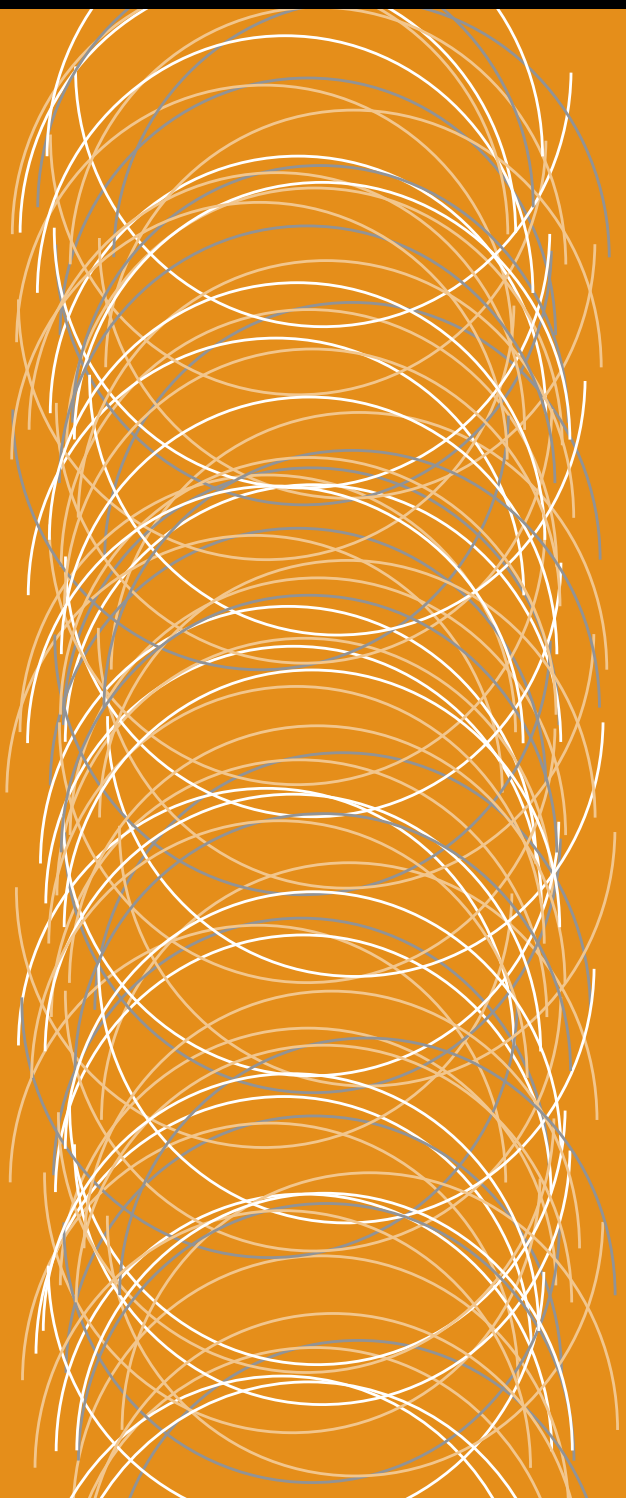
Australian Medical Council Limited

Accreditation of Bond University Faculty of Health Sciences and Medicine

AMC



Medical School Accreditation Committee
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Australian Medical Council Limited
PO Box 4810
KINGSTON ACT 2604

Email: amc@amc.org.au
Home page: www.amc.org.au
Telephone: 02 6270 9777
Facsimile: 02 6270 9799

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Acknowledgement of Country

The Australian Medical Council (AMC) acknowledges the Aboriginal and Torres Strait Islander Peoples as the original Australians, and the Māori People as the original Peoples of New Zealand.

We acknowledge and pay our respects to the Traditional Custodians of all the lands on which we live, and their ongoing connection to the land, water and sky.

We recognise the Elders of all these Nations both past, present and emerging, and honour them as the traditional custodians of knowledge for these lands.

Executive summary

Accreditation process

The Bond University, Faculty of Health Sciences and Medicine offers Bachelor of Medical Studies/Doctor of Medicine (BMedSt/MD) of four years and eight months, which has accreditation to 31 March 2022. The program meets the accreditation standards and there are no remaining conditions on its accreditation.

The Faculty is due to submit a comprehensive report for extension of the accreditation of the medical program to the AMC in October 2021.

In April 2020, as part of the changes made to medical programs as a result of the COVID-19 pandemic, the AMC received a notification of change form from the Faculty outlining plans to offer a second cohort intake in September 2020. The Medical School Accreditation Committee (the Committee) determined that this change did not constitute a material change on the understanding that it was a one-off intake responding to circumstances arising from COVID-19.

In September 2020, the Faculty submitted a revised proposal indicating that it wished to establish a routine second cohort intake in September of each year.

The Committee considered the revised proposal and:

- identified concerns that there were no explicit agreements in place with local health services to ensure that an adequate number of intern places will be available for those students who will start in September and finish mid-year
- considered that, for this change to be applied beyond the short term, the AMC would require greater confidence that the program will articulate with opportunities for internship. Standard 3.3 of the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012* states that the curriculum must articulate with subsequent stages of training, and on the evidence provided, the sub-group felt that this could not be assured for the whole of the proposed cohort.

The Faculty was invited to provide a submission for consideration by the Committee under Section 3.2.2 of the *AMC Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2019* (material change).

The Committee reviewed the submission against each of the Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012 (the accreditation standards) at its 29 March 2021 meeting and decided on the process for assessment of the changes. It agreed that the material changes to the medical program did not require a complete accreditation assessment of the program. The Committee agreed to appoint an AMC assessment team to assess the standards particularly relevant to the change proposals in order that the Committee could make an informed recommendation to AMC Directors on implications of the proposals on the medical program's ability to continue to meet the accreditation standards.

Decision on accreditation

Under the *Health Practitioner Regulation National Law*, the AMC may grant accreditation if it is reasonably satisfied that a program of study, and the education provider that provides it, meet the approved accreditation standards. It may also grant accreditation if it is reasonably satisfied that the provider, and the program of study, substantially meet the approved accreditation standards and the imposition of conditions will ensure the program meets the standards within a reasonable time.

Having made a decision, the AMC reports its accreditation decision to the Medical Board of Australia to enable the Board to make a decision on the approval of the program of study for registration purposes.

The Medical School Accreditation Committee considers the team's report and decides on the final report and recommendations for accreditation. The Committee presents its recommendations to AMC Directors who make the decision about the medical program's accreditation.

This report presents the Committee's findings against the particular *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012* that the Committee identified as relevant to the proposed change The analysis against the standards is presented in the key themes directed by the Medical School Accreditation Committee; the student experience of the medical program, clinical environment capacity and articulation with later stages of training. Each section begins with the relevant AMC accreditation standards, where a new assessment against the standards was necessary.

The AMC is satisfied that the medical program of the Bond University, Faculty of Health Sciences and Medicine substantially meets the approved accreditation standards.

AMC Directors at their 28 July 2021 meeting agreed:

(i) that the five-year Bachelor of Medical Studies/Doctor of Medicine (BMedSt/MD) of the Bond University, Faculty of Health Sciences & Medicine has its accreditation confirmed to 31 March 2022;

(ii) that accreditation of the program is subject to meeting the monitoring requirements of the AMC, including; satisfactory progress reports, and the following new conditions:

	Note that the number continues from conditions set in the 2015 accreditation assessment
11	Establish the full complement of staff necessary to support the expanded program (at the time of proposal this included four additional academic and two additional professional posts). (Standard 1.8.3)
12	Demonstrate comparable experiences through reporting analysis of May and September cohorts' evaluation feedback, and any actions planned or taken to investigate and address any identified disparities. (Standards 2.2.3 and 6.1)
13	Demonstrate comparable outcomes through reporting analysis of May and September cohorts' performance in assessment to demonstrate comparable outcomes and any actions planned or taken to investigate and address any identified disparities. (Standards 2.2.3 and 6.2)
14	Work with health services and intern training accreditation authorities to confirm the number and the detail of arrangements for appropriately supported mid-cycle intern training places available for the September 2020 cohort who are due to graduate in April 2025 and subsequent cohorts. (Standard 3.3)

15	Work with health services and intern training accreditation authorities to put arrangements in place to ensure that graduates are competent to practise safely and effectively under supervision as interns in Australia or New Zealand if mid-cycle internship places are insufficient to accommodate the number of students who are expected to graduate mid-cycle and progress to internship in Australia and New Zealand. (Standards 2.2.2 and 3.3)
16	Demonstrate that there are clear selection policies that can be implemented and sustained in practice and that are consistently applied through reporting on the implementation of and learning from the selection and allocation processes. Analysis should include how many applicants preferred the May and September intakes, the number of applicants offered a non-preferred intake and the percentage of those applicants who took up places in their preferred and non-preferred intake. (Standard 7.2.1)
17	Demonstrate engagement with students across May and September cohorts in the governance of the program, including in the oversight and decision-making related to the implementation of the September intake. (Standard 7.5.1)
18	Demonstrate that adequate facilities are being secured for all-cohort teaching sessions and the increasing numbers of small-group sessions as each year of the September 2020 cohort is implemented. (Standard 8.1)
19	Provide an annual progress report on developments in securing new placement sites, with evidence of completed Deeds or other Agreements, demonstrating that the number of placements and range of placements ensure that all students in the expanding student body have clinical experiences in a range of models of care across metropolitan and rural health care settings. (Standard 8.3.2)
20	Demonstrate that all students in the expanding student body have experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples. (Standard 8.3.3)
21	Demonstrate recruitment and training of adequate additional clinical supervisors with allocated time and specified responsibilities to support the expanded student numbers in clinical placements from Phase 2 of the program. (Standard 8.4)

Key findings

Under the *Health Practitioner Regulation National Law* (the National Law), the AMC can accredit a program of study if it is reasonably satisfied that: (a) the program of study, and the education provider that provides the program of study, meet the accreditation standard; or (b) the program of study, and the education provider that provides the program of study, substantially meet the accreditation standard and the imposition of conditions will ensure the program meets the standard within a reasonable time.

The AMC uses the terminology of the National Law (met/substantially met) in making decisions about accreditation of programs.

Conditions: Providers must satisfy conditions on accreditation in order to meet the relevant accreditation standard.

Recommendations are quality improvement suggestions for the education provider to consider, and are not conditions on accreditation. The education provider must advise the AMC on its response to the suggestions.

1. The context of the medical program	**Substantially Met**

Standard 1.6 is substantially met

Condition

To be met by 2022

11 Establish the full complement of staff necessary to support the expanded program (at the time of proposal this included four additional academic and two additional professional posts). (Standard 1.8.3)

Recommendations

G The Faculty engages in more detailed discussions with other Queensland medical schools so that they are fully aware of how the planned increase in student numbers will affect clinical placements, so that a collaborative approach can be taken to ensure that students at all Queensland medical schools have an appropriate balance of hospital, general practice and community health services as well as experience of health services in metropolitan and regional or rural settings. (Standards 1.6.2 and 8.3.4)

Commendations

The dedicated resources and strong governance at faculty and university level to support the change management associated with the proposal. (Standard 1.8.2)

2. The outcomes of the medical program	Substantially Met

Standard 2.2 is substantially met

Conditions

To be met by 2025 (annual progress updates)

12 Demonstrate comparable experiences through reporting analysis of May and September cohorts' evaluation feedback, and any actions planned or taken to investigate and address any identified disparities. (Standards 2.2.3 and 6.1)

13 Demonstrate comparable outcomes through reporting analysis of May and September cohorts' performance in assessment to demonstrate comparable outcomes and any actions planned or taken to investigate and address any identified disparities. (Standards 2.2.3 and 6.2)

Recommendations

H Share cohort-based analysis of assessment performance (including any supportive action to address disparities), with students to respond to their concerns about maintaining the quality of the expanded student pool. (Standard 2.2.3)

Commendations

The detailed and careful analysis conducted by curriculum leads in designing the pathway for the September intake to ensure that both intakes have comparable learning experiences.

3. The medical curriculum	Substantially Met

Standard 3.3 is substantially met

Conditions

To be met by the end of 2024

14 Work with health services and intern training accreditation authorities to confirm the number and the detail of arrangements for appropriately supported mid-cycle intern training places available for the September 2020 cohort who are due to graduate in April 2025 and subsequent cohorts. (Standard 3.3)

15 Work with health services and intern training accreditation authorities to put arrangements in place to ensure that graduates are competent to practise safely and effectively under supervision as interns in Australia or New Zealand if mid-cycle internship places are insufficient to accommodate the number of students who are expected to graduate mid-cycle and progress to internship in Australia and New Zealand. (Standards 2.2.2 and 3.3)

4. Teaching and learning	**Met**

The Committee was satisfied that the teaching and learning approaches remain the same for both cohorts, as in the existing accredited program.

5. The curriculum – assessment of student learning	**Met**

The Committee was satisfied that the assessment program, formats and approaches remain the same for both cohorts, as in the existing accredited program.

6. The curriculum – monitoring	**Met**

Conditions – nil additional conditions

Condition 7 from the 2015 accreditation report remains open.

7 Develop and implement a comprehensive evaluation and monitoring framework which addresses key elements of program delivery and provide evidence of a reporting schedule which prioritises key areas to be evaluated. (Standard 6.1)

Recommendations

I Work with student representatives on the 'quick response' monitoring mechanisms to ensure that May cohorts feel there are equal opportunities to share learning and raise concerns from their perspective. (Standard 6.1.1)

7. Implementing the curriculum – students	**Substantially Met**

Standard 7.5 is substantially met

Conditions

To be met by the end of 2023

16 Demonstrate that there are clear selection policies that can be implemented and sustained in practice and that are consistently applied through reporting on the implementation of and learning from the selection and allocation processes. Analysis should include how many applicants preferred the May and September intakes, the number of applicants offered a non-preferred intake and the percentage of those applicants who took up places in their preferred and non-preferred intake. (Standard 7.2.1)

To be met by 2022

17 Demonstrate engagement with students across May and September cohorts in the governance of the program, including in the oversight and decision-making related to the implementation of the September intake. (Standard 7.5.1)

Recommendations

J Work with students to identify appropriate communication channels for engagement with the wider student body on the implementation of the September intake. (Standard 7.5.1)

Commendations

The Faculty is commended on staffing allocated to student support across the program and the continued support of the Learning Coach initiative. (Standard 7.3.2)

8. Implementing the curriculum – learning environment	**Substantially Met**

Standards 8.1, 8.3 and 8.4 are substantially met

Conditions

To be met by 2025 (annual progress updates)

18 Demonstrate that adequate facilities are being secured for all-cohort teaching sessions and the increasing numbers of small-group sessions as each year of the September 2020 cohort is implemented. (Standard 8.1)

19 Provide an annual progress report on developments in securing new placement sites, with evidence of completed Deeds or other Agreements, demonstrating that the number of placements and range of placements ensure that all students in the expanding student body have clinical experiences in a range of models of care across metropolitan and rural health care settings. (Standard 8.3.2)

20 Demonstrate that all students in the expanding student body have experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples. (Standard 8.3.3)

To be met by the end of 2023 (annual progress updates)

21 Demonstrate recruitment and training of adequate additional clinical supervisors with allocated time and specified responsibilities to support the expanded student numbers in clinical placements from Phase 2 of the program. (Standard 8.4)

Recommendations

K Prioritise the confirmation of agreements for additional clinical placements in regional and rural settings in Queensland. (Standard 8.3.2)

Introduction

The AMC accreditation process

The AMC is a national standards body for medical education and training. Its principal functions include assessing Australian and New Zealand medical education providers and their programs of study, and granting accreditation to those that meet the approved accreditation standards.

The purpose of AMC accreditation is to recognise medical programs that produce graduates competent to practise safely and effectively under supervision as interns in Australia and New Zealand, with an appropriate foundation for lifelong learning and further training in any branch of medicine.

The *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012* list the graduate outcomes that collectively provide the requirements that students must demonstrate at graduation, define the curriculum in broad outline, and define the educational framework, institutional processes, settings and resources necessary for successful medical education.

The AMC's Medical School Accreditation Committee (the Committee) oversees the AMC process of assessment and accreditation of primary medical education programs and their providers, and reports to AMC Directors. The Committee includes members nominated by the Australian Medical Students' Association, the Confederation of Postgraduate Medical Education Councils, the Committee of Presidents of Medical Colleges, the Medical Council of New Zealand, the Medical Board of Australia, and the Medical Deans of Australia and New Zealand. The Committee also includes a member of the Council, a member with background in and knowledge of health consumer issues, a Māori person and an Australian Aboriginal or Torres Strait Islander person.

The AMC appoints an accreditation assessment team to complete an accreditation assessment. The medical education provider's accreditation submission forms the basis of the assessment. The medical student society is also invited to make a submission. Following a review of the submissions, the team conducts a visit to the medical education provider and its clinical teaching sites. Following the visit, the team prepares a detailed report for the Committee. The Committee considers the team's report and then submits the report, amended as necessary, together with a recommendation on accreditation to the AMC Directors. The provider is invited to comment on the report at both stages. The Directors make the final accreditation decision within the options described in the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2019*. The granting of accreditation may be subject to conditions, such as a requirement for follow-up assessments.

The AMC and the Medical Council of New Zealand have a memorandum of understanding that encompasses the joint work between them, including the assessment of medical programs in Australia and New Zealand, to assure the Medical Board of Australia and the Medical Council of New Zealand that a medical school's program of study satisfies approved standards for primary medical education and for admission to practise in Australia and New Zealand.

After it has accredited a medical program, the AMC seeks regular progress reports to monitor that the provider and its program continue to meet the standards. Accredited medical education providers are required to report any developments relevant to the accreditation standards and to address any conditions on their accreditation and recommendations for improvement made by the AMC. Reports are reviewed by an independent reviewer and by the Committee.

Changes to accredited medical programs

Section 3.2 of the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2019* outlines the process for the assessment of new developments.

When it considers the initial advice from an accredited education provider about planned changes, either through a specific notice of intent or through progress reports, the Committee will decide if it is a material change. If it is, the Committee will also decide whether the material change can be assessed for approval within the current accreditation of the program or is of comprehensive impact that would require reaccreditation of the whole program.

Definition of a material change:

Any of the following might constitute a material change in an accredited program or education provider as a change in the length or format of the program, including the introduction of new distinct streams; a significant change in educational outcomes; a substantial change in educational philosophy, emphasis or institutional setting; and/or a substantial change in student numbers relative to resources. Significant changes resulting from a major reduction in resources leading to an inability to achieve the purpose and/or outcomes of the program are also material changes. While the gradual evolution of a medical program in response to initiatives and review would not be considered a material change, the AMC may regard a number of minor changes in the areas listed as collectively constituting a material change.

Note: In deciding to grant accreditation, the AMC makes a judgment about the adequacy and appropriateness of the total resources available to support the program. For this reason, whilst it does not accredit programs for a specific student intake, the AMC would regard a substantial change in student numbers relative to resources as a major course change. The AMC expects accredited education providers will report on any planned or proposed increase in student intake in progress reports.

If the AMC decides to assess the change within the program's current period of accreditation the education provider will be required to provide a submission outlining the change, transitional arrangements for existing students if appropriate, the resources including clinical teaching resources available to deliver the program and evidence of engagement of stakeholders. The Committee will consider this submission and may seek further information from the provider and/or appoint an AMC accreditation team to undertake an assessment before making a recommendation to the AMC Directors on accreditation of the program including any specific monitoring requirements.

Accreditation Background - Bond University, Faculty of Health Sciences and Medicine

The key accreditation events for Bond University, Faculty of Health Sciences and Medicine are summarised in the table below.

Year	Assessment Type	Outcome/Notes
2004	Accreditation	Granted accreditation to 31 December 2011 (MBBS).
2006	Follow-up assessment	Confirmed the 2004 accreditation decision (MBBS).
2007	Follow-up assessment	Confirmed the 2004 accreditation decision (MBBS).
2008	Follow-up assessment	The AMC reduced the period of accreditation to 31 December 2009, subject to conditions and a follow up assessment in 2009 (MBBS).
2009	Follow up assessment	The AMC reinstated the Faculty's accreditation to 31 December 2011 (MBBS).
2011	Comprehensive report for extension of accreditation	Extension of accreditation granted for four years to 31 December 2015 (MBBS).
2015	Determination of material change – Transition to MD	The AMC determined that the planned transition from the MBBS to MD did not constitute a material change, but would be assessed in conjunction with the 2015 reaccreditation assessment.
2015	Re-accreditation	Granted accreditation for six years to 31 March 2022 (BMedSt/MD & MBBS).
2016	Report on conditions	Accepted.
2017	Report on conditions	Accepted.
2018	Progress report	Accepted.
2018	MBBS Concluded	MBBS program concluded.
2019	Progress report	Accepted (moved to biennial reporting).

2020	COVID-19 Notification of Change Form	Accepted (a second cohort of 60 students in September comprising students unable to start in May and approximately 40 new students as a 'one off' arrangement).
2021	Determination of material change – second cohort	Current assessment.
2021	Comprehensive report for extension of accreditation	Submission due October 2021.

The Faculty provided a material change submission on 1 March 2021 noting that it wished to make offers in mid-April for an intake in September 2021.

The Committee considered the submission at its 29 March 2021 meeting and determined that the changes to the medical program could be approved for introduction within the current accreditation of the program subject to further assessment of the proposed changes by an AMC assessment team. A comprehensive report for extension of the program's accreditation is due in 2021 and, due to the need for Bond to make a decision on the September 2021 intake, the AMC agreed with the Faculty for the further, focused assessment of the proposal to take place as soon as possible and for the Faculty to submit its Comprehensive Report in October 2021, taking into account the outcome of the assessment of the proposals.

In directing the areas of focus for the further assessment, the Committee considered the proposal for an additional annual intake of 60 students in September (resulting in an overall increase in 40 students per year) against all of the accreditation standards. It noted that many aspects of the accredited program remained unchanged, including the governance structures, program outcomes, curriculum content, teaching and learning methods, and monitoring mechanisms. The Committee therefore indicated that the scope of the assessment would focus on standards related to three key areas; how the Faculty will support a comparable education experience for the planned intake; the health services' capacity to support additional clinical placements; and the program's ability to articulate with subsequent stages of training (principally medical internship training).

An AMC team completed the material change assessment. It reviewed the Faculty's submission, the further information requested by the Committee and the student report. It conducted a virtual visit on Tuesday 15 June and Wednesday 16 June 2021 with students of both May and September intakes, academic and clinical teachers, student support staff, University and Faculty leaders, health service representatives, Department of Health Queensland representatives (including those with responsibilities for Prevocational Medical Accreditation Queensland) and the Health Education and Training Institute (the intern training accreditation authority in New South Wales).

This report

This report details the findings of the 2021 AMC team's material change assessment of the Bond University Faculty of Health Sciences and Medicine's (the Faculty) proposal to teach the full medical program for a continued September intake of 60 students per annum. Full details of the medical program accreditation can be found in the *Bond University Report*.

In undertaking the assessment, the AMC team reviewed documentation provided by the Faculty against of the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012* and confirmed that the governing arrangements, policies procedures, teaching and learning methods, assessment methods and approaches to the learning environment are the same as for the accredited medical program. This report therefore refers to the 'May cohort' and the 'September cohort' to denote the two different entry points to the same accredited medical program.

The accreditation report is divided into four sections, the first outlining the context and investment in the change, and the subsequent three sections corresponding to the three areas of focus directed by the Medical School Accreditation Committee, the student experience of the medical program, clinical environment capacity and articulation with later stages of training. Each section begins with the relevant AMC accreditation standards, where a new assessment against the standards was necessary.

The members of the 2021 AMC team are listed at **Appendix One**.

The groups met by the AMC team in 2021 via videoconference are at **Appendix Two**.

Appreciation

The AMC thanks the Faculty for the detailed planning and the comprehensive material provided for the team. The AMC acknowledges and thanks the staff, clinicians, students and others who met members of the team for their hospitality, cooperation and assistance during the assessment process.

The University and the Faculty

Bond University is a private, not-for-profit university, established in 1989 with its main campus in the Gold Coast, Queensland. The University is organised into four faculties; Business, Health Sciences & Medicine, Law, and Society & Design.

Currently, the University student profile consists of 36% from South East Queensland, 18% from the rest of Australia and 46% internationally. The enrolment for Health Sciences & Medicine is one-quarter of total enrolment by discipline.

The Bond University medical program sits within the Faculty of Health Sciences and Medicine (the Faculty). The academic year is organised into three-semesters.

The Faculty is led by an Executive Dean, and is composed of seven disciplines and related research centres:

Disciplines

- Biomedical Sciences
- Exercise & Sports Performance
- Exercise & Sports Science
- Health Sciences
- Healthcare Innovations
- Medicine
- Nutrition & Dietetics
- Occupational Therapy
- Physiotherapy
- Research.

Research Centres

- Institute of Evidence-Based Healthcare
- Centre for Urology Research
- Clem Jones Centre for Regenerative Medicine
- Translational Simulation Collaborative.

The medical program

The accredited Bond University Medical Program is four years and eight months long, running across academic years of three accelerated semesters. The program is made up of Phase 1 (two years and eight months) Bachelor of Medical Studies and Phase 2 (two years) Doctor of Medicine. Students in the established pathway begin in May and graduate in December, four years eight months later, then continue to start intern training in January.

Phase 1, (Years 1-3) is described as pre-clinical with learning centred on small group sessions, clinical skills laboratory, simulation activities, some community and clinical placements, and a cultural immersion experience. Year 1 is two semesters and focuses on the theme 'Health and Wellbeing across the Generations' guiding learning through the body systems, arranged in generations. Year 2 is three semesters and has the theme 'Challenges to Health' and involves a second cycle through the body systems focusing on; relationships between structure and function, mechanisms of disease and infectious organs, normal compensatory mechanisms for restoring normal bodily function. Year 3 is also three semesters long and has the theme 'Understanding and Recognition of Illness'. The format changes in Year 3 from facilitator-led small group learning to clinician-led case-based learning. Students begin placements that mirror the more intensive placements in Phase 2.

In Phase 2 (Years 4 and 5), students who enter the Doctor of Medicine (MD) component of the program spend seven weeks in each discipline rotating through Medicine, Child Health, Mental Health, Women's health, Surgery, Emergency, Critical Care and Orthopaedics (CCO), General Practice, a selective, an elective and an e-lective. Students are allocated at both private and public hospitals, and community settings in Queensland (QLD) and New South Wales (NSW) over their two clinical years.

The Bond medical program allows for lateral entry into Year 2 of the Bachelor of Medical Studies (BMedSt) for domestic and international students graduating from Bond University programs Bachelor of Biomedical Science (in the Pre-Health Professional major), the Master of Occupational Therapy, the Doctor of Physiotherapy or the Master of Nutrition and Dietetic Practice, meeting the minimum required GPA of distinction average. Students who have completed the Graduate Diploma in Healthcare Innovations or Master of Healthcare Innovations who completed a Bachelor of Biomedical Science prior to their Healthcare Innovations award and meet the minimum required GPA of distinction average may also be eligible. Currently these are the only two pathways into the BMedSt/MD and Phase 2 (two years) MD available to international students.

Currently, the student profile within the medical program consists of 45% from Queensland, 35% from New South Wales and 10% from other States and Territories of Australia and New Zealand. There are two enrolled international students, who joined through the lateral entry pathway, having previously completed an eligible degree at Bond and otherwise meeting the entry requirements.

The material change proposal

In September 2020 the Faculty introduced a second intake in light of the COVID-19 pandemic, which made it difficult for some students who were offered positions to start as scheduled in May 2020. The university made further offers to supplement the students who requested a September start, bringing the September start cohort up to 60 students, in addition to the 130 students who began in May 2020.

The Faculty is seeking to incorporate the running of the program for two annual intakes (from both May and September starts) as an ongoing material change to the accredited medical program. The length of program, the learning outcomes and the module structure are the same for May and September cohorts. There has been alteration to the order and timing of some subjects for the September cohort. This results in periods where the September cohort undertakes subjects with the preceding May cohort and times when they undertake modules with the following May cohort.

A steady state would lead to 120 students in the May entry cohort and 60 in a September start.

The September 2020 cohort will graduate in April 2025. Fourteen percent (eight students) have expressed an interest in further study options and expect to be intern-ready in January 2026. The remaining students will graduate ready for internship in April for a mid-year internship start. This modelling does not consider any students leaving or taking career breaks.

Data on Bond graduates' transition to intern training indicates that two-thirds of graduates choose their internship in QLD, the majority of the rest in NSW.

Currently there are small numbers (up to 17 annually across all of QLD) of graduates who begin intern training after the usual January start date. Discussions with stakeholders indicate that these have tended to be individuals who have graduated late or have a small delay to their start due to a range of personal circumstances and who start across a range of different health services. These arrangements have been ad hoc and made on a case by case basis.

Recognising that there are yet no firm agreements on mid-cycle internships and to maximise flexibility in training, the Faculty has developed four alternative pathways.

Pathway 1 – Deferred start intern positions. Students will graduate in April and then take up deferred start intern positions. The Faculty is working with health service stakeholders to develop a clear mid-cycle entry intern training pathway for the September intake. The AMC has received notification of support from two QLD health services, the Department of Health Queensland, the

Executive Directors of Medical Services Forum (all QLD EDMS) and two NSW hospitals to grow mid-year entry internship pathways to support the annual September intake of 60 that is proposed.

Pathway 2 – Leadership and Health Care Innovations pathway. This pathway will provide students with strong interests in leadership and health innovations the opportunity to complete the Bond University Masters of Health Care Innovations (MHCI) in two semesters on finishing the MD. Currently students who complete the MD receive recognition of prior learning for one subject within the MHCI. On starting the MD students can elect to do an appropriate capstone which would also then be eligible to be recognised for the MHCI, with the rest of the subjects completed in the May and September semesters. Students would graduate with the following May cohort and enter internship at the usual time.

Pathway 3 – Research Focused Pathway. This pathway will provide students with strong research interests the opportunity to undertake a research-based Honours program interleaved between the BMedSt and MD programs. The Honours program is a modification of the existing Bachelor of Health Sciences (Honours) program. The first offering of the new program is planned for 2022 – one year prior to when the current September cohort finish their undergraduate studies. With this pathway, students would enter the internship at the usual time, in January. Fourteen percent of the September 2020 intake have expressed a preference for the research focused pathway.

The two semester-equivalent intensive mode will enable students commencing the BMedSt in September to take the Honours program in the May and September semesters and then start the MD in January.

Pathway 4 – Career break (defined by the Bond Medical Program leadership as the Health and Wellbeing Option) to be taken at the end of Phase 1/Year 3 for two semesters, allowing students to rejoin the program in Phase 2 with the following May cohort and, enter internship at the usual time, in January.

The September 2020 cohort has been surveyed as to their own preferences, with a significant majority wishing to complete and start internship mid-year depending on availability. If a mid-year position did not become available, or a graduate chose not to apply for a mid-year internship, they would wait until the traditional January intake the following year.

A Context and investment in the change

This section of the report addresses standards relating to the context and the investment in the proposed change.

A.1 Standard 7 Admissions

7.1.1 The medical education provider has defined the size of the student intake in relation to its capacity to adequately resource the medical program at all stages.

7.2.1 The medical education provider has clear selection policy and processes that can be implemented and sustained in practice, that are consistently applied and that prevent discrimination and bias, other than explicit affirmative action.

In 2020, the Faculty admitted 130 students in May and 60 students in September. From 2021, the Faculty plans to admit 120 students in the May cohort and 60 students in the September cohort in steady state. Eighty percent of commencing students are direct from high school and 20% are postgraduates.

The Faculty will follow existing approved admissions processes. Applications are currently approximately 1300 per year, with a minimum ATAR of 96. Students undergo formal psychometric testing and those that meet the standard undergo an interview. The plan is for students to be able to preference the May or September entry subject to availability, plus random allocation.

Annually, there is a large pool of unsuccessful candidates who meet the current selection criteria so the Faculty is not concerned about a loss of quality with a larger intake. Modelling of the performance in Year 1 assessments across the May and September 2020 cohorts supports this expectation.

The team was satisfied that admissions processes were the same for both cohorts and will be interested to see how the preferencing system works in practice.

The team was pleased to see the introduction in 2021, of new scholarships of up to 100% to support Aboriginal and Torres Strait Islander student entry to the medical program (for either cohort). The AMC will be interested to learn the outcome of the number and extent of scholarships awarded and the Faculty is asked to report on this in its 2021 Comprehensive Report.

A.2 Standard 1.5 Financial resources

1.5.3 The medical education provider has the financial resources and financial management capacity to sustain its medical program.

Bond Medical Program budget for 2021 has been built on a total student commencing number of 180 between May and September cohorts. Significant financial investment has been made (approximately $715000) in six new academic and professional staff appointments, with full year effect from 2022. Further investment has been made in additional equipment and technology licences. The Vice-Chancellor is very supportive of the strategic direction of the medical program, and a Medical Program Expansion Group has been created as the governance mechanism to oversee the initiative.

The team were satisfied that there are sufficient financial resources to support the additional student numbers.

A.3 Standard 1.8 Staff resources

1.8.1 The medical education provider has the staff necessary to deliver the medical program.

1.8.2 The medical education provider has an appropriate profile of administrative and technical staff to support the implementation of the medical program and other activities, and to manage and deploy its resources.

Project management for the implementation of the new September cohort is provided by the Manager Medicine Program who was appointed in January 2021.

Two Assistant Professors – Foundation Science, and two Assistant Professors – Psychology/ Behavioural Science have been appointed to support the increase in students in 2020. Four further appointments at Assistant Professor level and three further appointments in professional staff are planned, pending approval of the continuing September intake.

Additional paid small group facilitators have also been recruited to ensure that small group sizes are maintained and facilitators do not support more than two sessions per day.

The team was pleased to note that additional funding has been received to support new academic positions in First Nations Health across the Faculty and that an Assistant Professor – First Nations Health has already been recruited with a further Associate Professor role and a Professor role advertised. The team would be interested in hearing progress on recruitment into these roles and understanding how these new roles will support the medical program when the Faculty submits its comprehensive report.

Students reported that one of the strengths of the Bond Student experience is the high ratio of teachers to students and they were keen for this to be maintained.

Overall, the team was satisfied that there will be sufficient academic and professional staff to support the proposed increase in student numbers.

B The student experience of the medical program

This section of the report addresses standards relating to students' experience of the medical program, the communications with students about the proposed material change and arrangements for monitoring and maintaining comparability of experience and outcomes across the May and September cohorts.

B.1 Standard 2.2 Medical Program Outcomes

2.2.3 The medical program achieves comparable outcomes through comparable educational experiences and equivalent methods of assessment across all instructional sites within a given discipline.

The curriculum content, learning outcomes, and teaching and learning methods are identical for both May and September entry points with the only difference being in the chronological order in which MEDI12-201 Challenges to Health and MEDI13-301 Understanding and Recognition of Illness modules taken in Phase 1 are different. For example, in MEDI12 Challenges to Health, the order of systems blocks Cardiovascular, Respiratory and Reproductive is changed to Reproductive, Cardiovascular then Respiratory. The number of weeks remains the same. In subject MEDI13 Understanding and Recognition of Illness the modules are order B, C, A rather than order A, B, C experienced by the May cohort. The diagrams below illustrate the change in order across the two cohorts.

Figure 1: Medical Program Phase 1 Semester Structure (2020 May Cohort)

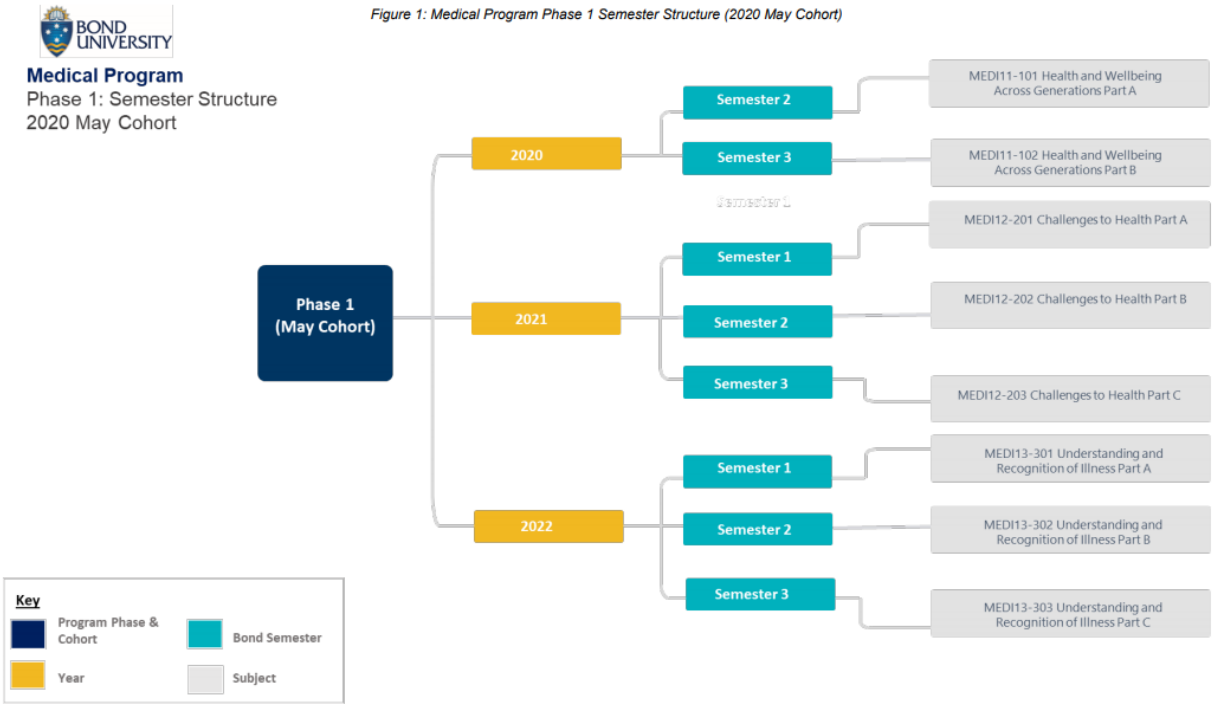
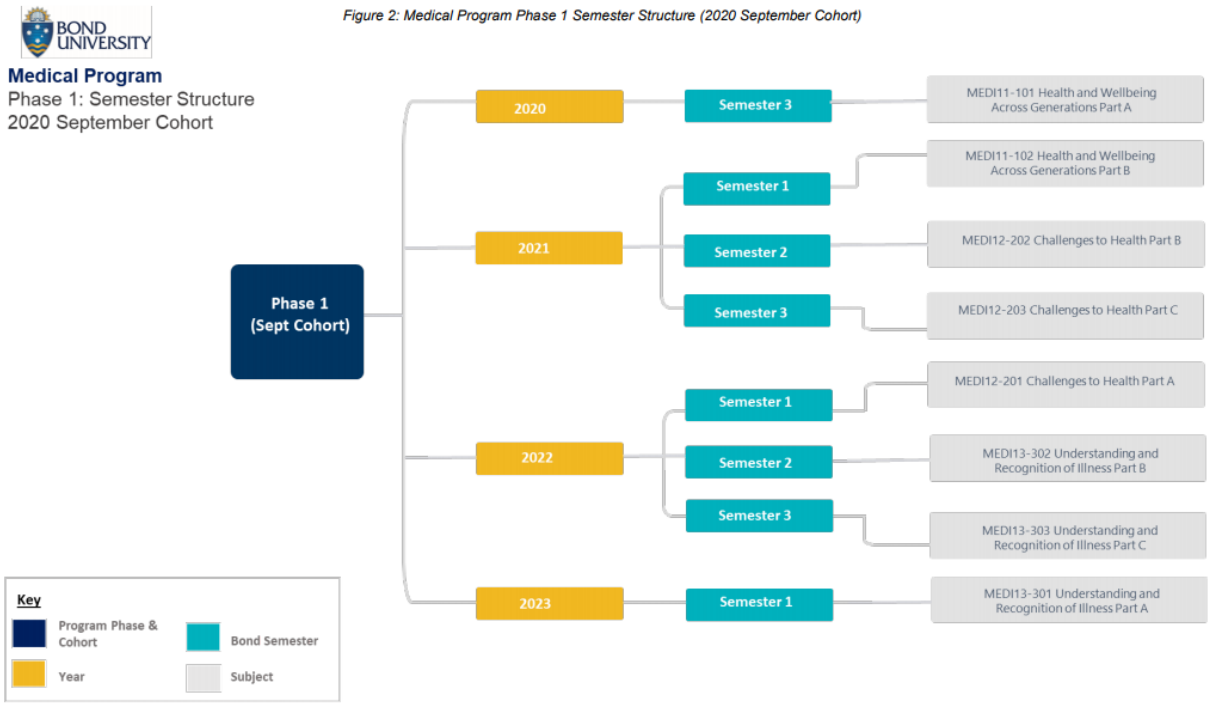


Figure 2: Medical Program Phase 1 Semester Structure (2020 September Cohort)



Some modules are taken separately by the May and September cohorts and some are taken together. The additional curriculum map information provided by the medical program was very helpful, highlighting where the September cohort learned alone and together with their May counterparts, and these pathways were verified in discussions with students and teachers.

The student experience of the September 2020 cohort has been positive, particularly with regard to the access and amount of resources and educators available to their cohort. On the whole, students across May and September cohorts reported that there were no significant knowledge differences between May and September cohorts that would lead to a poorer experience. Some concerns were raised by students regarding a difference in knowledge in a few specific areas, for example, of skeletomuscular anatomy that had been studied by the May but not the September cohort when the cohorts came together. The students reported that this was addressed promptly by the Faculty with bridging sessions. Academic leads gave other examples of extra sessions planned for the September cohort in subjects such as pharmacology to address any potential knowledge gaps due to the different order of curriculum delivery. It was evident to the team that thoughtful and detailed analysis of the curriculum had taken place in designing the intersecting pathways. The team was also reassured by students from both cohorts who reported that in the limited number of situations where the different curriculum order had the potential to affect student learning, the Faculty had promptly addressed concerns. The students also reported supportive peer to peer tutoring, which had benefits for both cohorts in reinforcing learning and bringing fellow students up to speed.

Over the two years of Phase 2, student learning is focused in clinical placements.

- In Year 4, students undertake six Core Clinical Practice rotations of seven week's duration. The six rotations are in Medicine, Surgery, Child Health, Mental Health, Women's Health and a COVID e-lective (to become an MD research focused block). The rotations may be taken in any order.
- In Year 5, students undertake five Extended Clinical Practice rotations of seven week's duration. Again, taken in any order, these are General Practice, Emergency Department, Critical Care and Orthopaedics, Capstone (or a student-organised elective) and Bond selective (specialist or extended core placement).

The medical program finishes with a four-week elective placement in preparation for internship.

It was clear to the team that both cohorts will begin Phase 2 having completed the same content. As Years 4 and 5 placement modules are already designed to be run in varying order, the experience of Phase 2 will be the same for both cohorts and, consistent with the existing approved program.

The assessment formats and progression rules will be the same for both cohorts. The program includes a mix of written exams, Objective Structured Clinical Exams, Workplace Based Assessments and the Prescribing Skills Assessment. These will remain the same.

The main exams are currently run twice, for a small number of resitting students. They will change to be routinely run twice, once for each cohort so that the cohorts will have the same prior learning leading up to the exams. The same blueprint will be used to ensure equity.

Data so far in Year 1 assessment shows no significant difference in performance between May and September cohorts. The Faculty is also encouraged to publish this analysis to allay student concerns about maintaining the quality of the expanded student pool.

The team explored whether the Faculty had capacity to maintain two sittings of each main written and clinical exam. Academic staff reported that the medical program has an extensive bank of questions developed "in-house" mainly by academics, with some contribution from clinicians. The Examsoft digital assessment solution contains approximately 10,500 questions and new questions are created annually.

For clinical knowledge-based and practical assessment items, the assessment team also has access to additional resources shared with other medical schools through the Medical Deans Australia and New Zealand (MDANZ), the Australian Medical Schools Assessment Collaboration (AMSAC) and ACCLAiM collaborations.

Workplace based assessments are delivered through an eportfolio that has been viewed favourably by staff and students for ease of use and rapidity of feedback at point of need. The Workplace based assessments are to be linked to the clinical placements and taken in the order of the placements, as is the case currently for Phase 2 students. The Faculty is confident that with the increased clinical supervisor recruitment as part of the expansion of clinical placements, clinical supervisors will have the capacity to deliver them with an increased cohort size. As noted below, the Faculty is required to report on progress in recruitment of additional clinical supervisors.

Overall, the team was satisfied that there was careful curriculum planning and early evidence of responsiveness to minor refinements, which backed up by analysis of assessment performance, indicates that in the first year comparable outcomes are being achieved through comparable educational experiences and equivalent methods of assessment. The Faculty must continue to monitor this carefully but the detailed curriculum planning, monitoring mechanisms, responsiveness to student feedback and the oversight by the Medical Program Expansion Group provide a good basis to ensure comparability as future years of the September intake are implemented.

B.2 Standard 6 Monitoring and Evaluation

6.1.1 The medical education provider regularly monitors and reviews its medical program including curriculum content, quality of teaching and supervision, assessment and student progress decisions. It manages quickly and effectively concerns about, or risks to, the quality of any aspect of medical program.

6.2.1 The medical education provider analyses the performance of cohorts of students and graduates in relation to the outcomes of the medical program.

In addition to the standard existing student feedback and evaluation processes, the Medical Program Expansion Group closely monitors curriculum development and progress of the

September cohort with respect to their peers. The team found that there is significant and frequent communication between staff and the September cohort that can pick up any issues quickly in order to resolve them. The team is satisfied that there is sufficient monitoring of the September 2020 cohort, and recommend that there is enhanced engagement with the May cohorts so that these cohorts feel that they have equal opportunities to share their perspectives and to help with identification of issues that may be affecting either cohort especially at times where cohorts come together for the first time.

It was evident to the team that the Faculty has undertaken and plans to continue detailed analysis of the comparability in the performance of the May and September intakes. The team noted that the eportfolio is capable of generating a range of outcome-based evaluative reports on students' experiences and assessment in clinical placements.

B.3 Standard 7.3 Student Support

7.3.2 The medical education provider has mechanisms to identify and support students who require health and academic advisory services, including:

- *students with disabilities and students with infectious diseases, including blood-borne viruses*
- *students with mental health needs*
- *students at risk of not completing the medical program.*

The Faculty is to be commended for its work in this area. There are a significant number of professional staff employed in a range of support services, including a clinical psychologist. This large team includes staff dedicated to the medical program and staff supporting students in the wider faculty.

There were some reports of bullying and a feeling of otherness among the September cohort which the students reported and was promptly and very effectively addressed by the Faculty, once identified.

There have been a number of initiatives to support students through the pandemic including individual learning plans for every student and learning coaches who are predominantly clinicians, and play a mentoring role. In response to the success of the learning coaches, the Faculty plans to continue this initiative and to recruit further learning coaches as the student numbers grow.

B.4 Standard 7.5 Student Representation

7.5.1 The medical education provider has formal processes and structures that facilitate and support student representation in the governance of their program.

There have been significant efforts in ensuring that students from both cohorts have equal representation on student bodies and in representative structures. The team met a large number of representatives across multiple years of May intakes and for the September 2020 intake. These student representatives appeared well connected to their wider student bodies and were articulate and balanced both in the written submission and in discussions with the team in describing the range of views and concerns held across the cohorts.

It was clear to the team that the model for student representation responded to the needs of both intakes and did not prioritise either. However it was less clear that this model was effective in facilitating representation in governance and decision-making in the program. The team heard that key student representatives were not engaged in consideration of either the September 2020 cohort proposal or the more recent proposal to continue the September intake.

The Faculty is advised to identify ways for student representatives to be involved in developmental work, for example in plans to recruit more small group facilitators and clinical

supervisors as this may help allay student concerns in areas that the Faculty has expressed to the team there is a clear commitment to address. For example, not increasing the size of small-groups and not adding additional students into existing clinical placements/reducing the clinical supervisor to student ratio.

The work of the Faculty with health services and the intern accreditation authorities on confirming details of mid-cycle internships is another area that is important to engage student representatives in, particularly to address health service stakeholder concerns about graduates not accepting the intern training places offered.

Similarly, the team heard that there were some concerns voiced by the students about poor communication from the Faculty regarding the proposal for an ongoing mid-year intake which the Faculty attempted to address by meeting with individual student representatives and holding a Town Hall style meeting. There was consistent feedback across the groups of students who the team spoke to that the Town Hall meeting was not well received and the Faculty is recommended to work with student representatives on methods of communication to support student representatives in their role and facilitate wider student engagement.

The September 2020 cohort did report that they received a number of communications from the Faculty and felt well informed about how the program would be adapted for them.

The Faculty acknowledges that their communication strategy to date has focused on supporting the September 2020 intake and that they were considering how to improve communication with the whole student body.

B.5 Standard 8.1 Physical Facilities

8.1.1 The medical education provider ensures students and staff have access to safe and well-maintained physical facilities in all its teaching and learning sites in order to achieve the outcomes of the medical program.

The medical program has access to sufficient numbers of small-group teaching spaces across the University campus that are of appropriate quality, size and ICT capability. Students reported that they did not always have access to their preferred small-group rooms. However it appeared to the team that, across campus, facilities were of appropriate quality.

Due to the increase in cohort size, there is now only is one large lecture theatre that has capacity to support the full cohort at the same time. It has more than enough capacity for increased student numbers. Students reported some challenges with sessions being run across two lecture theatres when the largest theatre was already booked. The Faculty acknowledges that there are improvements in timetabling that can be made to ensure that the right number and location of rooms are available, and the team will be keen to hear of progress on this. The team noted that there are few all-cohort sessions within the curriculum.

Year 3 students raised concerns about being 'displaced from their usual base' and relocated in a different part of the University. From discussions with the students it appeared to the team that the new location met students' needs but that students had genuine concerns about the communication related to the relocation being last minute and feeling unsupported, so it had fed into some unease in the student body about the impact of increasing student numbers.

The medical program is actively looking for new clinical partners in acute and community settings to support the increased student numbers. The team will be interested to see more details of these locations and agreements as they eventuate with respect to technology infrastructure and appropriate space to support student learning.

C Capacity in the clinical learning environment

This section of the report addresses standards relating to the capacity in the local health services to support clinical learning for the expanded annual intake of students.

C.1 Standard 8.3 Clinical Learning Environment

8.3.1 The medical education provider ensures that the clinical learning environment offers students sufficient patient contact, is appropriate to achieve the outcomes of the medical program and to prepare students for clinical practice.

8.3.2 The medical education provider has sufficient clinical teaching facilities to provide clinical experiences in a range of models of care and across metropolitan and rural health settings.

8.3.3 The medical education provider ensures the clinical learning environment provides students with experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples and/or Māori.

8.3.4 The medical education provider actively engages with other health professional education providers whose activities may impact on the delivery of the curriculum to ensure its medical program has adequate clinical facilities and teaching capacity.

It was noted by the team that the proposal includes a reduced intake of 120 students in the May cohort from 2022 so that, in steady state there will be approximately 40 additional students per year, when compared with the 2019 cohort.

The Faculty has committed not to add students to existing placements/increase the ratio of students to clinical supervisor per placement to ensure that patient contact and clinical placement experiences for the September intakes mirror the existing accredited program. It therefore recognises that additional clinical supervisors will need to be recruited at existing sites where there is capacity to increase student numbers and new clinical placement sites will also be needed.

The mapping of clinical placements provided to the team and explored through discussions with Discipline Leads and health service partners indicates the increased numbers are able to be accommodated in a mixture of private and public institutions. Specifically, Gold Coast Primary Health Network, Pindara, John Flynn, Buderim Private and the new Tweed Valley Hospital where the University has committed to making a capital investment into education and training facilities on the hospital site. The new expanded Tweed Valley Hospital will open in 2023, increasing capacity from 250 to over 400 beds, with new services such as comprehensive cancer care, acute cardiac care (angioplasty suite) and vascular services. The team noted the increased reliance on private hospitals and it will be important to monitor the range of settings that students are placed in, to ensure a balanced experience.

The mapping provided to the team indicated no change in numbers placed at Gold Coast Hospital and Health Services, a key placement provider shared with Griffith Medical School.

The medical program is also working with the Institute of Urban Indigenous Health to understand what partnership opportunities may be available as part of a planned community health rotation in 2022. Due to COVID-19, international placements and placements within rural and remote First Nations communities have not been possible, but are hoped to begin again in 2023. There are existing relationships with sites in India, Italy, Solomon Islands and South Africa, and in Cape York, Broken Hill and Port Headland First Nations communities. There are plans to expand with further placements in Alice Springs and Charleville. These were not included in the clinical placement mapping due to continuing uncertainty related to travel restrictions resulting from the pandemic. The Committee reviewed the impact of COVID-19 on students' experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples and/or Māori across the Faculty's range of

clinical placement settings in 2021, as part of its monitoring of the implications of COVID-19 on all accredited medical programs.

The Faculty recognises the need to support rural and regional placements in its budget envelope as the University does not receive Rural Health Multidisciplinary Training funding. It was understood by the team that these plans are not yet well developed so were not included in the clinical placement mapping submitted but that Queensland Health Department and EDMS support for the mid-cycle intern intake is predicated on the Faculty's investment in developing regional and rural placements so it will be important that early efforts are invested in developing these.

Though also not included in the mapping provided to the team, the clinical discipline leads were very committed and passionate about their plans for additional new placement opportunities in private, community, aged care and non-government organisations to support student learning. Examples include Leading Steps paediatric service, private mental health services and a new mental health Crisis Stabilisation Unit at Robina Hospital. It was reported that there is increasing private provider capacity in women's health due to increasing birth numbers.

The discipline leads were optimistic of an additional new public hospital at Coomera (not included in the mapping), although the timing of this is not certain and unlikely to be complete in the next five years as funding has not been confirmed despite planning being well advanced.

The team considered that the clinical placement mapping was appropriately conservative and nonetheless demonstrated that there would likely be capacity to support an increase of 40 students per annum. The team was pleased to see the further expansion plans, particularly in relation to regional and rural settings, and diverse community settings.

The team notes that agreements/Deeds with new and existing placement providers have not yet been negotiated and would like to see further reports on progress in confirming additional clinical placement capacity with analysis of how progress is aligning with projected student numbers to ensure that all students have experience of public, private, community, regional and rural placements.

The team heard that, although there had been some discussion of the proposal at the Medical School Liaison Forum, there had not yet been meaningful engagement on the plans for expansion of clinical placements. Given the Faculty's ambitions to develop more clinical placement partners in General Practice, community health settings and in regional and rural Queensland, the team encourages the Faculty to seek further engagement with Queensland medical schools on detailed plans and adopt a collaborative approach to ensure that all students, across Queensland medical schools, experience high quality clinical placements in a broad range of health service settings.

C.2 Standard 8.4 Clinical Supervision

8.4.2 The medical education provider supports clinical supervisors through orientation and training, and monitors their performance.

8.4.3 The medical education provider works with health care facilities to ensure staff have time allocated for teaching within clinical service requirements.

There is an active community of practice of Clinical Discipline Leads and the team was reassured that they are working closely with health partners to ensure adequate clinical supervision capacity (which is paid for directly by the Faculty) for the increased student numbers although variations to Deeds and exact numbers across each placement provider are yet to be confirmed. As additional students feed through into later clinical years of training in a projected increased number of placement sites, the team will be keen to see reports from the Faculty confirming the type and number of clinical supervisors across sites and how they are trained and quality-assured, and that the health provider gives adequate time for student supervision. The Faculty is required to demonstrate adequate clinical

supervisor recruitment and training across clinical sites, prior to the September 2020 cohort beginning Phase2.

C.3 Standard 1.6 Interactions with stakeholders

1.6.1 The medical education provider has effective partnerships with health-related sectors of society and government, and relevant organisations and communities, to promote the education and training of medical graduates. These partnerships are underpinned by formal agreements.

1.6.2 The medical education provider has effective partnerships with relevant local communities, organisations and individuals in the Indigenous health sector to promote the education and training of medical graduates. These partnerships recognise the unique challenges faced by this sector.

The medical program seems to have a good relationship with clinical placement provider stakeholders. All clinical placements are underpinned by formal deeds that are renegotiated cyclically.

There is an active Clinician Advisory Board, which is working with the Institute of Urban Indigenous Health on a seven-week community rotation in 2022, and rural/regional First Nations health services (once placements can begin again). This, together with the investment in additional First Nations academic positions, is welcomed.

The team will be interested to see further reports from the Clinician Advisory Group and outcomes of discussions with new placement providers in urban, community, regional and rural settings.

D Articulation with subsequent stages of training

This section of the report addresses standards relating to the way in which the Faculty's accredited medical program links with medical internship, following graduation.

D.1 Standard 3.3 Curriculum design

There is evidence of purposeful curriculum design which demonstrates horizontal and vertical integration and articulation with subsequent stages of training.

D.2 Standard 1.6 Interactions with stakeholders

1.6.1 The medical education provider has effective partnerships with health-related sectors of society and government, and relevant organisations and communities, to promote the education and training of medical graduates. These partnerships are underpinned by formal agreements.

In their submission, Bond provided correspondence from a number of health services supportive of their plans for a mid-year graduating cohort and stating that this group could be accommodated in some way. The Team interviewed representatives from the two local health services (Gold Coast and Northern NSW), as well as other interested services (Central Coast NSW and Metro South Brisbane [Princess Alexandra Hospital]). There were also interviews with the NSW and Queensland Intern Accreditation Authorities – Health Education and Training Institute (HETI) in NSW and Prevocational Medical Accreditation Queensland (PMAQ), part of the Medical Advisory and Prevocational Accreditation Unit (MAPAU), Prevention Division, Queensland Health. Whilst there has already been engagement with PMAQ and the broader workforce team within MAPAU, there is yet to be engagement with HETI.

Applicants eligible for an internship in Queensland are categorised into applicant groups. Group A identifies medical graduates who are guaranteed an offer of an intern position in Queensland. Bond graduates generally fall into Group A, which is defined as medical graduates of Queensland universities who are Australian or New Zealand citizens, or Australian permanent residents; and:

- are seeking an internship commencing in the year immediately following graduation; or
- have received Review Committee approval from a previous campaign to defer commencement of internship.

In 2020, there were 800 intern positions in Queensland (736 general intern positions and 64 rural generalist positions). Of the 800 intern positions, 655 general intern positions and 60 rural generalist positions, were filled, resulting in 85 unfilled positions. Previously, these have been filled by applicants from Groups B-D ie interstate domestic graduates, international students graduating from a domestic medical program with a campus in or outside Australia or graduates of international medical programs.

This year, NSW did not fill all available intern places. A priority system is used to rank applicants for posts. Previously, NSW has filled all places and placed applicants down to small numbers of Category 6 applicants. The categories are as follows:

- Category 1 is Australian/NZ Citizen or Australian Permanent Resident (PR) and Graduate of NSW.
- Category 2 is Australian/NZ Citizen or Australian PR and Graduate of New Zealand or Interstate University and Year 12 in NSW.
- Category 3 is Australian/NZ Citizen or Australian PR and Graduate of New Zealand or Interstate University.

- Category 4 is Graduate of NSW and who hold a visa that allows them to work or able to obtain a visa to work in Australia.
- Category 5 is Graduate of New Zealand or Interstate University and who hold a visa that allows them to work or able to obtain a visa to work in Australia.
- Category 6 is Graduate of Australian Medical Council accredited University with campuses that are located outside Australia or New Zealand (UQ Ochsner and Monash Malaysia) and who hold a visa that allows them to work or able to obtain a visa to work in Australia.

During the pandemic, there has clearly been capacity for 60 additional domestic graduates to enter existing funded intern training places. It is difficult to predict what the impact on other Australian medical schools will be in the context of the continuing pandemic and in light of changes to the National Framework for Prevocational Medical Training. It is likely that, in the future, the 40 additional Bond graduates will displace some international student graduates of Australian medical schools, if the pool of intern training places remains static. However, health service representatives reported that an increased focus on a mix of general and community placements as well as regional and rural experiences in prevocational training may increase the overall pool of intern training places as PGY1 and PGY2 positions undergoing some reconfiguration across more diverse settings.

All the health services were generally supportive of being able to accommodate a small group of mid-year graduates. Each service is subject to staffing shortfalls that often occur mid-year. These are usually mitigated with recruitment of PGY2-4 staff from UK, Ireland, India, Sri Lanka, Pakistan and other countries. Current travel and immigration restrictions due to COVID-19 have made this recruitment more challenging. Local and national workforce strategies are encouraging national self-sufficiency. By employing a small number of interns in mid-year, they would then be able to slot into some of these shortfall positions as they progress into PGY 2 and 3. It should also be noted that changes in the National Framework for Prevocational Medical Training, such as the proposed Certificate of Completion for PGY2 may change the impact and number of mid-year JMO vacancies.

Feedback from Northern New South Wales Local Health District (NSW LHD) also indicated that a mid-cycle cohort of interns has the potential to improve the experience of internship. This Local Health District reported a very positive experience with the Assistant in Medicine 12-week placements that were undertaken by medical students during 2020, in response to the pandemic. These students were given jobs equivalent to early interns, for example, ordering x-rays and this allowed the interns, who at that stage had gained some experience of practice, to work closer to the peak of their scope of practice.

Queensland Health, where there has been good engagement, indicated clear support for the proposal. In the view of the Department, a reliable mid-year graduating cohort would improve patient safety by providing some smoothing across the year of the number of doctors beginning practice. As experienced in Northern NSW LHD, the Department also considered that one of the benefits of a mid-cycle intake may be the improvement of the experience of internship, by allowing for greater gradation in responsibility within terms as interns with six months experience may focus on more complex tasks while interns who are just beginning are supported to transition to practice.

Whilst the engagement with HETI is yet to occur, it was clear that there is an administrative burden related to mid-cycle allocation based on previous experience. There is also concern based on the data from recent annual intern recruitment cycles that a proportion of graduates from Queensland universities do not take intern training places offered in NSW Health Services after initially applying for them. Therefore, while HETI indicated a clear willingness to work with Local Health Districts within NSW where there would be a reliable pipeline for a reasonable mid-cycle intern cohort (approximately 10) and detailed discussions had not yet taken place, it was unclear whether there would be support for additional funded intern training places (which was the aspiration of Northern NSW LHD) given the growth in services with the new hospital coming online in 2023. There is therefore

significant work for the Faculty to engage with NSW Health Services and HETI to address concerns and develop detailed plans. It will be important for the Faculty to engage with HETI, along with NSW Health Services to learn from HETI's experience of taking clusters of small numbers of graduates into intern training mid-cycle.

The team were assured from discussions with all local health services that there was a recognition of the need to adapt orientation and educational programs. The health services the team spoke to were at different stages in considering the mechanics, some had had only an initial discussion while others had developed thinking about the arrangements, however all had some experience of providing mid-cycle orientations, support and educational programs, whether for a few interns starting late or international medical graduates beginning mid-year in PGY2-4 roles.

It was clear from discussions that a number of elements would need to fall into place for this to be viable. This includes a steady and reasonably predictable supply of mid-year graduates interested in working in these health services, as well as a willingness on the part of health services to alter their recruitment, orientation and support arrangements for interns to support this group.

Additionally, while the support for the mid-cycle proposal was strong, there remains uncertainty about the numbers and demand from health services. Feedback from the Queensland Executive Directors of Medical Services Forum indicated clear support for the ability to absorb 60 graduates into mid-cycle intern training programs within Queensland. However, in the submission, it appears that currently the number of mid-year internships is small (up to 17 across all of Queensland) and any expansion would constitute a substantial change in process and increase in capacity. Each of the Hospital Service representatives who spoke with the team indicated that their preferred size of the mid-cycle intake, at least initially, would be 5-10 interns and these would need to be in addition to their allocated January start intern numbers. In relation to NSW, the Faculty's modelling based on existing behaviour, indicated that 20 graduates would apply for internship. However, demand in the health services, at least initially appeared to be closer to 15 and there continues to be some concern about the proportion of Queensland graduates not taking intern training offers in NSW.

The team recognises that Bond has put considerable thought and effort into alternative pathways that will allow September intake students to take opportunities out of the program and to then re-join the medical program with the following May intake, enabling graduation in time for the usual January intern training cycle.

The AMC's goal for medical education as expressed in the accreditation standards is to 'develop junior doctors who are competent to practise safely and effectively under supervision as interns in Australia and New Zealand, and who have an appropriate foundation for lifelong learning and for further training in any branch of medicine'. The importance of carefully supporting the transition from internship is well acknowledged with investment in work-readiness initiatives and collaboration on final years of medical programs across all states and territories in Australia as well as in New Zealand. The team were initially concerned that the program, which finishes in April, eight months before internship commences in January, may not be able to adequately prepare its graduates for the next stage of medical training. The team considered that there should be a reasonable prospect for graduates to enter structured and supported intern training programs shortly after graduation, to ensure a safe transition to practice.

In this instance, given the benefits of a mid-cycle intake to the local health system articulated by health service stakeholders and the support expressed by the Department of Health Queensland and the QLD EDMS Forum for developing an annual mid-cycle intern training intake for the September cohort of 60 students, the team is of the view that there is commitment from stakeholders to develop the detailed arrangements in time for the September 2020 cohort who are due to graduate in April 2025. In this context, the commencement of a 2021 September cohort would support health services to maintain that

commitment by creating a reasonably reliable pipeline of annual cohorts graduating in April each year.

The Faculty must now work with intern accreditation authorities and local health services to ensure there are clear and detailed arrangements in place describing opportunities for mid-cycle internship training, proximate to graduation and arrangements for graduates who are not able to start internship training proximate to graduation to maintain their skills and to enter an appropriately supported intern program competent to practice safely and effectively under supervision as interns.

It is possible that the September start may prove popular with international students (once they are allowed to return) as it aligns better with Northern Hemisphere transition points, and the number of domestic graduates seeking a mid-year internship will not comprise the whole cohort as a result. However, on the other hand, the inclusion of international students may create uncertainty in the pipeline for intern training in QLD and NSW and make it more difficult for local health services to support. If the Faculty, which currently has no international students, wishes to consider taking international students in the future it will need to work very closely with both intern training accreditation authorities and with local health services to ensure the articulation of the mid-cycle intake with intern training continues to be supported.

Appendix One Membership of the 2021 AMC Assessment Team

Professor Inam Haq (Chair) BSc Biochemistry (Hons), MBBS, MRCP, MD, FRCP (UK) FRACP
Associate Dean (Education), Faculty of Medicine and Health, The University of Sydney

Associate Professor Andrew Singer AM MBBS (Syd), FACEM, FIFEM
Principal Medical Adviser, Australian Government Department of Health, Associate Professor, Australian National University Medical School, Senior Specialist in Emergency Medicine, Canberra Health Services

Dr Mary White MB BCh, BAO (Ireland), FFARSCI (Ireland)
Senior Consultant in Intensive Care, The Royal Adelaide Hospital

Ms Kirsty White
Director, Accreditation and Standards, Australian Medical Council

Ms Brooke Pearson
Accreditation Officer, Australian Medical Council

Appendix Two Groups met by the 2021 Assessment Team

Meeting	Attendees
Monday 7 June 2021	
Stakeholder	
Griffith University, School of Medicine and Dentistry	Dean of Medicine and Head of School
Tuesday, 15 June 2021	
Bond University, Faculty of Health Sciences & Medicine	
Program Leadership	Vice Chancellor & President, Bond University
	Vice President Operations, Bond University
	Executive Dean, Faculty of Health Sciences and Medicine
	Deputy Dean, Faculty of Health Sciences and Medicine
	Faculty Business Director, Faculty of Health Sciences and Medicine
	Dean of Medicine
	Student Affairs and Service Quality, and Curriculum Lead, Bond Medical Program
	External Engagement and Marketing & Chair, Clinical Advisory Board
	Chair, Medical Program Research Committee
	Domain Leads Representative
	Manager, Curriculum & Assessment
Bond University, Faculty of Health Sciences & Medicine	
Students in the September 2020 intake	Six students
Student society and student representatives from both cohorts	Nine students
Students in May intakes, across years (other than the student representatives)	Eight students
Academic Teaching Staff	Curriculum Lead
	Domain Lead, Health & Society Theme
	Domain Lead, Scientist & Scholar Theme
	Domain Co-Lead, Professionalism & Leadership Theme
	Deputy Domain Lead, Clinical Practice
	Assessment Lead
	Manager, Curriculum & Assessment
Student Support Staff	Student Affairs and Service Quality
	Manager – Student Health & Wellbeing
	A/Manager – Student Affairs and Service Quality
	Phase 1 Student Support Lead (Y2 & Y3)
	Phase 1 Student Support Lead (Y1)
	Phase 2 Student Support Lead

Meeting	Attendees
	Medical Program Coordinator
Stakeholders	
Prevocational Accreditation Authority – Health Education and Training Institute (HETI)	Medical Director
	Program Manager, Allocation, Accreditation & Faculty
Health Services Stakeholders – Central Coast Local Health District (NSW)	Director, Prevocational Education and Training, Medical Workforce and Education Unit
	Manager – Medical Workforce and Education Unit
Health Services Stakeholders – Gold Coast Health and Hospital Service	Executive Director, Clinical Governance Education and Research
	Director, Medical Education & Clinical Training Medical Education Unit
Wednesday, 16 June 2021	
Stakeholders	
Health Services Stakeholders – Metro South Health	Acting Director Clinical Training, Princess Alexandra Hospital, Metro South Health
Health Services Stakeholders – Northern NSW Local Health District	Executive Director, Medical Services
Health Services Stakeholders – Queensland Health	Acting Deputy Director-General and Chief Medical Officer, Prevention Division
	Director, Medical Advisory and Prevocational Accreditation Unit