PORTFOLIO PATHWAY & SPECIALIST REGISTRATION | MODULE 05

Clinical scope, breadth, currency and competence

Demonstrate the required range and level of current practice through proportionate, assessed evidence rather than activity volume alone.

- ✓ 18 min reading
- ✓ Full teaching, practical next steps and reflection
- ✓ Six practice questions with answers and explanations
- ✓ Complete source list and jurisdiction notes

Prepared for SAS, locally employed and other UK doctors

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Using this module

Independent education

This is general professional information, not individual clinical, legal, employment, immigration, regulatory, tax or pensions advice. Current official instructions and the circumstances of the individual case remain controlling. Practice scores do not establish professional competence or accreditation.

The short answer

Clinical evidence must show what the doctor can do, at what level, across the required scope, how recently and with what outcome. Logbooks and activity lists establish exposure, but competence needs assessment and triangulation. Older experience can remain relevant when current evidence shows the capability has been maintained.

Three next actions

- Create a scope table covering settings, acuity, age or patient groups, procedures, on-call and emergency work required by the specialty.
- For each area, pair activity data with direct assessment, outcomes or supervisor evidence.
- Flag older or narrow evidence and design current sampling that demonstrates maintenance and breadth.

Learning objectives

- Distinguish exposure, volume, competence and outcome.
- Apply the GMC approach to evidence currency.
- Build a representative and proportionate clinical evidence sample.

Define scope before counting volume

Start with the specialty's required scope: clinical environments, presentations, complexity, emergencies, procedures, longitudinal care, multidisciplinary practice and decisions expected at completion of training. A large logbook from one narrow area may still leave major curriculum gaps.

Describe the applicant's actual responsibility: independent decision, supervised performance, advice given, escalation and outcome. Avoid inflating autonomy or using local titles as a proxy for level.

- Map required breadth first.
- State responsibility accurately.
- Explain context and supervision.

Four layers of clinical evidence

Activity records show that work occurred. Workplace-based assessments show observed performance. Outcomes, audit or feedback show aspects of effectiveness. Supervisor reports synthesise performance over time. Strong portfolios use these layers together and acknowledge their limitations.

Select methods appropriate to the capability: case-based discussion for reasoning, direct observation for procedure or encounter, multisource feedback for behaviours, longitudinal report for sustained performance, and objective data where valid. No single method is perfect.

- Triangulate activity, observation and outcome.
- Match method to claim.
- Use more than one context or assessor where possible.

Show mature autonomy, including escalation

Autonomy is not working without help. It is making appropriate decisions within scope, recognising uncertainty, seeking assistance at the right time and taking responsibility for follow-through. Evidence can include directly observed decisions, complex case discussions, referral quality, leadership during deterioration and supervisor reports.

Record the limits of authority and local system. An applicant should not perform beyond competence merely to create evidence. Planned supervision is a strength when it enables safe development.

- Show decisions and thresholds.
- Include appropriate escalation.
- Never manufacture independence.

Use the GMC currency policy correctly

The GMC policy states that evidence will normally relate to the most recent five years of practice, but this is not simply five calendar years immediately before application. Older evidence may be considered when current evidence demonstrates that the capability has been maintained. Some specialties may justify more recent evidence for particular skills.

A personal break does not need to be justified through unnecessary private disclosure. The evidential question is whether current knowledge, skills and experience are demonstrated. Use current practice, assessment, CPD and outcome evidence to show maintenance after a gap.

- Prioritise recent practice.
- Link older evidence to current maintenance.
- Protect unnecessary personal information.

Use representative sampling

The aim is not to upload every case. Select evidence that represents the required range, level and contexts, with a clear sampling rationale. Use summaries and indexes to show the wider denominator where appropriate, then provide assessable examples.

Avoid cherry-picking only perfect outcomes. Mature evidence may include complications, uncertainty or improvement when it demonstrates judgement, learning and safer practice. Patient identifiers must be removed and local information-governance rules followed.

- Explain the sample and denominator.
- Include learning as well as success.
- Anonymise before portfolio storage.

Close breadth gaps safely

Where the current post lacks a required area, seek a supervised attachment, revised duties, cross-site sessions, simulation where accepted, formal assessment or a future post. State the exact outcome to be gained and how it will be evidenced.

Do not rely on a past post if the capability is no longer current. The plan may need months of sustained practice rather than a brief observational visit. Ask the specialty adviser what level and duration are likely to be meaningful.

- Gain practice, not just observation.
- Use appropriate supervision.
- Confirm specialty expectations.

Common mistake

Avoid this	Confusing the number of cases with competence can produce a large portfolio that never shows the level, quality, breadth or currency of the work.

Pause and reflect

Which clinical claim in your map currently rests on activity volume without an independent assessment of performance?

Takeaways

- Define required scope before measuring volume.
- Triangulate activity, observed performance and outcomes.
- Older evidence needs a current maintenance bridge, not automatic exclusion or automatic acceptance.

Knowledge check

Choose one best answer. These practice questions support reflection; they do not assess a real case or confer accreditation. Answer positions match the browser edition.

1. A logbook contains 2,000 cases from one clinic but the curriculum requires acute and inpatient practice. What does the logbook show?

A. Evidence of independent breadth without needing context about supervision or case mix

B. No need for assessments

C. Complete equivalence

D. High exposure in one area, with breadth gaps still to address

2. Which evidence most directly strengthens a procedure log?

A. A generic course certificate

B. An unsigned personal statement

C. Contemporaneous direct observation and outcome or complication review

D. A job title

3. Which example best demonstrates autonomy?

A. Being alone on a rota

B. A complex decision with justified escalation and accountable follow-through

C. Working independently without explicitly defining escalation limits

D. Working beyond competence

4. Can evidence older than five years ever be relevant?

A. Only if a manager signs every page

B. Only for teaching

C. Exclude it solely because of age without checking the specialty guidance or maintenance of capability

D. Yes, particularly when current evidence demonstrates maintenance and specialty guidance permits it

5. Why include an appropriately handled complication?

A. It replaces all routine evidence

B. It should include patient identifiers

C. Remove it because evidence should contain only uncomplicated favourable outcomes

D. It can demonstrate judgement, candour, learning and improvement

6. A required emergency capability has not been practised for eight years. What is the strongest response?

A. Upload the old rota only

B. Arrange current supervised practice and assessment appropriate to the specialty

C. Ask a referee to say it is probably retained

D. Rely on the historic emergency experience without arranging a current capability review

Answers and explanations

1. D — High exposure in one area, with breadth gaps still to address

High exposure in one area, with breadth gaps still to address This follows the principle explained in “Define scope before counting volume”.

Re-read “Define scope before counting volume” and write down the evidence or decision you would need before acting.

2. C — Contemporaneous direct observation and outcome or complication review

Contemporaneous direct observation and outcome or complication review This follows the principle explained in “Four layers of clinical evidence”.

Re-read “Four layers of clinical evidence” and write down the evidence or decision you would need before acting.

3. B — A complex decision with justified escalation and accountable follow-through

A complex decision with justified escalation and accountable follow-through This follows the principle explained in “Show mature autonomy, including escalation”.

Re-read “Show mature autonomy, including escalation” and write down the evidence or decision you would need before acting.

4. D — Yes, particularly when current evidence demonstrates maintenance and specialty guidance permits it

Yes, particularly when current evidence demonstrates maintenance and specialty guidance permits it This follows the principle explained in “Use the GMC currency policy correctly”.

Re-read “Use the GMC currency policy correctly” and write down the evidence or decision you would need before acting.

5. D — It can demonstrate judgement, candour, learning and improvement

It can demonstrate judgement, candour, learning and improvement This follows the principle explained in “Use representative sampling”.

Re-read “Use representative sampling” and write down the evidence or decision you would need before acting.

6. B — Arrange current supervised practice and assessment appropriate to the specialty

Arrange current supervised practice and assessment appropriate to the specialty This follows the principle explained in “Close breadth gaps safely”.

Re-read “Close breadth gaps safely” and write down the evidence or decision you would need before acting.

Official and professional sources

Confirm the current source version and applicable nation, contract, scheme or specialty. A source list is not a statement that every rule applies to every reader.

GMC: specialist/GP registration overview and application route finder
UK · https://www.gmc-uk.org/registration-and-licensing/join-our-registers/applying-for-specialist-or-gp-registration

GMC: Information for Responsible Officers and supporters
UK · https://www.gmc-uk.org/cdn/documents/portfolio-pathway-applications---information-for-responsible-officers---dc21350_pdf-104695809.pdf

GMC policy on currency of evidence
UK · https://www.gmc-uk.org/cdn/documents/policy---sat---portfolio-pathway---policy-on-currency-of-evidence---dc21067_pdf-105651378.pdf

Scotland Deanery: Portfolio Pathway for SAS grades
Scotland · https://www.scotlanddeanery.nhs.scot/your-development/specialist-and-associate-specialist-doctors-and-dentists/portfolio-pathway-for-sas-grades-formerly-cesr/

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