Student reg. nr.: Name: Phone number:

AARHUS UNIVERSITY

GOP - International semester

COMPETENCES
FEEDBACK AND ASSESSMENT

This book serves as your documentation of approval of the clinical training.
Your book of competences is personal, so it is your responsibility to take care of it. It is also a prerequisite for attending the exam. You can take pictures of the approvals as back-up

Final approval of your clinical training

Approval of the competences

Your competence levels in PEDIATRICS are approved

_____

Date PCEO* signature

Your competence levels in GYNAECOLOGY-OBSTETRICS are approved

_____

Date PCEO* signature

Approval of your clinical stay

You have been active and professionally participating in the daily clinical work at the department correspondent to full working hours corresponding to an average of 7 hours and 24 minutes per day in the clinic (4 days in the clinic per week).

If you have been prevented from attending the department due to illness during your clinical stay, you have followed the instructions that apply to the department/unit regarding calling in sick. Any other absence must have been arranged with the PCEO. The total amount of absence must not exceed 20% of the stated time in the clinic.

You have participated in the introduction to the department and in the activities that appear in the workplan, available from the department (*PCEO: Pregraduate Clinical Education Officer, in Danish UPL)

_____

Date PCEO PEDEATRICS signature

_____

Date PCEO GYNAECOLOGY-OBSTETRICS signature

PEDIATRICS

Approval of participation in formative feedback

You have received formative feedback, and the number of needed formative competence cards have been signed by one of the doctors in the department.

_____

Date PCEO signature

Documentation for given peer feedback

You have given feedback to fellow students – at least once per competence.

Feedback on competence 1

Given to (type name of student):

_____

Date Signature from your fellow student, who received your feedback

Feedback on competence 2

Given to (type name of student):

_____

Date Signature from your fellow student, who received your feedback

Feedback on competence 3

Given to (type name of student):

_____

Date Signature from your fellow student, who received your feedback

GYNAECOLOGY-OBSTETRICS

Approval of participation in formative feedback

You have received formative feedback, and the number of needed competence cards have been signed by one of the doctors in the department.

_____

Date PCEO signature

Documentation for given peer feedback

You have given feedback to fellow students – at least one per competence.

Feedback on competence 1

Given to (type name of student):

_____

Date Signature from your fellow student, who received your feedback

Feedback on competence 2

Given to (type name of student):

_____

Date Signature from your fellow student, who received your feedback

Feedback on competence 3

Given to (type name of student):

_____

Date Signature from your fellow student, who received your feedback

Content

The frameworks for assessment of qualifications, information on Brightspace, rules and approval of fifth semester clinical training.

Competency 1, 2 and 3 as well as learning outcomes and assessment criteria

The overall learning outcome of your clinical training stay is formulated as three basic competences – competence 1, 2 and 3 – which contain the following:
1. To admit the patient for hospitalisation or ambulatory treatment
2. To check the medical plan for the patient during hospitalisation or in an outpatient procedure
3. To undertake discharge/conclude an outpatient procedure.

Please note that the number of competences you work with in the individual semester may vary. On the fifth semester/international semester, there will be 1-2 formative assessments and 1 summative assessment at the paediatric department.

Likewise in the Obstetric-Gynaecological department. The first formative assessment will be between two students, the next formative between a student and a doctor. The final summative assessment will be performed by the PCEO (Pregraduate Clinical Education Officer) or a doctor with the relevant charge. There will always be a summative assessment, as this serves as approval of the clinical training. This approval is required for attending exam.

Learning outcome and assessment criteria

Each competence has associated specific learning outcomes. The learning outcomes originate from the academic regulations and describe what the students are expected to learn during the individual clinical training stay. The learning outcomes are further clarified in the form of assessment criteria which are used as the basis for both the formative and summative assessments. Both learning outcome and assessment criteria can be found subsequent to the competence cards in the competency book. There are thus specific learning outcomes and assessment criteria for each individual competence card for the clinical training in question.

It is important that you familiarise yourself with both the learning outcomes and assessment criteria. They do not only have significance for the specific work with the competence cards in the clinic. Overall, the learning outcomes and assessment criteria must also support you in your learning and your professional development. It is therefore, recommended that you familiarise yourself with and are aware of the outcomes. By doing this, you will be in a position to take active co-responsibility for both your learning process and the competency progression that must take place during the clinical stays.

The difference between formative and summative assessment?

The concepts of formative and summative are used in learning contexts when describing two different types of assessment. In simple terms, we can say that formative assessment is an assessment *for* learning (in the future), while summative assessment is an assessment *of* learning (in retrospect). See further explanation of the two concepts below:

Formative: Encompass an assessment of how the learning process is progressing and how the learner can improve with a view to achieving a given competence. It is forward-looking, appreciative, and guiding, but has no consequences for the student.
Summative: Assessment/control of whether the given goals have been met. Summative assessment is accumulative and is carried out at the end of a stay or learning process. It is retrospective, specifies a value and has consequences for the student.

The formative assessment: During
As part of your learning in your clinical stay, you will be given feedback and assessment on your performance. The formative assessment is given "during" the stay, that is in the process of gaining both every single learning outcome and the competences as a whole. This feedback will initially be given by a fellow student (peer student/dyads) and the second time (midway) by a medical doctor at the department/unit.

The summative assessment: At the end
At the end of your clinical stay, you will be assessed as to whether you have achieved the required competences. The summative assessment is carried out by the Pregraduate Clinical Education Officer (PCEO) (in Danish referred to as a "UPL"). However, it may also be carried out by another doctor with the relevant charge.
Each competence card thus generally follows this process:

1. Formative assessment (student-student)
2. Formative assessment (student-medical doctor)
3. Summative assessment (student-PCEO)

However, there may be differences in how the process takes place on individual semesters/clinical stay. Therefore, please note that the process may vary.

The assessment criteria: Competence 1, 2 and 3
For competence 1, the assessment is made on the basis of receiving a patient for hospitalisation or first contact in the outpatient clinic, and the patient record that you have prepared. You record the patient's medical record, in which the medical history, objective findings and proposed treatment are presented, and with both the patient and preferably also the PCEO present during the presentation.
For competence 2, the assessment takes place on the basis of your handling of a patient in connection with the follow-up on a medical plan (observation of the consultation) in connection with e.g. the ward round or a check-up at the outpatient clinic.
For competence 3, the assessment takes place on the basis of one of the discharge summaries you have prepared.

With regard to the number of competences, it should be emphasised that there will be differences in how many are requested from semester to semester. This depends on factors such as e.g. length of the clinical stay, the medical speciality in question, and finally where in the degree programme the clinical stay takes place. This will be stated in the competency book for the individual semester, while the course manager for the semester will also provide the information.

Information about the competency book and the use of competence cards– see Brightspace and introductory videos

You can find further information about the competency book on Brightspace under your semester and the 'Competency Book' tab. We recommend that you read this information once you have received the competency book or when you start your clinical stay. Here you will receive an introduction to precisely this particular version of the competency book.
In addition, we recommend that all students who are to undertake clinical training watch the two introductory videos, which are also available on Brightspace under the 'Competency Book' tab. The introductory videos explain why and how the competence cards are employed, together with descriptions of the specific process for each of the competence cards. You will be better equipped to support your learning process if you prepare by watching these videos at.
See the videoes at: https://brightspace.au.dk or find them at "UPL-Medier" at Youtube.

Approval of the clinical training

The following assessments are also required for approval of the clinical training:

1. That you have been present at the department/unit corresponding to an average of 7 hours and 24 minutes per clinical day. Your full participation in the planned introduction is also included in this.
2. That you have participated in the activities listed in your work schedule from the department/unit.
3. That you have given and received formative and summative assessment/feedback to the extent outlined above.

Signatures in the Competence Book

You must have signatures in several places in the competence book. Partly on each competency card and partly on the front and back of the competency book. All places are signed with name and date.

Each competency card must be signed:

- Formative 1 (student-student) is signed by the student from whom you receive feedback
- Formative 2 (student-doctor) is signed by the doctor from whom you receive feedback / assessment
- Summative assessment (student- UPL /Associate professor) is signed by the UPL / Associate professor who makes the summative assessment.
- On the front page of the competency book (p.1.) You must have four signatures:
- The two top signatures are the UPL's signatures (pediatrics/obstretics-gynecology) that your competency cards with the summative assessment have been approved. In practice, you can see this if you flip through the competency book, but the signature on the front page makes it easy to quickly see that your competency cards are approved
- The two lower signature is the UPL's signature that your clinic course has been approved and meets the requirements for clinic courses, cf. time, attendance and possibly absence. Read more about this on the front page of the competence book.
- On the back of the front page of the competency book (p.2.) and on the following page, your fellow student must sign.
- Each time you have given peer feedback, Formative Assessment1 (student-student), the fellow student to whom you have given feedback must sign that he or she has received peer feedback for you, just as you must also state the recipient's name
- The number of signatures in connection with peer feedback varies from semester to semester. The back of the front page can thus have one or more signatures.

Why are signatures so important and what are they for?
The signatures in the competency book are used to document that the competencies have been obtained and the signatures on the front page are used in connection with the exam, where you can quickly ensure that the student has received the approvals required to take the exam.

Rules for absence
If you are prevented from attending the department due to illness during your clinical stay, you must follow the instructions that apply to the department/unit regarding calling in sick. Any other absence must be agreed with the doctor, who is head responsible for the programme (PCEO) at the department/unit.
Your clinical stay will not be approved if your absence exceeds 20 per cent of the clinical training time stated in the course catalogue, and you will thus use one examination attempt.
If your absence exceeds 20 per cent of the specified clinical training time, and if the reason is illness, you can apply to the board of studies for a dispensation to withdraw from the course. Remember to provide documentation from your doctor. If you have any questions about this, please contact HE Studies Administration's student guidance.

Second assessment: If your competence card is not approved at your second formative assessment

If your competence card is not approved at your second formative assessment, you must, together with your PCEO or clinical associate professor, plan at least one further formative assessment, which must be held before the summative assessment. An extra competence card, formative assessment 2, (Student - Medical Doctor) is attached in the back of the competency book. If you need further formative assessments, please make a photocopy of the extra competence card.

Student reg. nr.: Name: Phone number:

Gyn obs formative assessment 1 (Student-Student)

5th semester/international semester:
Gyn Obs Formative assessment 1(Student-Student)

Assessment and feedback for medical students by: Receiving a patient for admission or outpatient treatment, completion of medical plan or discharge/termination of pathway.

	Task	Assessment	Not observed/ assessed	Weak starting point - requires focus to expect to achieve competence	Well on the way - competence is expected to be achieved
1-1	Anamnesis	Structured collection of precise and relevant information	☐	☐	☐
1-2A	Objective examination	Systematic objective examination	☐	☐	☐
1-2B	Paraclinical tests	Systematic assessment of preclinical tests	☐	☐	☐
1-3	Tentative diagnosis	Relevant suggestions for diagnoses with differential diagnoses	☐	☐	☐
1-4	Further diagnostics and para clinical tests	Assessment of need for further para clinical tests and imaging diagnostics	☐	☐	☐
1-5	Treatment plan	Preparing a relevant treatment plan	☐	☐	☐
1-6	Medicine	Updating joint medicine card	☐	☐	☐
1-7	Discharge summary	Drafting a discharge summary	☐	☐	☐
2-1	Communication	Involving patients and any relatives, using relevant communication tools	☐	☐	☐
2-2	Empathy and professional conduct	Showing empathy and professional conduct	☐	☐	☐
2-3	Record keeping	Keeping records ethical correct and in accordance with current legislation	☐	☐	☐
2-4	Generel clinical competencies	Overall total assessment of items 1.1 - 2.3	☐	☐	☐

3-1 This was particularly good

3-2 This could/must be improved

3-3 How to improve your knowledge or competencies

Date+signatur:

Student reg. nr.: Name: Phone number:

Gyn obs formative assessment 2 (Student – Medical Doctor)

5th semester/international semester:

Gyn Obs Formative assessment 2 (Student-Medical doctor)

Assessment and feedback for medical students by: Receiving a patient for admission or outpatient treatment, completion of medical plan or discharge/termination of pathway.

	Task	Assessment	Not observed/ assessed	Requires focus to expect to achieve competence	Well on the way - competence is expected to be achieved
1-1	Anamnesis	Structured collection of precise and relevant information	☐	☐	☐
1-2A	Objective examination	Systematic objective examination	☐	☐	☐
1-2B	Paraclinical tests	Systematic assessment of preclinical tests	☐	☐	☐
1-3	Tentative diagnosis	Relevant suggestions for diagnoses with differential diagnoses	☐	☐	☐
1-4	Further diagnostics and paraclinical tests	Assessment of need for further paraclinical tests and imaging diagnostics	☐	☐	☐
1-5	Treatment plan	Preparing a relevant treatment plan	☐	☐	☐
1-6	Medicine	Updating joint medicine card	☐	☐	☐
1-7	Discharge summary	Drafting a discharge summary	☐	☐	☐
2-1	Communication	Involving patients and any relatives, using relevant communication tools	☐	☐	☐
2-2	Empathy and professional conduct	Showing empathy and professional conduct	☐	☐	☐
2-3	Record keeping	Keeping records ethical correct and in accordance with current legislation	☐	☐	☐
2-4	Generel clinical competencies	Overall total assessment of items 1.1 - 2.3	☐	☐	☐

3-1 This was particularly good

3-2 This could/must be improved

3-3 How to improve your knowledge or competencies

Date+signatur:

Gyn obs summative assessment (Student – PCEO)

5th semester/international semester:

Gyn Obs Summative assessment (Student-PCEO/Associate professor)

Assessment and feedback for medical students by: Receiving a patient for admission or outpatient treatment, completion of medical plan or discharge/termination of pathway.

	Task	Assessment	Not observed/ assessed	Competence-level not achieved	Competence-level approved
1-1	Anamnesis	Structured collection of precise and relevant information	☐	☐	☐
1-2A	Objective examination	Systematic objective examination	☐	☐	☐
1-2B	Paraclinical tests	Systematic assessment of preclinical tests	☐	☐	☐
1-3	Tentative diagnosis	Relevant suggestions for diagnoses with differential diagnoses	☐	☐	☐
1-4	Further diagnostics and paraclinical tests	Assessment of need for further paraclinical tests and imaging diagnostics	☐	☐	☐
1-5	Treatment plan	Preparing a relevant treatment plan	☐	☐	☐
1-6	Medicine	Updating joint medicine card	☐	☐	☐
1-7	Discharge summary	Drafting a discharge summary	☐	☐	☐
2-1	Communication	Involving patients and any relatives, using relevant communication tools	☐	☐	☐
2-2	Empathy and professional conduct	Showing empathy and professional conduct	☐	☐	☐
2-3	Record keeping	Keeping records ethical correct and in accordance with current legislation	☐	☐	☐
2-4	Generel clinical competencies	Overall total assessment of items 1.1 - 2.3	☐	☐	☐

3-1 This was particularly good

3-2 This could/must be improved

3-3 How to improve your knowledge or competencies

Date+signatur:

Pediatric formative assessment 1 (Student-Student)

5th semester/international semester:
Pediatrics Formative assessment 1 (Student-Student)

Assessment and feedback for medical students by: Receiving a patient for admission or outpatient treatment, completion of medical plan or discharge/termination of pathway.

	Task	Assessment	Not observed/ assessed	Weak starting point - requires focus to expect to achieve competence	Well on the way - competence is expected to be achieved
1-1	Anamnesis	Structured collection of precise and relevant information	☐	☐	☐
1-2A	Objective examination	Systematic objective examination	☐	☐	☐
1-2B	Paraclinical tests	Systematic assessment of preclinical tests	☐	☐	☐
1-3	Tentative diagnosis	Relevant suggestions for diagnoses with differential diagnoses	☐	☐	☐
1-4	Further diagnostics and para clinical tests	Assessment of need for further para clinical tests and imaging diagnostics	☐	☐	☐
1-5	Treatment plan	Preparing a relevant treatment plan	☐	☐	☐
1-6	Medicine	Updating joint medicine card	☐	☐	☐
1-7	Discharge summary	Drafting a discharge summary	☐	☐	☐
2-1	Communication	Involving patients and any relatives, using relevant communication tools	☐	☐	☐
2-2	Empathy and professional conduct	Showing empathy and professional conduct	☐	☐	☐
2-3	Record keeping	Keeping records ethical correct and in accordance with current legislation	☐	☐	☐
2-4	Generel clinical competencies	Overall total assessment of items 1.1 - 2.3	☐	☐	☐

3-1 This was particularly good

3-2 This could/must be improved

3-3 How to improve your knowledge or competencies

Date+signatur:

Pediatric formative assessment 2 (Student – Medical Doctor)

5th semester/international semester:

Pediatrics Formative assessment 2 (Student-Medical doctor)

Assessment and feedback for medical students by: Receiving a patient for admission or outpatient treatment, completion of medical plan or discharge/termination of pathway.

	Task	Assessment	Not observed/ assessed	Requires focus to expect to achieve competence	Well on the way - competence is expected to be achieved
1-1	Anamnesis	Structured collection of precise and relevant information	☐	☐	☐
1-2A	Objective examination	Systematic objective examination	☐	☐	☐
1-2B	Paraclinical tests	Systematic assessment of preclinical tests	☐	☐	☐
1-3	Tentative diagnosis	Relevant suggestions for diagnoses with differential diagnoses	☐	☐	☐
1-4	Further diagnostics and paraclinical tests	Assessment of need for further paraclinical tests and imaging diagnostics	☐	☐	☐
1-5	Treatment plan	Preparing a relevant treatment plan	☐	☐	☐
1-6	Medicine	Updating joint medicine card	☐	☐	☐
1-7	Discharge summary	Drafting a discharge summary	☐	☐	☐
2-1	Communication	Involving patients and any relatives, using relevant communication tools	☐	☐	☐
2-2	Empathy and professional conduct	Showing empathy and professional conduct	☐	☐	☐
2-3	Record keeping	Keeping records ethical correct and in accordance with current legislation	☐	☐	☐
2-4	Generel clinical competencies	Overall total assessment of items 1.1 - 2.3	☐	☐	☐

3-1 This was particularly good

3-2 This could/must be improved

3-3 How to improve your knowledge or competencies

Date+signatur:

Pediatric summative assessment (Student – PCEO)

5th semester/international semester:

Pediatrics Summative assessment (Student - PCEO/Associate professor)

Assessment and feedback for medical students by: Receiving a patient for admission or outpatient treatment, completion of medical plan or discharge/termination of pathway.

	Task	Assessment	Not observed/ assessed	Competence-level not achieved	Competence-level approved
1-1	Anamnesis	Structured collection of precise and relevant information	☐	☐	☐
1-2A	Objective examination	Systematic objective examination	☐	☐	☐
1-2B	Paraclinical tests	Systematic assessment of preclinical tests	☐	☐	☐
1-3	Tentative diagnosis	Relevant suggestions for diagnoses with differential diagnoses	☐	☐	☐
1-4	Further diagnostics and paraclinical tests	Assessment of need for further paraclinical tests and imaging diagnostics	☐	☐	☐
1-5	Treatment plan	Preparing a relevant treatment plan	☐	☐	☐
1-6	Medicine	Updating joint medicine card	☐	☐	☐
1-7	Discharge summary	Drafting a discharge summary	☐	☐	☐
2-1	Communication	Involving patients and any relatives, using relevant communication tools	☐	☐	☐
2-2	Empathy and professional conduct	Showing empathy and professional conduct	☐	☐	☐
2-3	Record keeping	Keeping records ethical correct and in accordance with current legislation	☐	☐	☐
2-4	Generel clinical competencies	Overall total assessment of items 1.1 - 2.3	☐	☐	☐

3-1 This was particularly good

3-2 This could/must be improved

3-3 How to improve your knowledge or competencies

Date+signatur:

Learning Goals and Assessment Criteria, competence 1 (ped)

Receiving a patient for hospital admission or outpatient treatment

Assessment of competence 1 is based on observations of the student. I.e. the pregraduate clinical education officer (associate professor) or another clinical educator/colleague observes the student perform various actions and while actions are performed or immediately after the student is given feedback on the action.
Beneath the respective learning goals and assessment criteria on which the student is assessed on basis of.

Learning goals	Assessment criteria
Completion of a **structured doctor-patient conversation** by obtaining an **anamnesis** with focus on paediatrics and by showing **empathy and professional conduct**.	**Obtaining the anamnesis:** Structured doctor-patient conversation based on the Calgary Cambridge Guide. Anamnesis (incl. communication). Invites the patient to tell; effective and relevant use of questions to collect precise, relevant and necessary information. Suitable use of non-verbal communication. **Empathy and professional conduct:** Shows respect and obtains a good contact and confidentiality; reacts appropriately to the patient's feelings, is humble and engaged.
Performance of a basic **objective examination** and a focused examination due to a paediatric condition.	**Objective examination:** Systematic (logic and relevant) Balance between screening and diagnostic examinations; informs the patient and conducts the examination considering the patient's convenience.
Showing **clinical judgement in the assessment** of available paraclinical data, planning a specific diagnostic programme for the patient with a paediatric condition.	**Clinical judgement and assessment:** Selectively prescribes/conducts diagnostic tests; considers relevance, disadvantages/risks and advantages.
Showing **general clinical competencies** by discussion and assessing relevant suggestions for tentative diagnoses and differential diagnoses.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
	General clinical competencies: Synthesises clinical problems; clinical problem solving, effective and efficient. **Organisation and collaboration:** Prioritises, receives/searches for and gives information accurately and conscientiously.
Counselling and guidance to patient and relevant parties concerning the medical plan showing **empathy and professional conduct** enabling the patient and the patient's parents to make an informed decision to give consent.	**Patient counselling and guidance:** Explains the rationale behind examinations/treatments to enable the patient to make a decision concerning consent. Counsels/instructs/educates concerning examination/treatment. **Empathy and professional conduct:** Shows respect and obtains a good contact and confidentiality; reacts appropriately to the patient's feelings, is humble and engaged.
Showing **general clinical competencies** in the assessment of needs for rehabilitation or cross-sectorial collaboration.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
Showing **general clinical competencies** in drafting a conclusive patient record of a paediatric patient and documenting ethically correct in the record in accordance with current legislation.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.

Learning Goals and Assessment Criteria, competence 2 (ped)

Controlling completion of a medical plan for a patient during hospital admission or outpatient treatment

Assessment of competence 2 is based on observations of the student. I.e. the pregraduate clinical education officer (associate professor) or another clinical educator/colleague observes the student perform various actions and while actions are performed or immediately after the student is given feedback on the action.
Beneath the respective learning goals and assessment criteria on which the student is assessed on basis of.

Learning goals	Assessment criteria
Showing **general clinical competencies** and identification of the medical plan, formulation of criteria for completion of the plan.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
Completion of a **structured doctor-patient conversation with** focus on a paediatric problem.	**Structured doctor-patient conversation based on the Calgary Cambridge Guide.** **Anamnesis (incl. communication).** Invites the patient to tell; effective and relevant use of questions to collect precise, relevant and necessary information. Suitable use of non-verbal communication. **Empathy and professional conduct:** Shows respect and obtains a good contact and confidentiality; reacts appropriately to the patient's feelings, is humble and engaged.
Performance of a **focused objective examination** of a child.	**Objective examination:** Systematic (logic and relevant) Balance between screening and diagnostic examinations; informs the patient and conducts the examination considering the patient's convenience.
Showing **clinical judgement in the assessment** of available data and the need for further paraclinical data including diagnostic procedures.	**Clinical judgement and assessment:** Selectively prescribes/conducts diagnostic tests; considers relevance, disadvantages/risks and advantages.
	Structured doctor-patient conversation based on the Calgary Cambridge Guide. **Patient counselling and guidance (incl. communication):** Explains rationale behind examinations/treatments enabling the patient to make decisions about consent: counsels/advises/educates about examination/treatment. **Empathy and professional conduct:** Shows respect and obtains a good contact and confidentiality; reacts appropriately to the patient's feelings, is humble and engaged. **Organisation and collaboration:** Prioritises, receives/seeks and gives information, timely and conscientiously.
Showing **general clinical competencies** by identifying and prioritising a future treatment and rehabilitation need in collaboration with the patient.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
Showing **general clinical competencies** by making notes in the record ethically correct and in accordance with current law.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient. .

Learning Goals and Assessment Criteria, competence 3 (ped)

Discharge/termination of outpatient pathway

The assessment of competence 3 is based on an assessment of a discharge summary. I.e. the pregraduate clinical education officer (associate professor) or another clinical educator/colleague assess the discharge summary and while performed or immediately after the competence card is filled out, and the student is given feedback on the discharge summary.
Beneath the respective learning goals and assessment criteria on which the student is assessed on basis of.

Learning goals	**Assessment criteria**
Showing **general clinical competencies** in the assessment of what is important information in the discharge summary in this speciality/at this department.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
Showing **general clinical competencies** in medicine review, updating of medicine lists and the joint medicine card (FMK) in accordance with guidelines for drawing up discharge summaries.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient. **Guidelines for drawing up the discharge summary:** Complies with current rules concerning medicine review, updating of medicine lists and the joint medicine card (FMK).
Showing **general clinical competencies** through effective **communication** in the discharge summary.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient. **Effective communication in the discharge summary:** Uses correct structure, appropriate degree of detail, medically correct language understandable to doctors outside the speciality.
Showing **general clinical competencies** by focusing on the receivers and the purpose of the discharge summary, which means ensuring relevant content of the discharge summary.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
	Professionalism in record-keeping: Uses: o Professional and respectful language o Ethically responsible language ensuring confidentiality as well as maintaining rules of confidentiality Legally correct language in compliance with GDPR privacy rules and health legislation

Learning Goals and Assessment Criteria, competence 1 (gyn/obst)

Receiving a patient for hospital admission or outpatient treatment

Assessment of competence 1 is based on observations of the student. I.e. the pregraduate clinical education officer (associate professor) or another clinical educator/colleague observes the student perform various actions and while actions are performed or immediately after the student is given feedback on the action.
Beneath the respective learning goals and assessment criteria on which the student is assessed on basis of.

Learning goals	**Assessment criteria**
Completion of a structured doctor-patient conversation by obtaining an anamnesis with focus on gynaecology/obstetrics and by showing empathy and professional conduct.	**Obtaining the anamnesis:** Structured doctor-patient conversation based on the Calgary Cambridge Guide. Anamnesis (incl. communication). Invites the patient to tell; effective and relevant use of questions to collect precise, relevant and necessary information. Suitable use of non-verbal communication. **Empathy and professional conduct:** Shows respect and obtains a good contact and confidentiality; reacts appropriately to the patient's feelings, is humble and engaged.
Performance of a basic **objective examination** and a focused examination due to a gynaecological/obstetric condition.	**Objective examination:** Systematic (logic and relevant) Balance between screening and diagnostic examinations; informs the patient and conducts the examination considering the patient's convenience.
Showing **clinical judgement in the assessment** of available paraclinical data, planning a specific diagnostic programme for the patient with a gynaecological/obstetric condition.	**Clinical judgement and assessment:** Selectively prescribes/conducts diagnostic tests; considers relevance, disadvantages/risks and advantages.
Showing **general clinical competencies** by discussion and assessing relevant suggestions for tentative diagnoses and differential diagnoses.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient. **Organisation and collaboration:** Prioritises, receives/searches for and gives information accurately and conscientiously.
Counselling and instruction to patient and relevant parties concerning the medical plan showing **empathy and professional conduct** enabling the patient to make an informed decision to give consent.	**Patient instruction and counselling:** Explains the rationale behind examinations/treatments to enable the patient to make a decision concerning consent. Counsels/instructs/educates concerning examination/treatment. **Empathy and professional conduct:** Shows respect and obtains a good contact and confidentiality; reacts appropriately to the patient's feelings, is humble and engaged.
Showing **general clinical competencies** in the assessment of needs for rehabilitation or cross-sectorial collaboration.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
Showing **general clinical competencies** in drafting a conclusive patient record of a gynaecological/obstetric patient and documenting ethically correct in the record in accordance with current legislation.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.

Learning Goals and Assessment Criteria, competence 2 (gyn/obst)

Controlling completion of a medical plan for a patient during hospital admission or outpatient treatment

Assessment of competence 2 is based on observations of the student. I.e. the pregraduate clinical education officer (associate professor) or another clinical educator/colleague observes the student perform various actions and while actions are performed or immediately after the student is given feedback on the action.
Beneath the respective learning goals and assessment criteria on which the student is assessed on basis of.

Learning goals	**Assessment criteria**
Showing **general clinical competencies** and identification of the medical plan, formulation of criteria for completion of the plan.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
Completion of a **structured doctor-patient conversation** with a special focus on a gynaecological/obstetric patient.	**Structured doctor-patient conversation based on the Calgary Cambridge Guide.** **Anamnesis (incl. communication).** Invites the patient to tell; effective and relevant use of questions to collect precise, relevant and necessary information. Suitable use of non-verbal communication. **Empathy and professional conduct:** Shows respect and obtains a good contact and confidentiality; reacts appropriately to the patient's feelings, is humble and engaged.
Performance of a **focused objective examination** of a gynaecological/obstetric patient.	**Objective examination:** Systematic (logic and relevant) Balance between screening and diagnostic examinations; informs the patient and conducts the examination considering the patient's convenience.
Showing **clinical judgement in the assessment** of available data and the need for further paraclinical data including diagnostic procedures.	**Clinical judgement and assessment:** Selectively prescribes/conducts diagnostic tests; considers relevance, disadvantages/risks and advantages.
	Structured doctor-patient conversation based on the Calgary Cambridge Guide. **Patient counselling and guidance (incl. communication):** Explains rationale behind examinations/treatments enabling the patient to make decisions about consent: counsels/advises/educates about examination/treatment. **Empathy and professional conduct:** Shows respect and obtains a good contact and confidentiality; reacts appropriately to the patient's feelings, is humble and engaged. **Organisation and collaboration:** Prioritises, receives/seeks and gives information, timely and conscientiously.
Showing **general clinical competencies** by identifying and prioritising a future treatment and rehabilitation need in collaboration with the patient.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
Showing **general clinical competencies** by making notes in the record ethically correct and in accordance with current law.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient. .

Learning Goals and Assessment Criteria, competence 2 (gyn/obst)

Discharge/Termination of outpatient pathway

The assessment of competence 3 is based on an assessment of a discharge summary. I.e. the pregraduate clinical education officer (associate professor) or another clinical educator/colleague assess the discharge summary and while performed or immediately after the competence card is filled out, and the student is given feedback on the discharge summary.
Beneath the respective learning goals and assessment criteria on which the student is assessed on basis of.

Learning goals	**Assessment criteria**
Showing general clinical competencies in the assessment of what is important information in the discharge summary in this speciality/at this department.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
Showing general clinical competencies in medicine review, updating of medicine lists and the joint medicine card (FMK) in accordance with guidelines for drawing up discharge summaries.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient. **Guidelines for drawing up the discharge summary:** Complies with current rules concerning medicine review, updating of medicine lists and the joint medicine card (FMK).
	General clinical competencies: Synthesises clinical problems; clinical problem solving, effective and efficient. **Effective communication in the discharge summary:** Uses correct structure, appropriate degree of detail, medically correct language understandable to doctors outside the speciality.
Showing general clinical competencies through effective communication in the discharge summary.	**General clinical competencies:** Synthesises clinical problems; clinical problem solving, effective and efficient.
	Professionalism in record-keeping: Uses: o Professional and respectful language o Ethically responsible language ensuring confidentiality as well as maintaining rules of confidentiality Legally correct language in compliance with GDPR privacy rules and health legislation

Cambridge-Calgary Guide

Structured doctor-patient consultation and the Calgary-Cambridge Guide are part of the learning outcome and assessment criteria which lie behind the competence licences. Please refer to the guide below.

The structure of the session: Calgary-Cambridge Guide
Preparing the session and clarifying your goal:

1. **Preparing and initiating the session**
   - Making initial contact
   - Clarifying/identifying the reasons for the consultation and making a common agenda

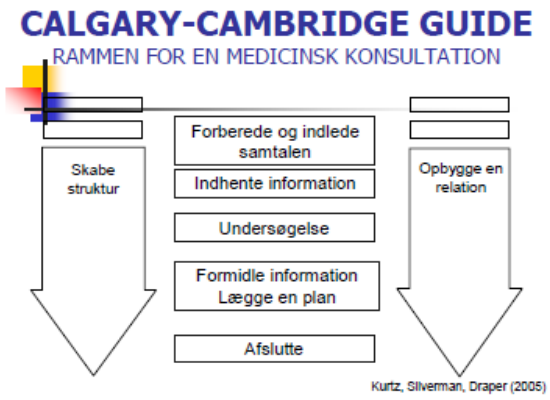
2. **Gathering information**
   - Examining and elaborating on the patient's problems
   - Further understanding of the patient's perspective

3. **Providing structure (continuity)**
   - Making structure visible
   - Attending to the flow of the session

4. **Building a relationship (continuity)**
   - Using appropriate non-verbal behaviour
   - Building rapport – develop the relation
   - Involving the patient

5. **Communicating information, diagnosis and planning**
   - Providing the correct amount of specific information
   - Supporting the patient in understanding and remembering the information
   - Working towards a shared understanding that incorporates the patient's perspective
   - Making a plan based on a shared (negotiated) decision

6. **Closing the session**
   - Agreeing on the proposed plan
   - Ensuring good closure – summary and check



After Silverman, Kurtz, Draper, 2005 (Lægeforeningen/ The Danish Medical Association, 2013).
You can also read more about the Calgary-Cambridge Guide (in Danish) and the structure of the consultation in Chapter 4 of "Lægens Roller", Louise Binow Kjær (ed.), 2017.**Translation of the Calagary-Cambridge Guide figure:**

Student reg. nr.: Name: Phone number:

Pediatric Extra formative assessment 2

5th semester/international semester: Pediatrics Extra Formative assessment 2 (Student-Medical doctor)
(Only to be used if there is need for an extra formative assesment before the summative)

Assessment and feedback for medical students by: Receiving a patient for admission or outpatient treatment, completion of medical plan or discharge/termination of pathway.

	Task	Assessment	Not observed/ assessed	Requires focus to expect to achieve competence	Well on the way - competence is expected to be achieved
1-1	Anamnesis	Structured collection of precise and relevant information	☐	☐	☐
1-2A	Objective examination	Systematic objective examination	☐	☐	☐
1-2B	Paraclinical tests	Systematic assessment of preclinical tests	☐	☐	☐
1-3	Tentative diagnosis	Relevant suggestions for diagnoses with differential diagnoses	☐	☐	☐
1-4	Further diagnostics and paraclinical tests	Assessment of need for further paraclinical tests and imaging diagnostics	☐	☐	☐
1-5	Treatment plan	Preparing a relevant treatment plan	☐	☐	☐
1-6	Medicine	Updating joint medicine card	☐	☐	☐
1-7	Discharge summary	Drafting a discharge summary	☐	☐	☐
2-1	Communication	Involving patients and any relatives, using relevant communication tools	☐	☐	☐
2-2	Empathy and professional conduct	Showing empathy and professional conduct	☐	☐	☐
2-3	Record keeping	Keeping records ethical correct and in accordance with current legislation	☐	☐	☐
2-4	Generel clinical competencies	Overall total assessment of items 1.1 - 2.3	☐	☐	☐

3-1 This was particularly good

3-2 This could/must be improved

3-3 How to improve your knowledge or competencies

Date+signatur:

Gyn obs Extra formative assessment 2

5th semester/international semester: Gyn Obs EXTRA Formative assessment 2 (Student-Medical doctor)
(Only to be used if there is need for an extra formative assesment before the summative)

Assessment and feedback for medical students by: Receiving a patient for admission or outpatient treatment, completion of medical plan or discharge/termination of pathway.

	Task	Assessment	Not observed/ assessed	Requires focus to expect to achieve competence	Well on the way - competence is expected to be achieved
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1-2B	Paraclinical tests	Systematic assessment of preclinical tests	☐	☐	☐
1-3	Tentative diagnosis	Relevant suggestions for diagnoses with differential diagnoses	☐	☐	☐
1-4	Further diagnostics and paraclinical tests	Assessment of need for further paraclinical tests and imaging diagnostics	☐	☐	☐
1-5	Treatment plan	Preparing a relevant treatment plan	☐	☐	☐
1-6	Medicine	Updating joint medicine card	☐	☐	☐
1-7	Discharge summary	Drafting a discharge summary	☐	☐	☐
2-1	Communication	Involving patients and any relatives, using relevant communication tools	☐	☐	☐
2-2	Empathy and professional conduct	Showing empathy and professional conduct	☐	☐	☐
2-3	Record keeping	Keeping records ethical correct and in accordance with current legislation	☐	☐	☐
2-4	Generel clinical competencies	Overall total assessment of items 1.1 - 2.3	☐	☐	☐

3-1 This was particularly good

3-2 This could/must be improved

3-3 How to improve your knowledge or competencies

Date+signatur:

Student reg nr: Name: Phone number:

Dear Student

Please bring this logbook to all mandatory elements of 5th semester.

The logbook includes registration of:

1) Quality improvement and patient safety in Health care
   (approved assignment) – **Mandatory**
2) Leadership in Medicine
   (approved assignment) – **Mandatory**
3) Communication – training skills
   (Approval of participation) – **Mandatory**

The approved assignments are, along with your approved competences, a part of your entrance-ticket to your examination.

Final approval of the mandatory elements:

The mandatory elements are approved, when all your signatures are on the front page (Logbook).

Student reg nr: Name: Phone number:

AARHUS UNIVERSITY

GOP - International semester

LOGBOOK

Mandatory elements

This book serves as your documentation of passed mandatory activites.

Your book of competences is personal, so it is your responsibility to take care of it. Is is also your entrance-ticket on your examinationdays.

You can take pictures of the approvals as a back-up

Quality Improvement and patient safety in Health care - approved assignment:

"Ethical aspects of and Quality Improvement potentials in Medical Errors"

_____

Date & signature

Leadership in Medicine - approved assignment:

_____

Date & signature

Communication skills training – Approval of participation:

_____

Date & signature