give mini lectures)
• Mentor professionalism & respect
• Encourage reflection about learning and teamwork
• Assess participation and provide individual and group feedback at mid-semester and end-of semester
• Reflect on their own tutoring practice and invite feedback (informally and formally) from their students
• Provide pastoral care (and refer on as appropriate)

Schedule for CBL each week

Before CBL Tutorial 1

• Review the Resources list for the week and begin reading the essential resources (and extension resources if you wish to understand a topic more deeply). Some essential resources will be marked to indicate they are to be read before the first CBL tutorial. Complete these as a minimum, however depending on the day of your CBL tutorial, you may also have completed others by that time.
• Attend scheduled lectures and practical classes.

CBL Tutorial 1

• Commence on time - student on computer duty logs in and opens the case.
• In first 5 mins:
  o Discuss any issues regarding the weekly resources
  o Intermittently reflect on the group process and discuss any group adaptations needed
• Next 2 hours 10 mins:
  o Chair to guide the group through the Main Case which is revealed and develops through a series of ‘triggers’
  o Scribe to document key information (‘cues’) from the given trigger on the whiteboard, as identified by the group
  o Group to consider, discuss and suggest a number of ‘hypotheses’ plus their respective ‘mechanisms’ from the information provided; the scribe to document these on the whiteboard
  o Group to identify further information needed (e.g. from further history, examination, investigations) before moving on to read the following trigger, again all documented by the scribe
  o Chair to use the discussion starters as a guide to facilitate and guide further group discussions. (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.)
  o As the group works through each sequential trigger (led by the chair), the scribe continues to document key cues that are revealed 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 where relevant). Other mechanisms may be identified and documented as the case progresses and the list of further information needed or ‘Need to Know’ will develop.
  o As the group works through the case, it will become apparent that there are gaps in the group’s knowledge. The scribe to jot these learning needs down for later discussion.
  o Tutor will guide group discussions, assist the chair, identify opportunities to integrate basic sciences with clinical application and help students to develop clinical reasoning skills.
• Last 5-10 mins: **Reflection and Planning (RAP)**
  o The group decides which of the identified learning needs are most relevant to the week, then defines GIFTs (see below) to be presented in CBL Tutorial 2
  o The group plans for CBL Tutorial 2 allocating (based on the group roster):
    ❖ 1 student to present each GIFT (usually 2-3, see below for examples)
    ❖ 1 student to present each of the CBL Tutorial 2 Short Cases (usually 2)
    ❖ 1 student to present a Case Summary of Main Case (see section on Case Summaries) – this is usually the role of the chair
    ❖ 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 cases
• All students continue to engage with their resources list, lectures, practicals, and other learning resources for the week

**CBL Tutorial 2**

• First 5 mins:
  o 1 student to present a Case Summary of the Main Case
• Next ~1 hour 55 mins: Short Cases (usually 2 per week, i.e. 55 mins per case)
  o Each allocated student leads the group through the short case they have prepared in advance
  o Tutor facilitates as with the Main Case
• Next ~20 mins: **GIFTs** (usually 2 per week)
  o Each allocated student presents the GIFT they have prepared, engaging the whole group

Times are flexible: some weeks may have one short case that takes longer than the other; some weeks may require longer dedicated time for GIFTs. Note that CBL sessions in year 2 are 2 hours duration, so these times will need to be adjusted accordingly.

**Description of specific roles in CBL Tutorials**

1. **Chairperson or “Chair”**

**The Role:**
The role of Chair provides the opportunity for each student to develop leadership skills which will be useful throughout their professional life. They lead the group through the CBL process, particularly in the first tutorial of the week. This includes *facilitating* (alongside the tutor) the group discussion of cues, hypotheses and mechanisms after each trigger, and what else they wish to know (e.g. further history) or do (e.g. specific examinations, investigations or management) and *why*. After thorough group discussion of each trigger, they will make use of the listed discussion starters to ensure the group has covered all the important issues before moving on to the next trigger. As gaps in knowledge are identified through this process, the chair also ensures the group and scribe note these down for consideration as GIFTs. At the end of the tutorial, the chair will (alongside the tutor) lead the Reflection and Planning (RAP) session (see ‘CBL Tutorial 1’ above).

**Do’s and Don’ts of the Chair Role:**
• **DO** prepare in advance:
  o Read the essential resources which are indicated as being required prior to the first CBL session (note all group members should do this).
  o Become familiar with the triggers and discussion starters for the case.
Think about ways to encourage participation of the whole group.
- BUT DON’T spend time preparing an answer for every discussion starter or making a PowerPoint – the chair is there to facilitate, NOT to provide all the answers.

- **DO** ensure (alongside the tutor) that the group starts punctually, keeps on time and stays focussed on the task at hand.
- **DO** ensure (alongside the tutor) that each trigger is adequately explored through group discussion (not rushing to finish).
- **DO** ensure that the scribe adequately records the points raised in discussion.
- **DO** ensure that during RAP session there is adequate time for key GIFTs to be identified and GIFTs and short cases to be allocated to those on the roster. DON’T leave this to the last 30 seconds of the tutorial.
- **DO** prepare a Case Summary of the Main Case to present in Tutorial 2 (although this can also be prepared by another group member). See Case Summary Chapter for suggested patterns of the summary.

2. **Board Scribe**

The Role:
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 1 below.
- Records the ‘cues’ (key information) that the group identifies in each trigger during Tutorial 1 (and some parts of Tutorial 2) on the 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).

<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 e.g. Jane, 55yo, brought in by ambulance with chest pain, started 1 hr ago, getting worse</td>
<td>Record the group’s thoughts, ideas, discussions e.g. Myocardial Infarction, Angina, Broken ribs, Pneumonia, PE, Lung cancer</td>
<td>Record proposed mechanisms for each hypothesis e.g. Blockage in coronary artery, Hypertension, Trauma, Infection, Clotting problem, Smoker?</td>
<td>Record what the group wants to know or do next in the case to work things out e.g. Cholesterol level, Diet, smoking, Family history, Medications, Has she been hurt, Blood pressure, Fevers Other blood clots, Past history</td>
<td>Identify knowledge gaps or learning needs, choose which to present e.g. What senses pain in the chest? What blocks coronary arteries? What is the difference between angina and infarction?</td>
</tr>
</tbody>
</table>
3. Computer Person

The Role:
The role of the computer person is to log on and open the Main Case promptly, look up relevant information during CBL and, depending on group preference, take soft copy notes of the group discussion.

4. Short Case Presenters

The Role:
The role of short case presenter provides the opportunity for each student to develop presentation and teaching skills which will be useful throughout their professional life. They lead the group through the CBL process for one Short Case in the second tutorial of the week. This includes preparing the case in advance, and then facilitating (alongside the tutor) the group discussion of the case. As with the Main Case, this includes ensuring the group identifies cues, hypotheses and mechanisms after each trigger, and what else they wish to know (e.g. further history) or do (e.g. specific examinations, investigations or management) and why. After thorough group discussion of each trigger, they will make use of the listed discussion starters to ensure the group has covered all the important issues before moving on to the next trigger. The short case presenter should be able to assist the group with any gaps in knowledge that are identified, due to their thorough preparation of the case. However, there may be additional learning needs identified (and although formal GIFTs are not developed, these should be noted for individual study).

Do’s and Don’ts of the Short Case Presenter Role:

- **DO** prepare in advance:
  - Thoroughly read all the triggers and discussion starters associated with the case. **Unlike the chair role** for the Main Case, you **DO** need to ensure you can provide an answer to almost all (if not all) the questions posed in the case. But **DON’T** spend too long researching any one question, especially if it is not clearly about one of the KLIs for the week, or is not covered in the weekly resources provided – the rest of your group and your tutor are still there to assist you if you get really stuck on something. Also remember some questions are designed to stimulate discussion, rather than every question having a clear right or wrong answer.
  - Thoroughly check the week’s resources list and lectures/practicals/tutorials for the relevant information that will allow you to prepare your short case (some details may also be in extension readings). **DO** use the resources recommended to you first. **DON’T** rely on “Wikipedia” or “Google”. If you need to go beyond the recommended resources for the week, ensure you use reputable textbooks or resources.
  - **DO** think about ways to encourage participation of the whole group
  - **DO** think about creative ways to discuss concepts (e.g. creating a flow chart on the board of the pathophysiological mechanisms at play in the case)
  - **BUT DON’T** just prepare a PowerPoint to lecture to your group. You are there to facilitate group discussion, with your preparation as the resource.
- **DO** ensure (alongside the tutor) that each trigger is adequately explored through group discussion (not rushing to finish). **DO** make your team work hard and provide their hypotheses and explain their reasoning. Remember, they should also have covered most of the resources by this stage. **DON’T** just give them your answers without discussing their ideas and exploring their understanding first.
- **DO** ensure the scribe role is used effectively to record the points raised in discussion.
- **DO** consider preparing a brief Case Summary for extra practice of this skill (See Case Summary Chapter).
- **DO** ensure (alongside the tutor) that the short case keeps on time and the group stays focussed on the task at hand.
5. GIFT Presenter

The Role:
Group Identified Focus Tasks (GIFTs)
An effective GIFT can take many forms and some key features of a successful GIFT are:

- **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 (e.g. anatomy, histology or pathology images with labels covered, or requiring students to extrapolate to surface anatomy or clinical signs, etc.)
- Flowcharts or diagrams with labels, arrows and/or explanations: build up the flowchart together as a group, or cover the labels and quiz the group, 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.
- Role-plays: Students may design a role-play situation to demonstrate the GIFT (e.g. write a short script for another student and play one role yourself)
- Create a mini-case to demonstrate GIFT and lead the group through your case
- Present and analyse a paper on recent research on the topic area
- Group quiz e.g. GIFT Presenters upload their presentations before Tutorial 2 for all the group members to read, and also produce 2-3 quiz questions from each GIFT. The questions are asked in the tutorial, to check understanding of GIFTs read in advance.
- Concept Maps: are a suitable learning tool in most weeks (e.g. a concept map of how the main case illustrated the KLIs; or how the physiology and pathophysiology link to the clinical presentation or management, etc.)
- Others as determined by individual groups

Do's and Don'ts of the GIFTs Role:

- **DO** prepare in advance, be thorough and reliable.
- **DO** ensure you are engaging by choosing the best style of GIFT presentation for the topic, BUT **DON'T** lecture your colleagues.
- **DO** use the resources provided to you in that week of learning or from other stated AND reliable resources, **DON'T** reference 'Wikipedia'!
Figure 2: Example of a flow chart outlining the Renin-Angiotensin-Aldosterone System.

Decreased renal blood flow

→ Renin (from JGA cells in kidney)

converts

Angiotensinogen
(from liver)

→ Angiotensin I
(in plasma)

converts

Angiotensin-converting enzyme
(ACE; from lungs)

Angiotensin II
(in plasma)

Adrenal cortex

→ Aldosterone

Hypothalamus

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

Blood vessels

→ Thirst

→ Vasoconstriction

Kidney

→ Sodium and water retention

Restoration of blood pressure
Tools & Tips for hypothesising

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><strong>V - vascular</strong></td>
<td>Myocardial infarction</td>
<td>Pulmonary embolism</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I - infection, inflammation</strong></td>
<td>Pericarditis</td>
<td>Pneumonia, Pleurisy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>N - neoplastic</strong></td>
<td></td>
<td></td>
<td>Lung Cancer</td>
<td>Bony metastases</td>
<td>Upper GIT cancer</td>
</tr>
<tr>
<td><strong>D - degenerative</strong></td>
<td>Aortic stenosis</td>
<td></td>
<td>Vertebral crush fracture</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>I - iatrogenic</strong></td>
<td>Drugs affecting heart</td>
<td></td>
<td></td>
<td>Gastritis from NSAIDS</td>
<td></td>
</tr>
<tr>
<td><strong>C - congenital</strong></td>
<td>Bicuspid aorta</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A - autoimmune, allergy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>T - trauma</strong></td>
<td></td>
<td>Pneumothorax</td>
<td>Fractured ribs</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>E - endocrine</strong></td>
<td>Hypermetabolic state affecting heart</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>S - pSych</strong></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.

- 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.

- **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.

- **Review material regularly!** This is a much more effective approach to retaining information than just cramming intensely close to exam time.

- **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.
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, pharmacology and pathology. 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 you with an important foundation upon which you will develop your clinical reasoning, clinical skills and professional behaviour. Both courses cover large areas of medical knowledge, grouped by bodily systems, and are intended to foster an integrated approach to medical decision-making.

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

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

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

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

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

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

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

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

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

4. **Nutrition 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, including how to perform a nutrition assessment and provide appropriate nutrition advice to patients.

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

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

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

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

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

2. **Self-guided patient history-taking and examination skills** – Small groups of students (minimum recommended 2) are encouraged to speak to patients and practise 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 full-day program is hosted at the Mater Clinical Unit (Whitty Building) and teaches students how to perform the gold-standard of intimate examinations for both male and female patients. Skills taught include appropriate communication skills, 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.
9. **Clinical Communication skills** – Six Clinical Communication Skills modules are delivered throughout the year through a program of interactive tutorials. Tutors will facilitate the learning of essential communication skills such as those required in breaking bad news, taking a sexual history, performing a mental health history and examination, facilitating behavioural change through motivational interviewing and communicating in a palliative care setting.

The competency level of skills developed throughout Phase 1 Clinical Practice is assessed in the Observed Structured Clinical Examination (OSCE). This examination is run in semester 2 (MEDI7222).
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”²

- 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.³

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.

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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](https://youtu.be/1Wl9qogPw1E)

**ISBAR Case Study 2**
[https://youtu.be/AmZKJ3JAPsE](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.
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. 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.

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 health system’s response to the challenges of illness and disability at the local, national and global level. This includes the contributions of National and local governments, civil society and, in Australia, Aboriginal and Torres Strait Health Services. HSR1 will equip you with the critical concepts of research and the use of research to inform 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. 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:


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 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.
As you progress through Phase 1 of the MD program, you will encounter a range of assessment types, including theory exams with multiple-choice and short-answer questions, multi-station “spotter” exams, individual and group assignments, and your Year 2 OSCE. You will also be assessed on your participation and engagement in your small group activities such as CBL tutorials and clinical coaching sessions.

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

The General Assessment Guidelines provide a clear explanation of what, for some students, can be a confusing topic. Please take the time to read through them.

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

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

You can read more about ExamSoft (and the ExamTaker app, Examplify) here.

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

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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.

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

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

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

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

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

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

Briefing sessions will be held during the year, and further information can also be found here.
THE UQ-OCHSNER MD PROGRAM

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

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 Higher Degree Research (HDR), either an MPhil or PhD, with the medical program. There are three ways to incorporate a PhD or an MPhil into the MD; the Intercalated MD-PhD or MD-MPhil, and the Concurrent MD-MPhil.

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

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

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

**Points to remember:**
- While there are a variety of research options available – not all students will be eligible for each option.
- Medical students are not provided with leave from the MD curriculum to focus 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 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 during your medical degree.
Phase One 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 (Ben Barry)
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.

Medical Student Support Team (Catherine Fitzgerald)
The Medical Student Support Team provides guidance 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 Student Adviser 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 Student Adviser 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. He provides academic leadership, fosters innovative teaching approaches, and works 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.
Office of Medical Education (OME) Operational Team
This team provides support for teaching and learning through services that enable effective academic decision-making, governance and information provision. Responsibilities include:

- supporting the formulation and management of academic guidelines;
- administration and coordination of course and program design, development and review;
- coordinate assessment and examinations; and
- publication of student newsletters.

Faculty of Medicine Student Administration Team
The Student Admin Team provides administrative support and information through all stages of student life from admission to graduation. We provide timely and accurate advice in relation to University policies and procedures, faculty guidelines, and process applications relating to your program of study.

As your first point of contact, please call +61 7 3346 4922 or email med.enquiries@uq.edu.au.
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.

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

mySI-net (https://sinet.uq.edu.au/ps/ugsinetsignin.html) is The University of Queensland’s online Student Administration system. The system is used to enrol, record and update personal details, view course profiles, sign on, view your timetable, manage your financials, and view your course grades.

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)

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.


**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.


**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.


**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.


**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 Adviser and Learning Adviser
- Student Help on Campus (SHOC)
- Medical Student Support Team

**Walk-in:**

- Level 4, Building 69, St Lucia Campus
- Level 1, McGregor Building, St Lucia Campus (once refurbishment is complete in early 2018)
- Level 5, Oral Health Centre, Herston Campus

**Telephone:** +61 07 3346 4922  
**Email:** med.enquiries@uq.edu.au

**The Medical Student Support Team**  
**Email:** med.mss@uq.edu.au

**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.mycompass.org.au/](https://www.mycompass.org.au/)

**MoodGym** is a free on-line cognitive program developed by ANU to help prevent and manage depression.  

**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)