Bond University Medical Program

Surgery Student/Clinician Clinical Placement Handbook

Surgery Placement

The aim of the Surgical Placement is to gain practical experience in the initial evaluation, investigation and management of acute and elective illnesses common to General Surgery patients. Students will be given training in the basics of general surgical principles, learning how to solve surgical problems as they build on basic knowledge, develop clinical judgement and perform motor skills through guided and supervised patient care.

This placement also provides students with learning experiences associated with the clinical care of surgical patients and for the development of clinical knowledge and understanding of the common conditions in Surgery and the principles of surgical management.

This handbook sets out the student requirements to successfully complete this clinical placement as part of the MD Program.

Surgery Placement Specific Learning Outcomes

By the conclusion of the Surgery Placement, students should be able to:

LOs	Description of the Surgery Placement Specific LOs	Aligned to 2026 LOs (Domains)
S1	Recognise serious illness requiring urgent management/intervention	SS2, CP4, CP5
S2	Plan investigations (including imaging) and be able to provide a rationale for their appropriateness (support or refute a diagnosis, cost-effectiveness, influence on management)	SS2, CP4, CP8
S3	Compose and dictate a discharge summary	CP11
S4	Demonstrate competence in basic surgical skills	CP6
S5	Interpret the results of commonly encountered diagnostic tests, imaging and procedures in surgical patients	CP6, CP8
S6	Demonstrate understanding of the principles that apply to assessment and management of surgical patients in the phases of preoperative, operative and postoperative care.	SS2, CP1-CP4, CP10 PL2, PL4

Timetable and Contacts

Students are expected to be present 5 days a week during their placements. Students are expected to attend all their assigned shifts, and it is their responsibility to ensure that they adhere to the Health Science and Medicine Faculty's *Attendance Policy* and requirements. If a student is unable to attend a shift for any reason, they must notify you, the hospital coordinator (if applicable), and the Placements Team at Bond University (Med-placements@bond.edu.au) in advance.

As well as displaying adequate clinical knowledge, students must also display other professional skills such as the ability to work well within a multidisciplinary team, the ability to consider the psychological and social impact of illness on the patient and their family, and the ability to be honest, empathetic and respectful with regard to the patient's choices and decisions. It is also important that students recognise their own limitations, competencies, and scope of practice associated with their stage of training.

Expected Experiences for Surgery

Students are expected to gain the following experiences:

- Outpatient clinic for assessment of new surgical presentations

- Preadmission clinic or equivalent preassessment process for surgery
- Operating theatre experience of procedures under general anaesthetic
- Minor operating under local anaesthetic or regional block
- Attachment to registrar/junior house officer
- Postoperative clinic or equivalent postop follow-up process
- Ward rounds
- Exposure to at least two specialties during the placement, included but not limited to vascular, cardiothoracic, neurosurgery, plastic, orthopaedic, otolaryngology, paediatric, urology, and the general surgery specialties (trauma, endocrine, breast, upper GI, hepatobiliary and colorectal surgery).

Surgery Placement: Common Presentations

The following are common surgical scenarios that students may encounter when caring for surgical patients. Exposure to these scenarios during the Surgery placement will reinforce and enhance learning. Students are encouraged to observe and, where appropriate, assess and manage presentations independently under supervision.

Specialty / Topic Area	Common Presentations
General Surgery	• Acute abdomen • Bowel obstruction • Appendicitis • Hernias • Gastrointestinal bleeding • Abscess
Colorectal Surgery	• Rectal bleeding • Change in bowel habits • Colorectal cancer • Perianal abscess • Diverticular disease
Hepatobiliary Surgery	• Jaundice • Right upper quadrant pain • Gallstones • Pancreatitis
Breast Surgery	• Breast lump • Nipple discharge • Mastalgia • Suspected breast cancer
Endocrine Surgery	• Neck lump • Hyperthyroidism • Adrenal mass • Parathyroid disease •
Vascular Surgery	• Claudication • Critical limb ischaemia • Varicose veins • Abdominal aortic aneurysm
Cardiothoracic Surgery	• Chest pain • Dyspnoea • Haemoptysis

Specialty / Topic Area	Common Presentations
	• Lung nodules • Valvular heart disease
Urology	• Haematuria • Urinary retention • Renal colic • Scrotal pain • Prostate symptoms
Orthopaedic Surgery	• Fractures • Joint pain • Back pain • Septic arthritis • Limb deformities • Bone malignancy
Neurosurgery	• Head trauma • Spinal cord compression • Intracranial haemorrhage • Brain tumour
ENT (Otolaryngology)	• Neck mass • Dysphagia • Hoarseness • Epistaxis • Otalgia
Plastic & Reconstructive	• Burns • Lacerations • Skin lesions • Hand injuries
Paediatric Surgery	• Inguinal hernia • Pyloric stenosis • Intussusception • Undescended testes
Trauma Surgery	• Blunt abdominal trauma • Penetrating injuries • Polytrauma • Haemorrhagic shock and techniques of haemostasis
Emergency Surgery	• Perforated viscus • Ischaemic bowel • Necrotising fasciitis
Students should take the opportunity to read about each of these conditions and develop an approach to their management. Supervisors may be available to help refine understanding.	

Procedural Skills List for Surgery Placement

Bond University encourages students not only to observe but also to actively engage and participate in clinical activities. All students have a record of procedures they have been certified to perform, readily accessible on their mobile phones via the Osler application.

It is also important for students to observe clinicians performing procedures so they understand expert/best practice and the indications, pitfalls and helpful hints which will scaffold them towards independent practice as an intern.

The table below is provided as a guide to support learning from clinical situations and should not be considered a complete or exhaustive list. It outlines core procedural skills that students are encouraged to observe and, where appropriate, perform independently under your supervision during the placement. Once you are satisfied that a student has observed or can safely complete a skill, please sign against that skill in the student's handbook as confirmation.

Basic Procedures
• Venepuncture / Phlebotomy • Insertion of intravenous catheter • Obtain arterial blood sample (arterial blood gas) • Insertion of urethral (Foley) catheter • Insertion of nasogastric tube • Removal of surgical drains • Administration of local anaesthesia • Wound preparation (e.g. draping and skin preparation) • Closure of surgical incisions • Suturing of simple lacerations • Removal of sutures/staples • Dressing changes • Operating room protocols (scrubbing, gowning, gloving, prepping, draping) • Assistance in operative procedures.

Clinical Supervision, Teaching and Assessment

Teaching

This placement is structured around weekly self-directed learning modules and student presentation sessions. Students should complete the background readings each week and answer the corresponding questions for each module. Supervisors may use clinical opportunities to augment learning on weekly topics during the clinical attachment. This work is formative in nature and therefore not assessed directly.

Any additional formal teaching which the host hospital may like to provide to students will be welcomed eg. Registrar teaching sessions, MDT meetings, hospital Grand Rounds.

For student presentations, there are 18 student presentation topics in the online curriculum that may be selected depending on the number of students allocated to a surgical placement. Topics outside of this list which relate to available clinical cases are also welcome to be used. Students in each site will be notified of the local arrangements for their student presentations. The expectation is for the student to deliver a brief presentation to their peer group followed by a group discussion led by the supervisor. The student presentation should include a clinical vignette followed by the aetiology, pathophysiology, anatomy and current surgical considerations relating to the vignette.

Suggested reading materials for students

- Textbook: Current Diagnosis and Treatment: Surgery, 16th Edition (2025), Gerard Doherty, and
- Textbook: Textbook of Surgery, 4th Edition (2020), Smith, Kaye, Christophi, Brown.

Core Student Skills and Topic per Week	
Week 1: Biohazards in Surgery	**Purpose** To develop awareness of important biohazards that may be encountered by patients and staff during surgical care. Students are expected to learn about the prevention and

	management of airborne, blood-borne, and surgical site pathogens. **Core knowledge and skills** • Standard aseptic technique • Surgical sterile technique • Airborne, blood-borne, and commensal pathogens (e.g. COVID-19, TB, HIV, Hepatitis B/C, multi-resistant organisms) • Biohazard precautions in healthcare facilities • Common pathogens in surgical wound infections and infection control. **Clinical competency focus** • Infection prevention and control practices • Occupational exposure and management • Maintenance of a safe surgical environment. **Suggested reading materials** • Doherty Chapter 3 Preoperative Preparation, sections 'Operating Room' and 'Preparation of the Operating Room Facility' • Textbook of Surgery: Ch 1 'Preoperative Management', Ch 5 'Surgical Techniques' **Questions** Using the suggested pre-reading and other reading materials, answer the following questions regarding biohazards in surgery: 1. Describe 'standard aseptic technique', the key components and when it is used. 2. What is 'surgical sterile technique' and how it is different to aseptic technique? 3. List potential air-borne, blood-borne and commensal pathogens and what biohazard precautions are taken in healthcare facilities. a. Covid-19 b. TB c. HIV d. Hep B e. Hep C f. Multi-resistant organisms 4. What are the common pathogens in surgical wound infections? What measures have been proven to reduce surgical site infections?
Week 2: Preoperative Preparation, Prophylaxis and Postoperative Care	**Purpose** To ensure students understand and can implement essential perioperative care for all surgical patients. This includes preoperative safety assessment, medication management, patient optimisation, nutrition, thromboprophylaxis, and postoperative respiratory care. Specific complications such as post-thyroidectomy haemorrhage and hypocalcaemia, post-Endoscopic Retrograde Cholangiopancreatography pancreatitis (ERCP), colorectal anastomotic leaks, and vascular reperfusion injuries should be discussed during relevant presentations. **Core knowledge and skills** • Preoperative safety assessment and optimisation • Perioperative medication management (antiplatelet and anticoagulant therapy) • Timing for preoperative cessation and continuation criteria • CHADSVASC scoring and cerebrovascular (CVA) risk assessment • Nutritional and metabolic optimisation • Thromboprophylaxis and venous thromboembolism (VTE) prevention • Postoperative respiratory care • Preoperative management of patients with comorbidities: Diabetes (and non-IDDM) Insulin-Dependent Diabetes Mellitus (IDDM, Type 1 Diabetes) and non-IDDM, Type 2 Diabetes), Atrial Fibrillation (AF), thyrotoxicosis, adrenal insufficiency, obesity, pregnancy, Anaemia, chronic kidney disease (CKD), chronic liver disease, organ transplant

	• Management of postoperative complications **Clinical competency focus** • Preoperative risk assessment and perioperative optimisation • Management of surgical comorbidities • Prevention of thrombosis and respiratory complications. **Suggested reading materials** • Doherty Chapter 3 Preoperative Preparation, sections 'Preparation of the Patient' and 'Preoperative Process' • Textbook of Surgery: Ch 1 'Preoperative Management', Ch 2 'Assessment of Surgical Risk' **Questions** Using the suggested pre-reading or other reading materials, answer the following questions regarding surgical patient perioperative care: 1. List the antiplatelet medications and the required pre-operative cessation time to eliminate their effect 2. List the anticoagulation medications and the required pre-operative cessation time to eliminate their effect 3. What circumstances may require continuation of antiplatelet or anticoagulation medications? 4. How is CHADSVASC calculated and what is the CVA risk in patients not receiving anticoagulation? 5. Summarise the risks and the necessary precautions when an operation is planned on a patient with the following condition: a. Diabetes (IDDM and non-IDDM) b. AF c. Thyrotoxicosis d. Adrenal insufficiency (including patients on long term steroids) e. Obesity f. Pregnancy g. Anaemia h. Chronic Kidney Disease i. Chronic Liver Disease j. Organ transplant 6. What care should patients receive to prevent thromboembolic complications?
Week 3: Skin lesions and Melanoma (Self-directed learning + Student Presentation)	**Purpose** To familiarise students with common and significant skin lesions, including actinic and seborrhoeic keratoses, benign naevi, epidermoid cysts, lipomas, basal cell carcinoma (BCC), squamous cell carcinoma (SCC), melanoma, and rare tumours such as Merkel cell carcinoma and dermal sarcoma. **Core knowledge and skills** • Skin anatomy and histology • Risk factors for skin lesions and cancers • Key diagnostic features and differential diagnoses • Appropriate biopsy techniques • Indications for specialist referral, investigations, and basic management concepts including disease staging, reconstruction options, and adjuvant therapies • Pathogenesis, distinguishing features, and management of epidermoid cysts and lipomas • Relationship between UVA and UVB exposure and skin cancer development • Features and management of Seborrhoeic keratosis, Actinic/Solar keratosis, Bowen's Disease, and Keratoacanthoma

	• Key management recommendations for rare cutaneous tumours: Merkel cell carcinoma, Dermatofibrosarcoma protuberans (DFSP), Atypical fibroxanthoma, Pleomorphic dermal sarcoma • Benign and malignant breast conditions (e.g., mastalgia, mastitis, abscess, nipple discharge, Ductal Carcinoma In Situ (DCIS), invasive carcinoma, reconstruction) • Thyroid surgical conditions (e.g., Graves' disease, Thyroiditis, Multinodular goitre, thyroid cancers) • Endocrine surgical conditions (e.g. adrenal incidentalomas, benign and malignant tumours, hyperparathyroidism). **Clinical Competency Focus** • Recognition and assessment of common and malignant skin lesions • Formulation of differential diagnoses for skin, breast, thyroid, and head & neck lesions • Appropriate use of diagnostic investigations, including biopsy and imaging • Referral criteria to specialist services • Basic management planning including staging, surgical options, and reconstruction • Safe and effective presentation of clinical findings. **Suggested reading materials** • Chapter 43 Plastic and Reconstructive Surgery, section 'Skin Lesions and Tumours' • Textbook of Surgery: Ch 44 'Tumours and cysts of the skin', Ch 45 'Soft tissue tumours' **Questions** All students will also be required to use the suggested pre-reading or other reading materials to answer the following questions: 1. Describe the pathogenesis, distinguishing features and management of epidermoid cysts and lipomas. What malignancies may be mistaken for one of these benign lesions? 2. What is the relationship between UVA and UVB and the development of skin cancers? 3. Describe the classic features and management options for: Seborrhoeic keratosis, Actinic/Solar keratosis, Bowen's Disease, Keratoacanthoma. 4. Provide a brief summary and key management recommendations for the following rare cutaneous tumours: a. Merkel cell carcinoma b. Dermatofibrosarcoma protuberans (DFSP), c. Atypical fibroxanthoma and Pleomorphic dermal sarcoma (PDS) d. Leiomyosarcoma, Liposarcoma and Angiosarcoma **Presentation topics** A student will be allocated to present on one topic. The presentation does not require a specialist surgeon level of knowledge. There should be a focus on key concepts that GPs and physicians should understand as they will inevitably be caring for patients with comorbid skin conditions. 1. Skin: BCC, SCC, Melanoma: Primary assessment and management 2. Benign breast conditions: Mastalgia, mastitis, abscess, nipple discharge, fibro-cystic disease, gynaecomastia, phyllodes. 3. Malignant breast conditions: DCIS, Invasive cancer, screening, diagnostics, management including surgery, radiotherapy and hormone therapy, reconstruction 4. Thyroid: Surgical aspects to managing Graves Disease, Thyroiditis, Multinodular Goitre. Workup for thyroid nodules. Thyroid cancers. 5. Endocrine: Adrenal incidentalomas, benign tumours and malignancy. Surgical management of hyperparathyroidism. 6. Head and Neck lumps: Salivary gland tumours, Sialadenitis, Cervical lymphadenopathy, Branchial cyst/fistula, Cystic hygroma and ranula.
Week 4: Fluid, Electrolytes,	**Purpose** To develop competence in managing perioperative fluids, electrolytes, and nutrition, and

TPN, Blood products	in understanding the indications for blood product administration. **Core knowledge and skills** • Normal daily fluid and electrolyte requirements (e.g. for an 80 kg adult: water, sodium, potassium, glucose) • Parameters for fluid balance assessment • Fluid replacement therapy for disease states • Indications for total parenteral nutrition (TPN) • Indications for blood product administration (anaemia, platelets, international normalised ratio (INR) abnormalities) • Standard preoperative fasting times • Enhanced recovery after surgery (ERAS): components and application • Causes and management of postoperative fever • Oesophageal conditions (e.g., gastro-oesophageal reflux disease (GORD), hiatus hernia, dysphagia, Zenker's diverticulum, malignancy) • Gastric conditions (e.g., Peptic ulcer disease, Helicobacter pylori, gastric malignancy, gastrointestinal stromal tumour (GIST)) • Gallbladder and bile duct disorders (spectrum of gallstone-related diseases, malignancy) • Pancreatic conditions (pancreatitis, pancreatic neoplasia) • Bariatric surgery (indications, options, outcomes, complications) • Trauma surgery (early management of severe trauma (EMST) principles, injury mechanisms, injury grading for liver, spleen, pancreas, duodenum, trauma laparotomy, and damage control). **Suggested reading materials** • Doherty Chapter 11 Fluid, Electrolyte & Acid-Base Disorder, sections 'Fluids and Electrolytes' and 'Electrolyte Disorders' • Chapter 10 Surgical Metabolism and Nutrition, section 'Nutrition Intervention' Textbook of Surgery: Ch 4 'Postoperative Care', Ch 7 'Nutrition and the Surgical Patient **Questions** Using the suggested pre-reading or other reading materials, answer the following questions: 1. What are the normal daily fluid and electrolyte requirements for a 70kg man a. Water b. Sodium c. Potassium d. Glucose 2. What parameters are considered when performing a patient fluid balance assessment 3. What disease states require fluid replacement therapy in addition to daily maintenance fluids? 4. What are the indications for commencing TPN? 5. What are the indications for administering blood products? (consider anaemia, platelets, INR) 6. What are standard pre-operative fasting times? 7. What is ERAS? What are the key components? Can ERAS be applied to all patients? 8. List the potential causes of post-operative fever and how you would manage each. **Presentation topics** A student will be allocated to present on one topic. The presentation does not require a specialist surgeon level of knowledge. 1. <u>Oesophagus:</u> GORD, hiatus hernia, dysphagia, Zenker's Diverticulum, Malignancy 2. <u>Stomach:</u> Peptic ulcer disease, Helicobacter Pylori, Gastric malignancy, GIST 3. <u>Gall bladder and bile duct:</u> Spectrum of gallstones related disorders, malignancy

	4. Pancreas: Aetiology, pathophysiology and management of pancreatitis. Pancreatic neoplasia. 5. Bariatric surgery: Indications, options, outcomes, management of complications 6. Trauma surgery: EMST principles of management, mechanisms of injury, injury severity grading for liver, spleen, pancreas, duodenum, trauma laparotomy and damage control. **Learning integration** Provide a clerked case or verbal presentation to one of your supervisors. This should be a surgical patient case that includes preoperative assessment, preoperative optimisation, operative and post-operative management and a relevant discussion.
Week 5: The Acute Abdomen	**Purpose** To develop a clear understanding of what constitutes an acute abdomen through reading and clinical experience. **Core knowledge and skills** • Definition, causes, and pathophysiology of the acute abdomen • Symptoms and signs considered pathognomonic • Aetiology and mechanisms of pain in intra-abdominal infection (e.g. appendicitis, cholecystitis) • Systematic diagnostic approach and investigation pathway • Surgical and non-surgical causes • Hernias (inguinal, femoral, ventral, incisional, obturator, Spigelian, lumbar) • Colonic conditions (diverticular disease, volvulus, polyps, bowel cancer, screening) • Colitis (infective, inflammatory, ischaemic; Inflammatory Bowel Disease (IBD), including Ulcerative Colitis (UC) and Crohn's Disease • Proctological conditions (haemorrhoids, fissure, abscess, Fournier's, fistulae, prolapse, pilonidal disease) • Arterial diseases (Peripheral Vascular Disease (PVD), Abdominal Aortic Aneurysm (AAA), carotid disease, diabetic foot, gangrene) • Venous diseases and lymphoedema (varicose veins, phlegmasia, chronic venous insufficiency, ulcers, venous thromboembolism (VTE), post-phlebitic syndrome, congenital/acquired lymphoedema) **Clinical competency focus** • Assessment and prioritisation of patients with acute abdomen • Early recognition and management of surgical emergencies • Communication and escalation of deteriorating patients. **Suggested reading materials** • Doherty Chapter 25 The Acute Abdomen • Textbook of Surgery: Ch 68 'The acute abdomen, peritonitis and intra-abdominal abscesses' **Questions** Using the suggested pre-reading or other reading materials, answer the following questions regarding the acute abdomen: 1. Write your definition of 'the acute abdomen'. What symptoms and signs do you regard as pathognomonic for the diagnosis of an acute abdomen? 2. What is the aetiology and pathophysiology of pain associated with an acute abdomen? (use an example of intra-abdominal infection such as acute appendicitis or cholecystitis) 3. Using a systematic approach of your own preference, present a comprehensive list of conditions that may cause an acute abdomen, appropriate investigations and suggested management. 4. What are 'non-surgical' causes of an acute abdomen?

	Presentation topics A student will be allocated to present on one topic. The presentation does not require a specialist surgeon level of knowledge. 1. Hernias: Inguinal, femoral, ventral, incisional, obturator, Spigelian, lumbar 2. Colon: Diverticular disease, volvulus, polyps, bowel cancer, screening 3. Colitis: Infective, Inflammatory, Ischaemic colitis, IBD: UC, Crohn's 4. Proctology: Haemorrhoids, fissure, abscess, Fourniers, fistulae, prolapse, pilonidal disease 5. Arterial disease: Peripheral vascular disease (including acute and chronic limb ischaemia), abdominal aortic aneurysm, carotid artery disease, diabetic foot & gangrene. 6. Venous disease and lymphoedema: Venous drainage of lower limbs, varicose veins, phlegmasia, chronic venous insufficiency, lower limb ulcers, VTE & post phlebitis syndrome, congenital and acquired lymphoedema. **Learning Integration** Provide differential diagnoses for a patient presenting with a lump in the groin.
Week 6: Healing, Wound Care, Plastic and Reconstructive Surgery	**Purpose** To understand the physiological and clinical principles of wound healing and apply evidence-based approaches to wound care and reconstructive surgery. **Core Knowledge and Skills** • Phases of normal wound healing • Factors impairing or prolonging acute wound healing • Management of venous, ischaemic, exudative, cellulitic, and bone ulcers • Biofilm management and infection control • Maturation process of split and full-thickness skin grafts • Factors contributing to graft failure **Clinical Competency Focus** • Wound assessment and classification • Principles of plastic and reconstructive surgery • Infection prevention and tissue viability management. **Suggested reading materials** • Doherty Chapter 6 Wound Healing • Textbook of Surgery: Ch 6 'Management of Surgical Wounds', Ch 9 'Surgical Infection', Ch 47 'Principles of plastic surgery' **Questions** All students will also be required to use the prescribed pre-reading or other reading materials to answer the following questions: 1. Describe the stages and steps in normal wound healing? 2. What factors impair or prolong acute wound healing, and contribute to development of a chronic wound? 3. Outline the recommendations for managing the following wounds: a. Venous ulcer b. Ischaemia ulcer c. Highly exudative wound d. Biofilm e. Cellulitic wound f. Bone ulceration 4. Describe the process of maturation of a split and full thickness skin graft. What factors contribute to graft failure.

Note	Week 6 or 7 students do their Clerked case presentations (summative assessment)

Assessment

In addition to the above, students have a variety of workplace-based assessments (WBA) to successfully complete during this Clinical Placement as detailed below. All WBAs are completed in Osler ePortfolio, a cloud-based mobile assessment technology, giving students, supervisors and faculty immediate access to WBA feedback and evaluation. WBAs are not only the students' richest source of personal feedback on performance but are also evidence of their clinical skills development and safety to practice.

At the end of each clinical placement, the Board of Examiners (BOE) will review all required WBA to decide whether the student has passed the Clinical Placement. If all WBAs are not submitted by the due date, the BOE may not have sufficient evidence to make an Ungraded Pass decision and the student progression in the Medical Program may be delayed.

The BOE assessment is holistic. A satisfactory performance on attendance, professionalism, and WBAs is required to pass the rotation.

All WBAs are to be submitted in Osler by 8 am Monday following the end of each Clinical Placement

In the final Clinical Placement 12 (Subject MEDI72-503) all WBA are due end of W5.

For assistance, please contact the following:

- For assistance with Osler contact: osler@bond.edu.au
- For assistance with WBA contact: Med-assessment@bond.edu.au
- For full details of all WBA requirements, read the WBA booklet located on iLearn.

In-Training Assessments (ITAs) (Mid-placement due Wk 3/4, End-placement due Wk7)

This workplace-based assessment tool provides the opportunity for the clinical supervisor to comment on the student's global performance on that placement to date. The ITA is a summary evaluation of whether students have met the requirements at the expected level of that placement at the time of completion for:

- Clinical knowledge
- Procedural skills
- Clinical History taking and physical examination skills
- Communication
  - Communication with patients, children, staff and their families
  - Appropriate clinical handover using ISBAR
- Personal and professional behaviour
- Attendance on placement.

The ITA is completed by the assigned supervising Consultant or their delegated registrar, after seeking

input from the clinical team about the student's performance throughout the placement, with a particular focus on whether the student is performing 'at expected level'. This process supports an informed and balanced evaluation.

Students can fail for lack of professional behaviour or for not meeting attendance requirements on Clinical Placement. Inadequate presence prevents students from spending sufficient time with patients to demonstrate competence.

Mini-Clinical Examinations (Mini-CEXs) (due Wk6)

Students are expected to actively engage in the development of core clinical skills by interacting with patients through taking histories or performing physical examinations and participating in discussions with the clinical supervisors/consultants. While these interactions should be an everyday occurrence, four examples will be assessed as Mini-Clinical Examinations (Mini-CEXs).

Mini-CEXs offer a valuable formative learning opportunity, as students receive personalised feedback from experienced clinicians. This feedback helps students monitor their own progress, identify areas for improvement, and supports progression decisions within the program.

During the clinical placement, students will be supervised by the clinical supervisor/consultant or their delegate, which can include a range of clinicians in specialist training pathways within the medical team, senior house officer or higher. Postgraduate Year 1 (PGY1) and PGY2 interns are not permitted to complete Mini-CEXs.

Students are required to complete and evidence **four (4) Mini-CEXs.** Students are required to complete and evidence four (4) Mini-CEX:

- 2 x Mini-CEX: History taking skills
- 2 x Mini-CEX: Physical examination skills.

Students are required to complete and evidence **four (4) Mini-CEX** at an **entrustability rating Level 3 or above**:

1. **Unsatisfactory:** Unable to complete the task and requires direct instruction and intervention from supervisor (Repeat task)
2. **Borderline:** Performs the task but supervisor intervention is required (Repeat task)
3. **Clear Pass:** Performs the task competently with minimal supervisor input and intervention (clear Pass for med. student)
4. **Excellent:** Performs the task competently and independently with supervision nearby if required (Intern level - Pass).

If students are given a Level 1 (Unsatisfactory) or Level 2 (Borderline) score, the clinical task must be repeated until a Level 3 (Clear pass) or Level 4 (Excellent) is reached by the end of the clinical placement.

Clerked Case (due WK7)

Students will submit and present one Clerked Case. They are provided with resources, a video demonstration, and a template to use. Students will take a history, examine a patient, then complete and submit a written Clerked Case which they will also present in Wk 6 or 7 to their supervisor.

The Purpose of the Clerked Case is for students to:

- Practice the skill of concise and relevant documentation

- Develop their ability to articulate clinically relevant patient information in both oral and written formats
- Guide their deeper clinical understanding of core conditions, including management options
- Develop their clinical reasoning – their ability to formulate a diagnosis from the History and Physical examination, supported by specific tests.

Process of Clerked Case Completion:

- The student is required to spend time with a patient sufficiently to take a full history and examination and extract the relevant findings.
- Wk5: Students then concisely document their findings and write a problem list and care plan, including a GP letter, with reference to the literature in support of their clinical decision- making: 1500 word maximum with 250-word abstract assigned to you in Osler.
- Wk6/7 the student presents the patient case orally and answers questions, enabling evaluation of their clinical reasoning. A good presentation should demonstrate the student's understanding of the patient's issues, concerns and goals and model a patient-centred approach to care.
    - Students will need guidance on when to present their clerked case orally to their supervisor.
    - Supervisors are encouraged to ask questions at any time in the presentation about the case and how students arrived at their diagnosis/management plan
- The supervisor may determine the format required for the presentation:
    - E.g. students to present a power point presentation
    - E.g. complete an oral presentation in front of peers for group learning
    - It can also be conducted at the bedside.
- Once the student has presented, please complete the assessment in Osler ePortfolio.
- The Osler ePortfolio assessment is due on Friday Wk7, the last day of the placement.

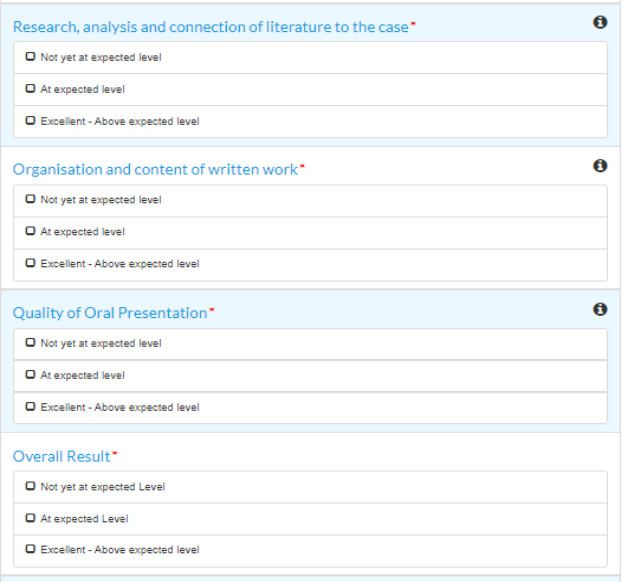
Evaluation of the Clerked Case will be based on performance in the following three domains:

1. Research, analysis, and relevance of recent literature to the case
2. Organisation and content of written work
3. Quality of Oral presentation

The Global assessment given is an overall result:

- Not yet at expected level (Repeat)
- At expected level (Pass)
- Above expected level (Excellent).

*Refer to the **Clerked Case Marking Rubric**.*



Clerked Case Marking Rubric

Criteria	Not Yet At Expected Level / Fail	At Expected Level / Pass	Excellent – Above Expected Level
1. Abstract (250 words)	Missing key information Poorly structured with illogical sequence	Contains most of the relevant information Structured in logical sequence	Contains all relevant information Concise, accurate well sequenced description of documented information
2. Presentation of history (Hx), medication and physical examination (PE)	Unable to identify the presenting complaint History is delivered out of sequence/date line not clear Forgets to mention some or all medications/Hx components PE: Misses relevant vital signs or core components of the PE, particularly medication and allergy Hx	Identifies presenting complaint (symptoms) in patients own words Provides history with clear date line/logical sequence and correct use of medical terminology Lists patients' current medication, Family and social Hx PE: Vitals given and clearly lists findings of general PE	Identifies how medication could be contributing to the presenting complaint Conducts systems review and full Hx with all components completely accurately PE: Lists finding of general and focused physical examination Uses correct medical terminology and logical sequence
3. Clinical Summary and Differential diagnosis (DDx)	Provides 2 or < differential Dx and illogical ranking Unable to adequately support DDx with information from the Hx and PE Unable to articulate the mechanism of action (MOA)	Provides 3 or 4 differential Dx under consideration with mostly logical order of priority Supports DDx with information derived from the Hx and PE. Demonstrates some understanding of MOA	Able to identify the most common condition and what must not be missed with logical ranking Able to support DDx in addition with information based on anatomy, physiology to explore the MOA
4. Investigations (Ix)	Misses key investigations Unable to explain the rationale for investigations or how they help confirm the Dx	Clearly and accurately identifies the investigations carried out and the rationale for each	Can summarise and interpret results and identify which negative results refute the diagnostic hypothesis and which positive results helped to confirm the Dx
5. Management (Mx) Plan…	Can only describe the immediate Mx plan Forgets some of medication and/or non-pharm interventions Ignores multidisciplinary team involvement in the Mx Plan	Clearly and accurately describes the proposed Mx Plan Including medication Able to describe the plan for follow up and multidisciplinary team members involved	Able to describe the proposed Mx Plan including medication and non-pharmacological interventions as well as continuing management in response to progress and long-term follow up. Clearly articulates roles of Multidisciplinary team members
…including GP Letter	Unable to summarise and provide relevant information in a concise format – lengthy and full of prose	Concise clinical handover document including Dx, Rx, Medication and Mx. Includes follow-up information	Encourages collaborative care with clear handover and clearly articulated future plans
6. Case Discussion	Insufficient/incoherent discussion Unable to articulate how the Dx was made Demonstrates only poor clinical reasoning	Mostly coherent discussion Able to clearly articulate how the Dx was made Demonstrates adequate clinical reasoning Discussion supported in parts by the literature	In-depth discussion and analysis of the diagnostic and decision-making process Demonstrates excellent clinical reasoning Discussion well supported by quality and relevant literature
7. Research, analysis, and connection of literature to the patient case	Insufficient critical analysis and synthesis of information related to the case. Poorly researched evidence from the literature in support. Multiple errors in referencing.	Demonstrates some critical analysis and connection of literature to the patient case. Uses high quality academic literature with standardised methodology including research articles, RCT and current textbooks. Minor errors in referencing.	High level of critical analysis of the literature with ability to synthesise current best practice with the patient case. Exceptional research and use of recent (< 5 years) evidence from authoritative and quality journal articles. Uses Systematic/ Cochrane reviews. References sources accurately.
8. Organisation and content of written submission	Incorrect use of medical terminology and non-standard abbreviations. Illogical sequence with core information missing. Does not demonstrate sufficient knowledge of the patient condition.	Correct use of medical terminology. Well-structured and logical flow of information. Core information included with red flags identified. Demonstrates good knowledge of the patient condition	Always uses standard abbreviations with accurate grammar and spelling. Concise and thorough information provided in a well-structured, logical flow. Demonstrates in-depth knowledge of the patient condition.
9. Oral presentation	Hesitancy in speaking, lacks confidence. Unable to answer some questions. Shows little insight to the patient experience	Clear speaking manner with minimal hesitancy Answers questions about the patient competently Shows insight to the patient experience	Articulate, persuasive speaking manner with exceptional use of medical terminology. Answers questions confidently, demonstrating good insight to the patient experience
Global / Overall result	Not yet at expected level	At expected level	Excellent – above expected level

Procedural Skills and Clinical Tasks

Bond Medical Students are required to complete the following Procedural Skills and Clinical Tasks to graduate with the MD. Eleven skills are to be completed on patients under guided supervision whilst three clinical tasks and three theory modules support their skills development.
Opportunities for all Skills and Tasks are not expected in any one rotation. Students are expected to take the initiative in seeking opportunities across the whole of their MD program. A wide range of health professionals can evaluate Skill or Task competency, including doctors, nurses, and allied health.

Students and supervisors can choose the location and timing of when they are ready to conduct this skill for assessment. Students are encouraged to practise the skill multiple times prior to being assessed for competency.

#	**Required Procedural Skills**	**Best opportunity**	**Additional Advice**
1	In-dwelling Catheter insertion	WH, ED, Surgery	• **These procedures must be observed <u>conducted on patients</u> or being performed in the clinical setting at a L3 Entrustment rating.** • Skills 1 – 9 require you to: (p.20) 1. Watch the Osler learning module 2. Pass a Quiz to generate the WBA. 3. This WBA must be assigned to the observing clinical team member.
2	Intravenous Cannulation (2)	MED, ED, ACSR	
3	Suturing – basic wound closure	Surgery, ED	
4	Intramuscular injection	GP, MED, ED	
5	Subcutaneous injection	GP, MED, ED	
6	Electrocardiograph acquisition	MED, ED, GP, MH, Surgery	
7	Venesection	MH, Surgery, ED	
8	Blood Culture Sampling	Ward Call, ED, ICU	
9	Sterile handwash, gown, and glove	Surgery	
10	*Airway Management: Bag/Mask technique – no Osler learning module	ED, Surgery, anaesthetics	
11	Glasgow Coma Scale Interpretation	ED, MED, ICU, Ward Call	
	Required Theory Modules		
12	Personal Protective Equipment		Theory Module in Osler ePortfolio.
13	Assessment of the ICU patient		Theory Module in Osler ePortfolio.
14	Pulse Oximetry		Theory Module in Osler ePortfolio.
	Required Clinical Tasks		
15	Deteriorating patient	ED, ACSR Ward Call	Refer to additional information.
16	Discharge Summary (conducted in ieMR)	MED, Surgery, WH, CH, MH	Refer to additional information.
17	Indigenous health task	MED, Surgery, WH, CH, MH, ED, GP	Refer to additional information.

Evaluation of **student procedural skills performance** is based on an **entrustability rating scale**:

1. **Unable to complete the task** and requires direct instruction and intervention from supervisor (Repeat task)
2. Performs the task but **supervisor intervention is required** (Repeat task)
3. Performs the task competently with **minimal supervisor input or intervention** (Pass at medical student level)
4. Performs the task competently and **independently with supervision nearby** if required (Pass

at Intern level).

For Airway Management only - Level 2 is an acceptable pass due to the necessary requirement for active supervisor guidance, support, and intervention during this complex task. Students are required to conduct a Bag and Mask ventilation on a patient under guided supervision or can participate in two person techniques, such as oropharyngeal and nasopharyngeal airway insertion.

Additional Assessment Requirements

For context, MD students will conduct the following other assessments outside of the rotational structure:

- **Clinical Skills:** Students will sit an MD OSCE at end of year following CP6 as a check on clinical skills competency and safety to progress to the final year of the program.
- **Clinical Knowledge:** to promote continuous development in clinical knowledge, students will conduct five (5) written knowledge Progress Tests, one at the end of each subject as well as a Prescribing Skills Assessment (PSA).
- **Competency in specific skills:** Examples include but are not limited to - Advanced Life Support, Ultrasound Course, Women's Health Assessment Training (intimate Examinations).
- **Advanced Research and evidence-based practice:** MD Portfolio including MD Project and Conference presentation.

MD Program Outcomes (Year 4 and 5s)

The following MD program outcomes for students in Years 4 and 5 are provided as an overview for context. Not every outcome needs to be addressed in any one rotation.

MD Program Outcomes (Year 4 and 5s)

MEDI71-401, 402 and 403 Core Clinical Practice A, B and C

MEDI72-501, 502 and 503 Extended Clinical Practice and Research, A, B and C

The Australian Medical Council's Graduate Outcome Statements are organised into four domains. Within this Subject, the framework mapped to the learning outcomes (LOs) are:

Clinical Practice: The medical graduate as practitioner (CP) (LOs 1-11)
Professionalism and Leadership: The medical graduate as a professional and leader (PL) (LOs 12-18)
Health and Society: The medical graduate as a health and wellbeing advocate (HS) (LOs 19-25)
Science and Scholarship: The medical graduate as scientist and scholar (SS) (LOs 33-40)

2026 PLO	2026 Domain#	2026 Program Learning Outcomes On successful completion of this Program, the learner will be able to:	AMC Outcomes
01	**CP 1**	Adapt communication skills to engage safely, effectively and ethically with patients, families, carers, and other healthcare professionals, including fostering rapport, eliciting, and responding to needs or concerns whilst supporting health literacy. **[Communication]**	1.1, 1.3, 1.4, 1.6, 2.4
02	**CP 2**	Elicit an accurate, structured medical history from the patient and, when relevant, from families and carers or other sources, including eco-biopsychosocial features. **[Medical History]**	1.8, 1.5
03	**CP 3**	Demonstrate competence in relevant and accurate physical and mental state examinations. **[Physical Examination]**	1.9

04	**CP 4**	Integrate and interpret findings from the history and examination of a patient to make an initial assessment, including a relevant differential diagnosis and a summary of the patient's mental and physical health. **[Clinical Reasoning]**	1.10
05	**CP 5**	Demonstrate proficiency in recognising and managing acutely unwell and deteriorating patients, including in emergency situations. **[Emergency Care]**	1.20, 1.21
06	**CP 6**	Demonstrate competence in the procedural skills required for internship. **[Procedural Skills]**	1.14
07	**CP 7**	Prescribe and, when relevant, administer medications and therapeutic agents (including fluid, electrolytes, blood products and inhalational agents) safely, effectively, sustainably and in line with quality and safety frameworks and clinical guidelines. **[Therapeutics]**	1.17, 1.18
08	**CP 8**	Select, justify, request and interpret common investigations, with due regard to the pathological basis of disease and the efficacy, safety and sustainability of these investigations. **[Investigations]**	1.15
09	**CP 9**	Demonstrate responsible use of health technologies in the management and use of patient data and incorporate their use to inform, support and improve patient health care and digital health literacy, especially among groups who experience health inequities. **[Digital Technologies]**	1.19, 1.24, 2.15, 3.8
10	CP 10	Formulate an evidence-based management plan in consultation with the interprofessional team, including patients and families across a variety of clinical settings with consideration of eco-biopsychosocial aspects that may influence management at all stages of life. **[Patient Management]**	1.1, 1.2, 1.5, 1.11, 1.12,1.16, 1.22, 1.23
11	**CP11**	Record, transmit and manage patient data accurately and confidentially. **[Documentation]**	1.19, 2.3, 2.15
12	**PL 1**	Display ethical and professional behaviours including integrity, compassion, self-awareness, empathy, discretion, and respect for all in all contexts. **[Professional Behaviour]**	2.1, 2.18
13	**PL 2**	Demonstrate effective interprofessional teamwork to optimise patient outcomes whilst respecting boundaries that define professional and therapeutic relationships. **[Teamwork]**	2.2, 2.6, 2.9, 2.11, 2.12, 2.17
14	**PL 3**	Apply principles of professional leadership, followership, teamwork, and mentoring by contributing to support, assessment, feedback and supervision of colleagues, doctors in training and students. **[Leadership]**	2.2, 2.16
15	**PL 4**	Integrate the principles and concepts of medical ethics and ethical frameworks in clinical decision-making and patient referral, including through appropriate use of digital technologies and handling of patient information. **[Ethical Behaviour]**	2.3, 2.10
16	**PL 5**	Critically apply understanding of the legal responsibilities and boundaries of a medical practitioner across a range of professional and personal contexts. **[Legal Responsibilities]**	1.19, 2.15
17	**PL 6**	Actively seek feedback and demonstrate critical reflection and lifelong learning behaviours to improve and enhance professionalism and clinical practice recognising complexity and uncertainty of the health service and limits of own expertise to ensure safe patient outcomes and healthcare environment. **[Critical Self-reflection]**	2.5, 2.8 2.13, 2.14, 2.17, 2.18
18	**PL 7**	Actively monitor and implement strategies to manage self-care and personal wellbeing in the context of professional, training, and personal demands. **[Self-care]**	2.7, 2.8, 2.9
19	**HS 1**	Demonstrate culturally safe practice with ongoing critical reflection on their own knowledge, skills, attitudes, bias, practice behaviours and power differentials to deliver safe, accessible and responsive health care, free of racism and discrimination. [**Culturally safe practice]**	1.5, 2.18, 3.2, 3.4, 3.5
20	**HS 2**	Describe Aboriginal and/or Torres Strait Islander knowledges of social and emotional wellbeing and models of healthcare, including community and eco-sociocultural strengths. [**Striving for Aboriginal and Torres Strait Islander Health and wellbeing equity]**	1.7, 3.11, 4.3
21	**HS 3**	Recognise and critically reflect on historical, individual, and systemic challenges to Aboriginal and Torres Strait Islander peoples. [**Barriers to Aboriginal and Torres Strait Islander Health and well-being equity]**	3.2, 3.3, 3.4, 3.5
22	**HS 4**	Apply health advocacy skills by partnering with communities, patients and their families and carers to define, highlight, and address healthcare issues, particularly health inequities and sustainability. [**Health and well-being advocacy]**	3.6
23	**HS 5**	Critically apply evidence from behavioural science and population health research to protect and improve the health of all people. This includes health promotion, illness prevention, early detection, health maintenance and chronic disease management. [**Public Health]**	1.22, 3.6, 3.7, 4.2 (4.1)
24	**HS 6**	Describe ecologically sustainable and equitable healthcare in the context of complex and diverse healthcare systems and settings. [**Environmentally sustainable healthcare]**	3.1, 3.10

25	**HS 7**	Describe global and planetary issues and determinants of health and disease, including their relevance to healthcare delivery in Australia and Aotearoa New Zealand, the broader Western Pacific region and in a globalised world. [**Global and Planetary Health]**	3.2, 3.12, 4.1, 4.2
26	**SS 1**	Apply and integrate knowledge of the foundational science, aetiology, pathology, clinical features, natural history, prognosis and management of common and important conditions at all stages of life. [**Foundational science**]	1.13, 4.1, 4.4
27	**SS 2**	Apply core medical and scientific knowledge to populations and health systems, including understanding how clinical decisions for individuals influence health equity and system sustainability in the context of diverse models and perspectives on health, wellbeing and illness. [**Population and health systems**]	4.1, 4.2, 4.3, 3.9
28	**SS 3**	Critically appraise and apply evidence from medical and scientific literature in scholarly projects, formulate research questions and select appropriate study designs or scientific methods. [**Research and scientific methods**]	4.5, 4.6
29	**SS 4**	Comply with relevant quality and safety frameworks, legislation and clinical guidelines, including health professionals' responsibilities for quality assurance and quality improvement. [**Quality and safety**]	1.1, 3.9, 4.7

Guidelines for AI Use on Clinical Placement

Artificial Intelligence (AI) tools are increasingly used in healthcare and education. While these technologies can enhance learning and clinical practice, their use must comply with Bond University, placement provider, and state health policies. These guidelines aim to protect patient privacy, maintain professional standards and uphold academic integrity for medical students during clinical placements.

1. Compliance with Policies

Students must adhere to:

- **Bond University Policies:**
  - *Academic Integrity Policy*
  - *Student Code of Conduct Policy*.

- **Placement Provider Requirements:**
  - Local site rules and approved technology use.

2. Protecting Patient Privacy

Patient confidentiality is paramount. Students must:

- Never input identifiable or sensitive patient data into unapproved AI systems or AI tools.
- Use only site-approved AI tools in clinical areas, as directed by your supervisor.
- Comply with relevant privacy legislation:
  - *Queensland*: Queensland Health Privacy Policy (Queensland Privacy Principles under the Information Privacy Act 2009).
  - *NSW*: Health Records and Information Privacy Act 2002 and NSW Health Privacy Manual for Health Information.

What Constitutes Identifiable Patient Data?

Any information that can directly or indirectly identify a patient, alone or in combination, including:

- **Personal details**: Name, date of birth, address, phone number, email.
- **Health identifiers**: Medicare number, hospital URN, medical record number.

- **Clinical details linked to identity**: Appointment dates, admission/discharge dates, rare conditions combined with location.
- **Images or media**: X-rays, scans, photos or videos showing the patient or unique features.
- **Combinations of data**: Even seemingly harmless details (e.g., age + condition + medication list) can make a patient identifiable.

3. Principles for Responsible AI Use

- Always maintain patient privacy.
- Use only site-approved AI tools in clinical settings.
- AI must never replace clinical judgment or decision-making.
- Verify the accuracy of AI-generated content before using it in documentation.
- Declare AI assistance where required to maintain transparency.
- Comply with cybersecurity and data security standards.

4. Examples of Approved vs. Prohibited AI Use on Clinical Placement

Approved AI tools:

- AI tools integrated into Queensland Health systems for clinical documentation or decision support.
- NSW Health-endorsed AI tools within secure platforms.
- University-approved learning platforms (see *Generative Artificial Intelligence (Gen-AI) guide for students and staff*).

Prohibited AI tools:

- Public AI tools (e.g., DeepSeek, ChatGPT) for patient-related tasks.
- Uploading identifiable patient data to external websites or applications.

5. Guidance on AI Scribes

Expectations:

- Students may only use AI scribes that are provided and approved by the hospital or placement site, and only with supervisor permission.
- Students must not use any AI tools they have purchased or subscribed to independently (e.g., Otter.ai, Notion AI, ChatGPT Plus).
- Developing competency in writing clinical notes is a priority. Students should not rely on AI scribes until they have demonstrated proficiency in manual documentation.
- Students must verify the accuracy of any AI-generated content before including it in patient records.
- Students must comply with all privacy and confidentiality requirements when using AI scribes.