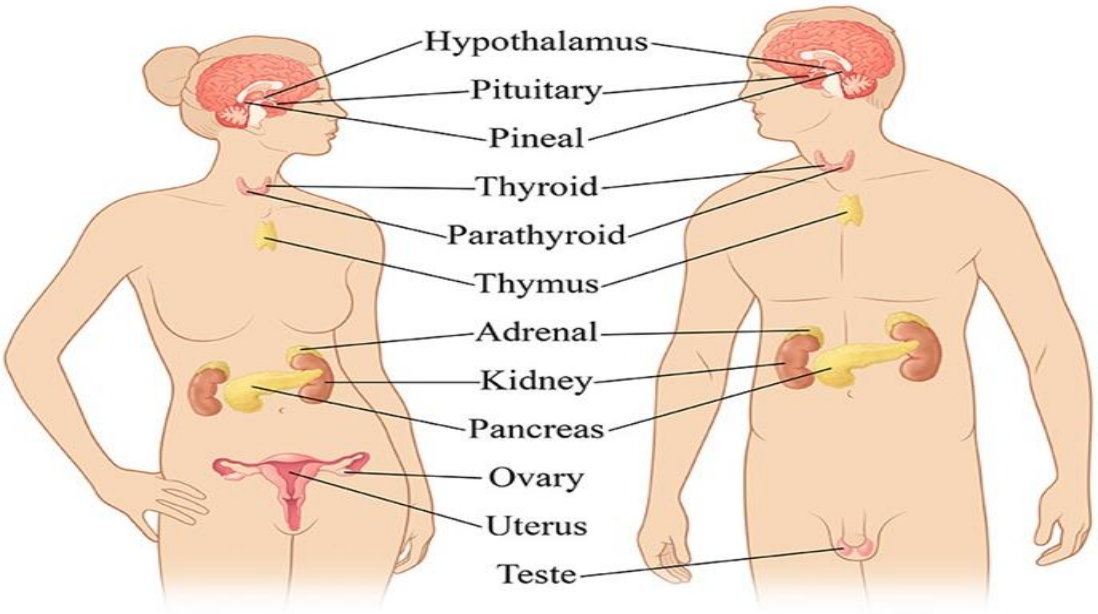
King Saud University
College of Medicine
Medical Education Department



STUDENT'S GUIDE OF CLINICAL SKILLS

Reproduction Block

(REPRO 224)

YEAR 2

2016-2017
1437-1438

King Saud University
College of Medicine
Medical Education Department

Reproduction Block

(REPRO 224)

(Academic year 1437-1438)

Year 2

TABLE OF CONTENTS

Introduction and rationale:

Early students' clinical exposure to skills is essential for systematically learning and developing clinical skills appropriate to working in a clinical environment, and application of skills when they move onto their clinical rotations.

The transition from preclinical to clinical training is huge for the students and several studies have documented that the transition is quite stressful. (O'Brien et al., 2007).

We aim from the clinical skills to do a smooth transition in clinical skills from preclinical to clinical years.

The clinical skills took in consideration the requirement of SaudiMed for the graduates of Saudi medical students through integration with the different blocks and courses.

The clinical skills will be learnt through spiral approach system to gradually increase students' confidence in performance when interacting with patients during their clinical years.

*The aims of e*arly clinical skills teaching:

1. improvement in the students' **knowledge and competence** to perform examinations
2. Increased student's perceived levels of **confidence**.
3. Enrichment of the **safe environment** that helps in bridging the gap between the preclinical and clinical years in medical undergraduate education. ***(Swamy et al., 2013)***

Objectives of the Clinical Skills:

By the end of this course the students should be able to know and show how to:

1. To take an ideal history related to obstetrics signs and symptoms.
2. Bimanual Vaginal (PV) Examination and taking a Pap Smear
3. Examine the breast
4. Examine the external genitalia of male

Tutorials (3 hours):

W1	Pelvic examination and taking a Pap Smear
W2	Examine the external genitalia of male
W3	To take an ideal history related to obstetrics symptoms
W4	Examine the breast
W5	OSCE

Objectives of the Clinical Skills:

By the end of this course the students should be able to know and show how to:

5. To take an ideal history related to obstetrics signs and symptoms.
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Tutorials (3 hours):

W1	Pelvic examination and taking a Pap Smear
W2	Examine the external genitalia of male
W3	To take an ideal history related to obstetrics symptoms

W4	Examine the breast
W5	OSCE

Week 1: Pelvic examination and taking a Pap smear

Objectives: By the end of the session the students should be able to:

1. Identify the indications for bimanual Vaginal (PV) Examination and taking a Pap smear
2. Discuss the steps of speculum examination.
3. Discuss the steps of bimanual examination.
4. Discuss the steps of taking a pap smear.
5. Apply the principles of asepsis when performing the pelvic examination.
6. Demonstrate speculum and bimanual examination in addition to taking a pap smear om manikins.

Week 2: Examine the external genitalia of male

Objectives: By the end of the session the students should be able to:

1. Identify the indications for examination of the male external genitalia.
2. Discuss the steps of examination of the male external genitalia.
3. Apply the principles of asepsis when performing the examination of the male external genitalia.
4. Demonstrate the examination of the male external genitalia including inspection, palpation of the penis and scrotum, in addition to trans illumination on Manikin.

Week 3: To take an ideal history related to obstetrics signs and symptoms.

Objectives: By the end of the session the students should be able to:

1. Identify the importance of taking a history related to obstetrics signs and symptoms.
2. Discuss the steps of taking a history related to obstetrics signs and symptoms.
3. Demonstrate taking a history related to obstetrics signs and symptoms including chief complaint, present illness, past medical history, systemic enquiry, family history, drug history, and social history on simulated patient.
4. Record the notes while taking the history
5. Demonstrate good communication with the simulated patient while taking the history.

Week 4: Examine the breast

Objectives: By the end of the session the students should be able to:

1. Identify the importance of physical examination of the breast.
2. Describe the anatomic location and components of the breast, and the location of lymphatics (axillary, infraclavicular and supraclavicular.)
3. Describe and demonstrate inspection of the breast with arms at sides, overhead, and against hips (tensing the pectoralis.) Include skin, nipple, areola, symmetry.
4. Describe and demonstrate palpation of the breast, using a systematic approach that ensures

complete examination, including the subareolar area, the nipple, four breast quadrants, and t he tail extending toward the axilla.

5. Describe and demonstrate examination for nipple discharge.
6. Describe and demonstrate inspection of the axilla.
7. Describe and demonstrate palpation of the lymphatics of the axilla and chest: Central, pector al, lateral, subscapular, infraclavicular and supraclavicular.
8. Perform a complete examination of the breast and axilla, in a manikin.

Teaching and Learning Modes:

1. The clinical skills will be learnt by hands on the different clinical skills.
2. The tutor will do a demo in front of students, and then each student is expected to do by himself
3. The tutor will give feedback to the students according to the provided checklists

Mode of assessment:

1. **Formative assessment during the sessions**
   The students will be asked to perform the examination after the instructor's demonstration and will get the feedback by the instructors and his/her colleagues.

2. **Summative assessment: 5 marks**

The students will expose to 3-4 OSCE stations by the end of the block.

The OSCE stations are expected to be structured according to the provided templates

The staff will evaluate the students for each station according to a structured checklists and the final mark of OSCE is out of 5.

Learning Resources:

1. The clinical skills tutor
2. The clinical skill lab facilities during SDL (need to be arranged with the clinical skill staff in advance)
3. The provided checklists
4. Recommended reference textbooks and website:

- Physical Exam by Barbara Bates
- Current Medical Diagnosis
- Current Surgical Diagnosis

Website:

-Martindales Clinical Examination (martindalecenter.com)

Checklists

Academic Support Team **CHAIRPERSON :** Dr. Malak Al Hazmi Pathology Department Extension : Mobile : / Bleep : Email :		**CO-CHAIR :** Department Extension : Mobile : / Bleep : Email :	
MEMBERS	**DEPARTMENT**	**CONTACTS**	**E-MAIL ADDRESS**
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Dr. Milda	Clinical skills	Extension : 92587 Mobile :	dr.milda@hotmail.com
Dr. Nur	Clinical skills	Extension : 92589 Mobile :	dr.strange@ymail.com
Dr. Sahar Mostafa	Clinical skills	Extension: 56526	samoustafa@yahoo.com

Week 1: Bimanual Vaginal (PV) Examination

King Saud University
College of Medicine
Department of Medical Education
Riyadh, KSA

OBJECTIVE: Bimanual or PV examinations are performed for a number of clinical reasons e.g. problems relating to menstruation, irregular bleeding, dyspareunia, abnormal vaginal discharge or pelvic pain. The

main objective is to systematically examine each part of the female genital system and identify variations in normal anatomy as well as abnormal physical signs i

MATERIALS: Proper Light **, clean gloves and lubricant.**

D: Appropriately done PD: Partially done ND: Not done/Incorrectly done

	STEP/TASK	D	PD	ND
	Preparation			
1.	Introduce yourself to the patient and Confirm patient's ID.			
2.	Explain the procedure, reassure the patient and get patient's consent. Explain she may feel little discomfort and that the examination should be over fairly quickly.			
3.	The patient should be exposed from the waist down. Ask her to lie on her back, ankles together and to let her knees fall apart as much as possible. You should try to maintain some of her modesty by putting a cover over her. A chaperone is required for this examination.			
	Examination			
4.	Wash your hands, put on clean gloves and inspect the outside of the vagina. Check the labia and clitoris looking for any obvious abnormalities such as erosions.			
5.	Lubricate the index and middle finger of your right hand. Explain to the patient that you are about to start the procedure.			
6.	Use the thumb and index finger of your left hand to separate the labia majora and firstly insert your index finger, checking for any cervical excitation. If none is present, then insert your middle finger.			
7.	Palpate all of the vaginal walls as you advance your fingers feeling for any obvious abnormalities.			
8.	Slide your fingertips, palpate the cervix, feel for its size, shape and mobility – check with the patient if it is tender.			
9.	Bimanual pelvic examination: At this point palpate the uterus by pressing it between your right middle and index fingers and your left hand placed on the lower abdomen. Feel for any masses.			
10.	You should also try to palpate each of the ovaries. This is done by placing your internal fingers in the right fornix and trying to press the ovary between them and your left hand placed in the right iliac fossa. Do the same for the left ovary. Note any tenderness or masses which you may feel.			
11.	Once complete, remove your fingers, check your glove for any discharge or blood, and then discard your gloves in the clinical waste bin.			
12.	If needed or indicated perform a Vaginal Speculum Examination and collect sample for cytological and bacteriologic tests and for biopsies when indicted.			

13.	Offer the patient a tissue, cover her up and thank her. You should now report your findings to the examiner.			

***D**: Appropriately done **PD**: Partially done **ND**: Not done/Incorrectly done*

Taking a Pap Smear

OBJECTIVE: Cervical cytology or smear test is an intimate investigation to obtain cells from the cervix. It can be performed at any time (previously not within 10 days of period) however it is best if the women is not menstruating.

MATERIALS: Gloves , speculum, lubricant, a cervical brush, a pot of cytology preservative solution and a light source

***D**: Appropriately done **PD**: Partially done **ND**: Not done/Incorrect*

	STEP/TASK	D	PD	ND
	Preparation			
1.	Introduce yourself to the patient and Confirm patient's ID.			
2.	Explain the procedure, reassure the patient and get patient's consent. Explain she may feel little discomfort and that the examination should be over fairly quickly.			
3.	The patient should be exposed from the waist down. Ask her to lie on her back, ankles together and to let her knees fall apart as much as possible. You should try and maintain some of her modesty by putting a cover over her. A chaperone is required for this examination.			
	Examination			
4.	Wash your hands, put on some gloves and inspect the outside of the vagina. Check the labia and clitoris looking for any obvious abnormalities such as erosions			
5.	warm the blades of the speculum with warm water. The water also acts to lubricate the speculum but you may also like to apply some lubricant. Ensure the lubricant is not placed at the end of the speculum as this may alter the result.			
6.	Inform the patient that you are about to start the procedure. Use your left hand to part the labia minora and insert the speculum with the screw facing sideways.			
7.	As you advance the speculum, turn it so that the screw faces upwards. Open the blades and fix them open with the screw. Ensure that you can see well by adjusting the light source. Check for any gross pathology and identify the transition zone.			

➔ *Continues on the next page*

	STEP/TASK	D	PD	ND
	Examination			
8.	Place the tip of the cervical brush into the external cervical os and rotate it three times through 360 degrees ensuring that it is always in contact with the cervix.			
9.	Remove the brush ensuring it does not wipe against anything. Tap the brush 10 times on the edge of the pot of cytology medium.			
10.	Release the screw on the speculum and carefully remove it from the vagina, completing the examination.			
11.	Offer the patient some tissue, cover the patient, and thank her. You should explain to the patient that her smear results will be sent to them in approximately 6 weeks thus ensuring appropriate follow-up.			

Sources and References:

A. Books

1. Bates' guide to physical examination and history-taking

Lynn S.Bickley - Peter G.Szilagyi - Barbara Bates - Wolters Kluwer Health/Lippincott Williams & Wilkins – 2013

2. Clinical Examination: A Systematic Guide to Physical Diagnosis

Simon O'Connor - Nicholas Joseph.Talley - Elsevier – 2014

3. Current medical diagnosis & treatment

Stephen J.McPhee - Maxine A.Papadakis - McGraw-Hill Medical - 2012

B. Websites

1. OSCE Skills

http://www.osceskills.com/

King Saud University
College of Medicine
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Week 2: Examination of Male Genital System

OBJECTIVE: To correctly perform a complete examination of the male genital system and identify variations in normal anatomy as well as abnormal physical signs in relation to the aetiology of common conditions.

MATERIALS: Proper Light equipment**, clean gloves and lubricant, tissues for clean up.**

D: Appropriately done PD: Partially done ND: Not done/Incorrect

		D	PD	ND
	Preparation			
12.	Introduce yourself to the patient and confirm his ID.			
13.	Explain the procedure, reassure the patient and get his consent. Explain that he may feel little discomfort and that the examination should be over fairly quickly.			
14.	The patient should be exposed from the waist down.			
15.	The examination is easier to perform with the patient standing while you are seated in front of him. In this position, it is easier to examine the testes, evaluate for inguinal hernias and perform the rectal exam. However, if the patient is unable to stand, it can be performed while they lie on the exam table.			
	Examination			
16.	Wash your hands, put on clean gloves and observe for any bulges or scars in the inguinal region or any obvious skin abnormalities on the penis, scrotum or surrounding areas.			
17.	Examination of the Penis: Examine the glans (i.e. the head) of the penis. If the patient is uncircumcised, draw back the foreskin so that you can look at the glans in its entirety. Observe any superficial lesions and palpate any obvious lesions for induration and tenderness. Compress the glans anteroposteriorly between the thumb and forefinger to open and inspect the meatus and terminal urethra.			
18.	Examination of the Scrotum: The scrotum is examined by inspection and palpation. Transillumination is readily performed; it is most informative for examining the scrotal contents.			
19.	Examination of testes: Gently feel the testes, palpating the tissue between the thumb and next 2 fingers of your examining hand. Each should be of the same consistency and size. Examine for any discrete lumps or bumps within the body of the testis.			
20.	Examination of the Epididymis: Locate each epididymis by palpating the smooth testis to find a vertical ridge of soft nodular tissue beginning at the upper pole and extending to the lower pole. Usually the epididymis is behind the testis.			
21.	Examination of the Spermatic Cord: With the thumb in front and the forefinger behind the scrotum, gently compress the cord, then have the patient bear down to increase the intra abdominal pressure. The normal vas deferens is felt as a distinct hard cord, which can be separated from other cord structures. Compare the spermatic cords by simultaneously grasping each at the neck of the scrotum.			
22.	The hernial orifice examination should be performed on all male patients, regardless of whether you suspect any underlying abnormality. Before palpating this region, have the patient cough while you look at the inguinal region.			

23.	Rectal/Prostate Exams: This will be covered with the PR examination.			
	After the Procedure			
24.	Summarize your findings and offer a differential diagnosis if needed.			
25.	On completion of the examination, either clean the patient or provide tissue to the patient.			
26.	Cover the patient up. Thank him and ensure that he is comfortable.			

Sources and References:

A. Books

1. Bates' guide to physical examination and history-taking

Lynn S.Bickley - Peter G.Szilagyi - Barbara Bates - Wolters Kluwer Health/Lippincott Williams & Wilkins – 2013

2. Clinical Examination: A Systematic Guide to Physical Diagnosis

Simon O'Connor - Nicholas Joseph.Talley - Elsevier – 2014

3. Current medical diagnosis & treatment

Stephen J.McPhee - Maxine A.Papadakis - McGraw-Hill Medical - 2012

B. Websites

1. OSCE Skills

http://www.osceskills.com/

2. A Practical Guide to Clinical Medicine, University of California, San Diego

https://meded.ucsd.edu/clinicalmed/neuro2.htm

Week 3: Obstetric History Taking

King Saud University
College of Medicine
Department of Medical Education
Riyadh, KSA

Obstetric History Taking

OBJECTIVE: To take an ideal history related to obstetrics signs and symptoms.
MATERIALS: There will be standardized patent to take the history from her.

D: Appropriately done PD: Partially done ND: Not done/Incorrect

5.	STEP/TASK	D	PD	ND
1.	Introduce yourself to the patient and Confirm her ID			
2.	Gain consent and explain the need to take history.			
3.	Ensure the patient is comfortable			
4.	**Personal data**			
	Name, Age, Nationality, Occupation.			
5.	**Chief complaint**			
	Short statement of the problem that brought the patient, better recorded in the patient's own words.			
6.	**History of presenting illness.**			
	Use open questioning to elicit the patient's presenting complaint like 'what brought you here'.			
7.	For each complaint enquire about the following: **Onset** – when did the symptom start? / was the onset acute or gradual? **Duration –** minutes / hours / days / weeks / months / years **Severity –** e.g. if symptom is vaginal bleeding – how many sanitary pads are they using? **Course** – is the symptom worsening, improving, or continuing to fluctuate? **Intermittent or continuous? –** is the symptom always present or does it come and go? **Precipitating factors –** are there any obvious triggers for the symptom? **Relieving factors –** does anything appear to improve the symptoms **Associated features** – are there other symptoms that appear associated e.g. fever / malaise **Previous episodes –** has the patient experienced these symptoms previously?			
8.	**Pregnancy related questions**			
	Nausea / vomiting – if severe may suggest hyperemesis gravidarum **Abdominal pain** – may suggest the need for imaging **Vaginal bleeding** – fresh red blood / clots / tissue **Dysuria / urinary frequency** – urinary tract infection **Fatigue** – may suggest anaemia **Headache / visual changes / swelling** – pre-eclampsia **Systemic symptoms** – fever / malaise			
9.	**History of current pregnancy**			

	Is this the patient's first pregnancy? **Last menstrual period (LMP)** – first day of the LMP **Estimated date of delivery (EDD)** – estimated by scan or via dates (LMP + 9 months + 7 days) Did the patient take folic acid during the first trimester? Any other scans or tests whilst been pregnant? – dating scan / anomaly scan **Fetal movements** – usually experienced at around 18-20 weeks gestation **Labour pains** – more relevant in the third trimester **Planned method of delivery** – vaginal / c-section Medical illness during pregnancy – if so are they taking any medications?			
10.	**Past Obstetric history**			
	Gravidity – defined as the number of times a woman has been pregnant regardless of the outcome **Parity** – X = (any live or still birth after 24 weeks) | Y = (number lost before 24 weeks) Details of each pregnancy including the mode of delivery and any complications (**antenatal, intranatal or post natal**)			
11.	**Gynaecological History**			
	Previous cervical smears if done and results Previous gynecological problems & treatments – STDs / PID / Ectopic pregnancy Current or previous contraception Any Gynaecological surgery in the past.			
12.	**Past Medical History**			
	PE / DVT – high risk for further events in following pregnancy **Diabetes** – tight glycaemic control is essential – risk of congenital defects / macrosomia **Epilepsy** – some antiepileptics are teratogenic **Hypothyroidism** – need close monitoring **Previous pre-eclampsia**– higher risk to develop it in the current pregnancy Other relevant medical conditions			
13.	**Drug History**			
	Document all regular medications like iron, folic acid. Over the counter drugs – ensure nothing is unsafe / teratogenic			
14.	**Family and Social History**			
	Inherited genetic conditions – cystic fibrosis **Pregnancy loss** – recurrent miscarriages in mother & sisters **Pre-eclampsia** – in mother or sister – increased risk Enquire about Smoking, alcohol and Recreational drug use – All can affect the fetus adversely. Living situation Who lives with the patient? – important for care on discharge from hospital **Occupation**			

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https://meded.ucsd.edu/clinicalmed/neuro2.htm

Simulated Patient Case Script

Pregnancy

Your role in this session is to role-play a Pregnant patient .

Trigger

You have applied to your GP with a presenting symptom of fatigue described as "easily getting tired."
Wait for the Doctor's (student) questions, and answer them based on the provided list below.
(If you face any unexpected questions, try to skip that question with a suitable phrase like:
"I have not recognized" "I did not pay attention" "I don't know" and inform the faculty about that/those questions).
Please do not forget to add the gestures and mimics related to your scenario.

Personal and Social History: name, age, female, occupation – *Please use as your own*.
Married but living with parents. No tobacco use.

Possible questions and answers about your present complaint:

1- How long have you had these complaints? **For the last 2 weeks, its bothering me.**

2- When do you usually feel these symptoms? **Most of the day**

3- Do you have any additional symptoms? **I noted feeling nauseated in the morning since last week,**

It's not that much, maybe it will pass.

4- Does anything make it better or worse? **Taking a rest makes me feel better. But I don't think taking the day off to rest is a good idea.**

5- Have you noticed a weight loss or weight gain? **No. It has been the same for at least 5 years.**

6- Do you have fever? **No, I did not feel any fever.**

7- Do you have any bleeding from your body parts recently? **No.**

8- Have you applied to a doctor with these symptoms? **No, it's my first time.**

9- Do you fell like having colds or sore throat? **No.**

10- Are you on any medication? **No.**

11- How is your diet like? **These past days I feel like choosy, maybe I'm just moody.**

12- **When was your last menstruation? When do you expect it? I was expecting it last week,**

This is the first time I'm delayed this long.

Past medical history: Nothing specific, No important disease history, No operation, No current medication, No allergy.
Family history: Parents are healthy and alive, no major history of disease.

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Week 4: Breast Examination

OBJECTIVE: To properly conduct a breast examination.

MATERIALS: Gloves, Swabs and Cytology slides.

D: Appropriately done PD: Partially done ND: Not done/Incorrect

	STEP/TASK	D	PD	ND
	Preparation			
27.	Introduce yourself to the patient and confirm her identity			
28.	Explain the procedure to the patient and get her consent.			
29.	The patient should be exposed from the waist up. Hand her a drape/blanket to protect her modesty.			
30.	Ask her to sit on the edge of the couch and ensure that she is comfortable.			
	Procedure			
	General inspection			
31.	From a distance, observe the patient's general appearance, state of general health, obvious signs that can be apparent on inspection.			
	Local Examination			
	Inspection			
32.	Position the patient to sit upright with her chest fully exposed.			
33.	Make a general inspection of both breasts.			
34.	Look at the nipples for: • Retraction, Redness or Bleeding around the area. • Any visible discharge.			
35.	Look at the skin for: • Any visible veins, skin dimpling, peau d' orange. • Ask the patient to lift up both her breasts to inspect the area hidden under the mammary folds.			
36.	Ask the patient to raise her arms above her head and lower slowly to look for: • Tethering of the nipples or skin, Shift in position of the nipples or a fixed mass distorting the shape of the breast. • Look for any apparent masses in the Axilla.			
37.	Ask the patient to rest her hands on her hips and press her hands against her hips. Check for: Any Dimpling or Fixation			
	Palpation of the Breast			
38.	Examine each breast individually.			
39.	Ask the patient to lie down. If the breasts are large you may ask the patient to place her hand on her forehead when you are examining the lateral side and bring her elbow to level with her shoulder when examining the medial side.			
40.	Ensure that there is no chest/breast pain.			
41.	Gently and using the pulp of your 3 middle fingers: • Start with the normal breast if there is some suspicion of abnormality on the othere side. • Palpate each quadrant 3 times with increasing pressure towards the chest wall using an even rotary movement.			
42.	Check the concentric trail.			
43.	If a mass is found, assess for: • Position (in terms of quadrant and proximity to the nipples), Size, Shape, and Consistency, Tenderness, Fixation to the skin.			
	Palpation of the Nipple			
44.	Hold the Nipple between the thumb and the forefinger and gently compress it to express any discharge. Alternatively, you can ask the patient to express any discharge she might have.			

45.	Any fluid discharged should be Swabbed for Microbiology Investigations and Smeared for Cytology.			
46.	Feel the area behind the Nipples for any Lumps.			
	Palpation of the Axillae			
47.	Ask the patient to sit up at the side of the bed Make sure she is comfortable, explain to her how you are going to examine her axillae and why			
48.	Hold the left hand arm of the patient with your left hand asking the patient to relax at the shoulder and let her arm rest on yours			
49.	Palpate the left axilla with your right hand, feeling for any masses with the tip of the fingers in a rolling motion all around. Repeat with the other hand on the other side in the same way			
50.	End the examination with palpation of the supraclavicular fossa with behind asking the patient to hunch her shoulders up and relax the neck muscles.			
	After the Examination			
51.	Cover up the patient and thank her.			
52.	Answer her queries and make sure she is comfortable			
53.	Document the examination.			
54.	Wash hands.			

Sources and References:

A. Books

1. Bates' guide to physical examination and history-taking

Lynn S.Bickley - Peter G.Szilagyi - Barbara Bates - Wolters Kluwer Health/Lippincott Williams & Wilkins – 2013

2. Clinical Examination: A Systematic Guide to Physical Diagnosis

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B. Websites

1. OSCE Skills

http://www.osceskills.com/

Student's Guidelines of CSL

- All students are required to wear their school uniforms, all white or scrub suits plus white coat.

- All students are expected to read about the topic basics before coming to the session so as to be able to comprehend the steps of the skills or the procedure.
- The students are expected to come to the sessions regularly and on time. Students late by more than 10 minutes will not be allowed to join so as not to disturb the ongoing session
- No student will be allowed to leave the session in between and before time
- The students are expected to keep their mobile phones on silent mode while in the session.
- The students are required to sign the attendance sheets posted on their respective rooms, in addition to their log books.
- All the students should carry their log books during the sessions and get it signed by the assigned tutor after the session. In case any student forgets to bring his log book along, he should request the assigned tutor to record his name and year until he gets the log book for the signature the next day.
- All students are expected to practice the skills on an individual basis. For some sessions where individual practice is not feasible due to time and other constraints, groups of students should be asked to perform the skill in a collective manner.
- At the end of each session the tutor should make sure that the student is able to do all the steps correctly, observe him while practicing and assess his performance where necessary.

Clinical skills schedule

Sunday	Monday	Tuesday	Wednesday	Thursday

8:00 - 10:00am	8:00 - 10:00am	8:00 - 10:00 am Clinical skills YEAR 2 Group A	8:00 - 10:00 am Clinical skills YEAR 2 Females	8:00 - 10:00 am
10-12 am	10-12 am	10 - 12am	10-12am	10:00 - 12:00 am
Lunch 12:00 – 1:00pm	Lunch 12:00 – 1:00pm	Lunch 12:00 – 1:00pm	Lunch 12:00 – 1:00pm	Lunch 12:00 – 1:00pm
1:00-3:00 pm	1:00-3:00 pm	1:00-3:00 pm	1:00-3:00 pm Clinical skills YEAR 2 Group B	1:00-3:00 pm