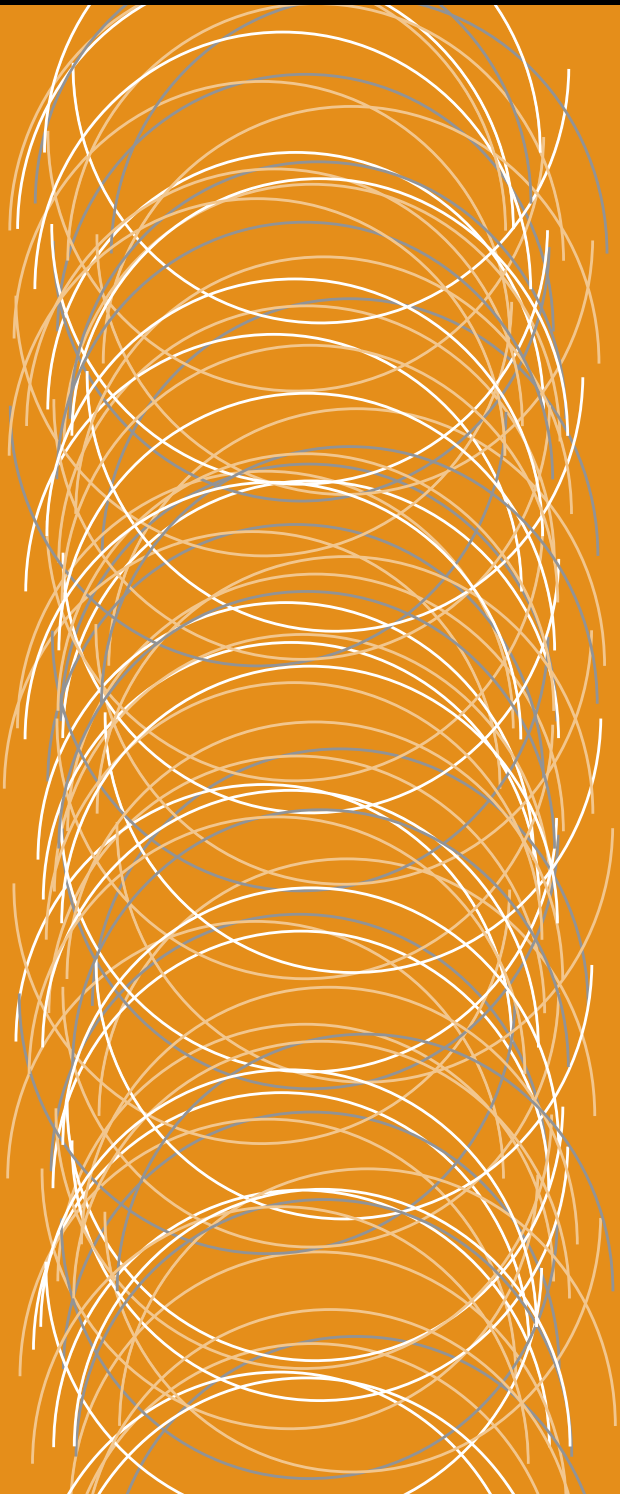
Australian Medical Council Limited

Accreditation of the James Cook University, College of Medicine and Dentistry Medical program

AMC



Medical School Accreditation Committee
August 2021

December 2021

ABN 97 131 796 980

ISBN 978-1-925829-49-5

Copyright for this publication rests with the
Australian Medical Council Limited

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

Contents

Acknowledgement of Country **1**

Executive summary 2021 .... **1**

Key findings **4**

Introduction **9**

1 The context of the medical program **13**

1.1 Governance 13
1.2 Leadership and autonomy 16
1.3 Medical program management 16
1.4 Educational expertise 17
1.5 Educational budget and resource allocation 17
1.6 Interaction with health sector and society 18
1.7 Research and scholarship 18
1.8 Staff resources 18
1.9 Staff appointment, promotion & development 19

2 The outcomes of the medical program **21**

2.1 Purpose 21
2.2 Medical program outcomes 22

3 The medical curriculum **24**

3.1 Duration of the medical program 24
3.2 The content of the curriculum 24
3.3 Curriculum design 26
3.4 Curriculum description 27
3.5 Indigenous health 27
3.6 Opportunities for choice to promote breadth and diversity 28

4 Learning and teaching **30**

4.1 Learning and teaching methods 30
4.2 Self-directed and lifelong learning 31
4.3 Clinical skill development 31
4.4 Increasing degree of independence 32
4.5 Role modelling 32
4.6 Patient centred care and collaborative engagement 33
4.7 Interprofessional learning 34

5 The curriculum – assessment of student learning **35**

5.1 Assessment approach 35
5.2 Assessment methods 36
5.3 Assessment feedback 37
5.4 Assessment quality 38

6 The curriculum – monitoring **39**

6.1 Monitoring 39

6.2 Outcome evaluation ... 42
6.3 Feedback and reporting ... 42

7 Implementing the curriculum – students ... 44

7.1 Student intake ... 44
7.2 Admission policy and selection ... 44
7.3 Student support ... 45
7.4 Professionalism and fitness to practise ... 47
7.5 Student representation ... 47
7.6 Student indemnification and insurance ... 47

8 Implementing the curriculum – learning environment ... 48

8.1 Physical facilities ... 48
8.2 Information resources and library services ... 48
8.3 Clinical learning environment ... 49
8.4 Clinical supervision ... 50

Appendix One Membership of the 2021 AMC Assessment Team ... 52

Appendix Two Groups met by the 2021 Assessment Team ... 53

Appendix Three Teaching and facilities observed by the 2021 Assessment Team ... 61

Figure 1 Organisational structure of the College relevant to the medical program ... 14
Figure 2 Medical Program Governance Chart ... 15
Figure 3 JCU curriculum outline ... 27
Figure 4 Example of a typical student week in MBBS Years 1-3 ... 30
Figure 5 College of Medicine and Dentistry Evaluation Framework ... 40

Acknowledgement of Country

The Australian Medical Council 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 2021

Accreditation process

According to the Australian Medical Council's (AMC) *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2019,* accredited medical education providers may seek reaccreditation when their period of accreditation expires. Accreditation is based on the medical program demonstrating that it satisfies the accreditation standards for primary medical education. The provider prepares a submission for reaccreditation. An AMC team assesses the submission, and visits the provider and its clinical teaching sites.

The accreditation of the James Cook University, College of Medicine and Dentistry program expires on 31 March 2022.

The College of Medicine and Dentistry provided responses to the accreditation standards, as well as plans for future changes to its program in their submission for this reaccreditation assessment.

The AMC reaccreditation assessment was conducted by the Team which reviewed the College's submission and the James Cook University Medical Student Association (JCUMSA) report. The AMC had planned a team visit to the main campus and associated clinical teaching sites in early May 2020 but because of the timing of the reaccreditation assessment and the unusual circumstances of the COVID-19 pandemic, an extension of accreditation was granted for 12 months. The reaccreditation assessment was conducted over a period of two weeks in May/June 2021 where the Team met the College remotely via videoconference for three days in the first week followed by another three days in the subsequent week in-person in Cairns and Townsville, Queensland.

This report presents the AMC's findings against the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012*.

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.

Reaccreditation of established education providers and programs of study

In accordance with the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2019*, section 5.1, the accreditation options are:

(i) Accreditation for a period of six years subject to satisfactory progress reports. Accreditation may also be subject to certain conditions being addressed within a specified period and to satisfactory progress reports (see section 4). In the year the accreditation ends, the education provider will submit a comprehensive report for extension of accreditation. Subject to a

satisfactory report, the AMC may grant a further period of accreditation, up to a maximum of four years, before a new accreditation review.

(ii) Accreditation for shorter periods of time. If significant deficiencies are identified or there is insufficient information to determine that the program satisfies the accreditation standards, the AMC may grant accreditation with conditions and for a period of less than six years. At the conclusion of this period, or sooner if the education provider requests, the AMC will conduct a follow-up review. The provider may request either:

- a full accreditation assessment, with a view to granting accreditation for a further period of six years; or
- a more limited review, concentrating on the areas where deficiencies were identified, with a view to extending the current accreditation to the maximum period (six years since the original accreditation assessment). Should the accreditation be extended to six years, in the year before the accreditation ends, the education provider will be required to submit a comprehensive report for extension of the accreditation. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to the maximum possible period, before a new accreditation assessment.

(iii) Accreditation may be revoked where the education provider has not satisfied the AMC that the complete program is or can be implemented and delivered at a level consistent with the accreditation standards. The AMC would take such action after detailed consideration of the impact on the healthcare system and on individuals of withdrawal of accreditation and of other avenues for correcting deficiencies.

If the AMC revokes accreditation, it will give the education provider written notice of the decision, and its reasons; and the procedures available for review of the decision within the AMC. (See 3.3.11)

An organisation that has its accreditation revoked may re-apply for accreditation. It must first satisfy the AMC that it has the capacity to deliver a program of study that meets the accreditation standards by completing a Stage 1 accreditation submission.

The AMC is satisfied that the medical program of the James Cook University, College of Medicine and Dentistry meets the approved accreditation standards.

AMC Directors at their 21 October 2021 meeting resolved that:

(i) The six year Bachelor of Medicine / Bachelor of Surgery (MBBS) medical program of the James Cook University, College of Medicine and Dentistry is granted accreditation for six years to 31 March 2028, subject to the following conditions, and AMC monitoring requirements including satisfactory annual progress reports.

To be satisfied by 2022	
2	Demonstrate clear communication to students about the learning outcomes or objectives for Years 5 and 6. (Standard 3.4)
4	Review the College evaluation processes to ensure that a coherent set of monitoring and evaluation activities relate to an overarching framework and that the framework and the contribution of the various activities to that framework are clearly articulated for staff and students. (Standard 6.1.1)
6	Clarify and publish the process for appealing selection decisions. (Standard 7.2)
7	Work with students, including Aboriginal and Torres Strait Islander students, to identify and address gaps in student support services perceived by students. (Standard 7.3.1)

To be satisfied by 2023	
3	Demonstrate responsiveness to student feedback so that concerns about, or risks to, the quality of the medical program across all clinical sites are addressed. (Standard 6.1.1)
5	Implement systematic mechanisms and formal pathways to deliver and obtain feedback to and from staff. (Standard 6.1.2)
To be satisfied by 2024	
1	Work with students to address their concerns that the biomedical sciences teaching in foundation years does not have sufficient clinical context and, therefore, does not appear to relate clearly to their clinical placements in later years of the curriculum. (Standard 3.3)

Key findings

Under the *Health Practitioner Regulation 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 programs and providers.

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	**Met**

Recommendations

A Work with local health services to further develop research opportunities that will provide benefits to the local communities as well as the College and its students. (Standard 1.7.1)

B Improve recruitment and training of Indigenous staff by enacting commitments in the Reconciliation Action Plan. (Standard 1.8.3)

C Improve the efficiency of recruitment processes for staff appointments to vacancies in senior roles. (Standard 1.9.1)

Commendations

The College's passion for clinical education and education research, along with its commitment to strengthening educational expertise in the program's leadership team. (Standard 1.4.1)

The recruitment and development of a growing group of Indigenous academic and professional staff at the Murtupuni Centre for Rural and Remote Health in Mt Isa, achieving greater-than-population parity representation. (Standard 1.8.3)

The strong collaborative engagement with and support for community members and patient volunteer teachers that has resulted in a successful program of volunteer simulated patients. (Standards 1.8.4 and 4.6)

The enthusiastic and highly committed staff who work well together, and are dedicated to improving student outcomes. (Standard 1.9)

2. The outcomes of the medical program	Met

Recommendations

D Develop formal processes for community consultation across all of the communities in which clinical teaching sites are based to inform curriculum renewal. (Standard 2.1.4)

Commendations

JCU graduates are recognised for their work readiness, their commitment to remote and rural health, and for their understanding of the issues and needs of the North Queensland communities. (Standards 2.2.1 and 2.2.2)

3. The medical curriculum	Substantially Met

Standards 3.3 and 3.4 are substantially met

Conditions

1 Work with students to address their concerns that the biomedical sciences teaching in foundation years does not have sufficient clinical context and, therefore, does not appear to relate clearly to their clinical placements in later years of the curriculum. (Standard 3.3) by 2024

2 Demonstrate clear communication to students about the learning outcomes or objectives for Years 5 and 6. (Standard 3.4) by 2022

Recommendations

E Work with students to increase opportunities to develop skills in critical appraisal and develop an Evidence Based Medicine framework to signpost the acquisition of skills in research methodology, science and scholarship, and improve students' confidence in these areas. (Standards 3.2.1 and 4.2)

F Provide more detailed briefing materials for staff and supervisors for Year 4 clinical rotations and consider more formal attachments to clinical teams. (Standard 3.2.2)

G Include more group discussions and debriefing sessions around professional behaviour in the PEAL assessment items from Years 1 to 3, and review the balance of the burden and utility of written reflective activities. (Standards 3.2.4 and 4.2)

H Complete the development and population of the Database of Curriculum, Teaching and Assessment database to assist students and staff in the management and understanding of the curriculum. (Standard 3.4)

I When reviewing the content of the Aboriginal and Torres Strait Islander health curriculum, consider how to address perceptions of stereotyping and deficit framing. (Standard 3.5)

Commendations

The positive College culture that discourages competitiveness and privileges collaborative learning. (Standard 3.2.4)

The clear commitment of the Program to collaborative work with Aboriginal and Torres Strait Island communities on the development and delivery of the Indigenous Health curriculum. (Standard 3.5)

4. Teaching and learning	Met

Recommendations

J Work with students and supervisors to address students' concerns about the difficulty in accessing research supervisors and opportunities, particularly at regional sites. (Standard 4.5)

K Include further opportunities (beyond pharmacy) for medical students to learn alongside students from other disciplines when developing the College's new IPL framework. (Standard 4.7)

Commendations

The Acute Care Clinic workshop and the simGPclinic, which are innovative simulated learning opportunities for clinical skills development. (Standard 4.3)

The Program's commitment to learning through clinical experience and the clearly solid foundation for intern training that the program provides. (Standard 4.4)

The College's clear commitment to patient centred care within the Program's design and delivery. (Standard 4.6)

5. The curriculum – assessment of student learning	Met

Recommendations

L Consider a change from a high stakes end of year exam in Year 5 to a more even spread of lower stakes assessments across the year, which would enable multiple perspectives on students' performance within authentic clinical settings and enhance longitudinal assessment. (Standard 5.2.1)

M Review the utility of the Basic Science Retention Exams and consider alternate methods of reinforcing basic science knowledge retention. (Standard 5.2.1)

Commendations

The leadership roles and academic activities undertaken in the ACCLAiM collaboration.

6. The curriculum – monitoring	Substantially Met

Standards 6.1.1 and 6.1.2 are substantially met

Conditions

3 Demonstrate responsiveness to student feedback so that concerns about, or risks to, the quality of the medical program across all clinical sites are addressed. (Standard 6.1.1) by 2023

4 Review the College evaluation processes to ensure that a coherent set of monitoring and evaluation activities relate to an overarching framework and that the framework and the contribution of the various activities to that framework are clearly articulated for staff and students. (Standard 6.1.1) by 2022

5 Implement systematic mechanisms and formal pathways to deliver and obtain feedback to and from staff. (Standard 6.1.2) by 2023

Recommendations

N Include student representation in the Evaluation Strategy Committee to support the review and development of monitoring and evaluation activities. (Standard 6.1.1)

O Work with students to develop a more accessible mechanism to communicate results of evaluation activities to the entire student body. (Standard 6.3.2)

P Document the range of feedback mechanisms for external stakeholders across the program and clinical sites, and centralise the collection and analysis of this feedback to augment the engagement in the annual College Summit. (Standard 6.2)

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

Standards 7.2.4 and 7.3.1 are substantially met

Conditions

6 Clarify and publish the process for appealing selection decisions. (Standard 7.2) by 2022

7 Work with students, including Aboriginal and Torres Strait Islander students, to identify and address gaps in student support services perceived by students. (Standard 7.3.1) by 2022

Recommendations

Q Investigate and identify solutions to address staff concerns the College's current plagiarism prevention tool (SafeAssign) does not effectively identify unprofessional behaviour of this nature. (Standard 7.4.2)

R Include student representation in the Aboriginal and Torres Strait Islander Strategy Committee and the Evaluation Strategy Committee. (Standard 7.5)

Commendations

The University's investment in work with Aboriginal and Torres Strait Islander high school students to encourage participation in tertiary education and the medical program. (Standard 7.1.3)

The College's dedication to its mission and proud tradition of graduating doctors to serve rural, remote, Indigenous and other underserved communities in the region. (Standard 7.1)

8. Implementing the curriculum – learning environment	Met

Recommendations

S Engage with the leadership of local health services in a collaborative long term planning exercise that builds from a common vision, and incorporates issues of evolving space needs to secure robust and mutually beneficial, long term partnerships. (Standard 8.1)

T Work with supervisors to develop mechanisms to provide feedback on their performance to support their development. (Standard 8.4.2)

Commendations

The commitment to early and comprehensive patient contact across a wide range of healthcare settings. (Standards 8.3.1 and 8.3.2)

The strong partnerships with health services and Aboriginal Community Controlled Health Organisations, and extensive experience in the provision of culturally competent care for Aboriginal and Torres Strait Islander peoples available to all students. (Standard 8.3.3)

The significant investment in a wide range of general and targeted opportunities to support academic and clinical teachers' professional development as medical educators. (Standard 8.4.2)

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 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 a reaccreditation 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 Medical School Accreditation Committee providing opportunities for the medical school to comment on successive drafts. 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 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 Medical School Accreditation Committee.

The University, the Faculty and the School

The James Cook University (JCU) consists of a geographically dispersed network of campuses, study centres, field stations, research hubs, training sites and clinical schools in Northern Queensland. In 2021, the medical program had in total, 63.1 full-time equivalent (FTE) academic staff, 64.1 FTE Administrative staff, and 27.9 FTE Research staff, distributed across the sites. In addition, 14 medical training hubs support vertically integrated medical training under the GP Training program covering 90% of Queensland. As at February 2021, there are 335 adjunct and Full Academic Title Holder (FATH) appointments supporting the medical program.

For JCU, the total enrolment of student headcount in 2020 was 21,277, and an equivalent full-time student load of 14,428 students.

The University Council is the governing body of the University, established by the James Cook University Act 1997 and consists of 22 members including official, appointed and elected members. The primary role of Council is to oversee the affairs of the University, ensuring that the appropriate structures, policies, processes and planning are in place. Chaired by the Chancellor, decisions are made with the support of committees or through authorised delegations.

The operational and academic governance is organised into the Indigenous Education and Research Centre, three national research hubs, and five divisions:

- Research and Innovation
- Service and Resources
- Student Life
- Tropical Environment and Societies
- Tropical Health and Medicine.

The Division of Tropical Health and Medicine is led by the Deputy Vice Chancellor and comprises the Division Office, the Office of Academic Quality and Strategy, the Australian Institute of Tropical Health and Medicine (AITHM), the Murtupuni Centre for Rural and Remote Health (CRRH), and three colleges:

- Healthcare Sciences
- Public Health, Medical and Veterinary Sciences
- Medicine and Dentistry.

The College of Medicine and Dentistry is composed of five organisational units: the College itself, Medicine, Dentistry, Pharmacy and General Practice Training (delivering the Australian General Practice Training (AGPT) program for General Practice Registrars). The Medicine, Dentistry and Pharmacy units coordinate and deliver the professional entry degree course, relevant honours, postgraduate course work and higher degree by research offerings, and a range of short courses, Continuing Professional Development (CPD) opportunities and skills training. The College taught 1,124students in the MBBS program in 2020.

The Dean of the College delegates responsibility for academic matters of the medical program to the Head of Medical Education and to Chairs of relevant committees.

The foundation years of the Bachelor of Medicine / Bachelor of Surgery (MBBS) program (Years 1 to 3) are largely based on the Townsville campus, and the clinically focused years (Years 4 to 6) are delivered from the three main sites in Cairns, Townsville and Mackay. All students undertake substantial rural placements in Years 2, 4 and 6, with opportunities for some students to participate

in extended integrated rural placements in Years 5 and 6. The program features clinical exposure through the following three clinical schools:

- Cairns Clinical School
- Townsville Clinical School
- Mackay Clinical School.

In addition, students have clinical exposure through the Rural Clinical School situated across northern Queensland, including the Atherton Tablelands Clinical School and the Murtupuni Centre for Rural and Remote Health in Mt Isa.

For 2021, the MBBS student intake was 191 students, including eight Aboriginal and Torres Strait Islander students. The planned student numbers for 2022 include 155 government supported and 50 international students pending border restrictions.

Accreditation Background

The AMC first assessed the MBBS program delivered by James Cook University, College of Medicine and Dentistry in 1999, and the College was granted accreditation for six years until 31 December 2006, subject to conditions. Follow-up assessment visits were conducted in 2000 and 2002. Following the 2002 visit, the AMC granted accreditation until 31 December 2007, subject to satisfactory annual reports.

In its 2006 comprehensive report, the College advised that it planned to increase student numbers, from an initial cohort of 60, to 100 in 2007 and to 150 in 2008. The Medical School Accreditation Committee decided that a short AMC team visit was required in 2007. Following this visit, accreditation of the program was extended until 31 December 2010.

James Cook University provided a report for reaccreditation in 2010 and an AMC assessment team visited the College and associated clinical teaching sites. The program was granted accreditation for six years until 31 December 2016, subject to the submission of satisfactory progress reports.

In 2016, the Committee considered the College's comprehensive report and accreditation was extend to 31 March 2021.

In the College's 2018 progress report, the Committee was concerned with changes in the College's financial circumstances and the sustainability of these adjustments and the impact on teaching and learning. The Committee has asked for this matter to be addressed in the 2021 submission for reaccreditation.

In 2020, an extension of accreditation was granted for twelve months, until 31 March 2022, to accommodate the deferral of the reaccreditation assessment due to the unusual circumstances related to the global COVID-19 pandemic.

This report

This report details the findings of the 2021 reaccreditation assessment of the James Cook University, College of Medicine and Dentistry medical program. The assessment examines the detail of the currently accredited program, incorporating iterative revisions.

Each section of the accreditation report begins with the relevant AMC accreditation standards.

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**.

The teaching sessions observed by the AMC team in 2021 via videoconference are at **Appendix Three.**

Appreciation

This accreditation has occurred under very unusual circumstances, during a global pandemic. The AMC Team acknowledges the extraordinary circumstances in which the College is operating, and under which this assessment has occurred. The Team acknowledges the many personal and professional challenges that all staff and students, and other stakeholders are currently facing, and truly appreciates how adaptable everyone involved in the assessment has been. Against this backdrop, the openness and responsiveness of all people we have spoken to have been impressive and is testament to the commitment to high quality medical education at this College.

1 The context of the medical program

1.1 Governance

1.1.1 The medical education provider's governance structures and functions are defined and understood by those delivering the medical program, as relevant to each position. The definition encompasses the provider's relationships with internal units such as campuses and clinical schools and with the higher education institution.

1.1.2 The governance structures set out, for each committee, the composition, terms of reference, powers and reporting relationships, and allow relevant groups to be represented in decision-making.

1.1.3 The medical education provider consults relevant groups on key issues relating to its purpose, the curriculum, graduate outcomes and governance.

The overarching governance structure of James Cook University consists of an upper layer of Council and Vice Chancellor/President, below which sits the Provost/Academic Board/Chief of Staff and Indigenous Education and Research Centre. The main structure of the University that feeds into this layer is the five Divisions, each headed by a Deputy Vice Chancellor (DVC). Two of the divisions are academically focused: the Division of Tropical Health and Medicine (DTHM) and the Division of Tropical Environments and Societies (DTES).

There is also a Division of Student Life, and the fifth is the operational Division of Services and Resources. The Medical School of James Cook University sits within the DTHM, a Division led by the DVC. The DTHM, aside from the Division Office and the Office of Academic Quality and Strategy, comprises of five organisational units: the Australian Institute for Tropical Health and Medicine (AITHM), the Murtupuni Centre for Rural and Remote Health (CRRH), and three academic colleges, namely, the College of Medicine and Dentistry (CMD), the College of Public Health, Medical and Veterinary Sciences (CPHMVS), and the College of Healthcare Sciences (CHS).

The CMD, led by a newly appointed the Dean, comprises five organisational units, of which one is Medicine. The other four units of the College are the College's operational division, Dentistry, Pharmacy and post-graduate Australian General Practice Training (AGPT) program that oversees training of General Practice Registrars in the region.

The University's medical degree program, the MBBS, is a six year, largely direct-from-high-school entry program. Responsibility for the coordination and delivery of the MBBS degree course, relevant honours, and higher degree by research offerings occurs within the committee structure of the CMD, particularly the Board of Studies (Medicine).

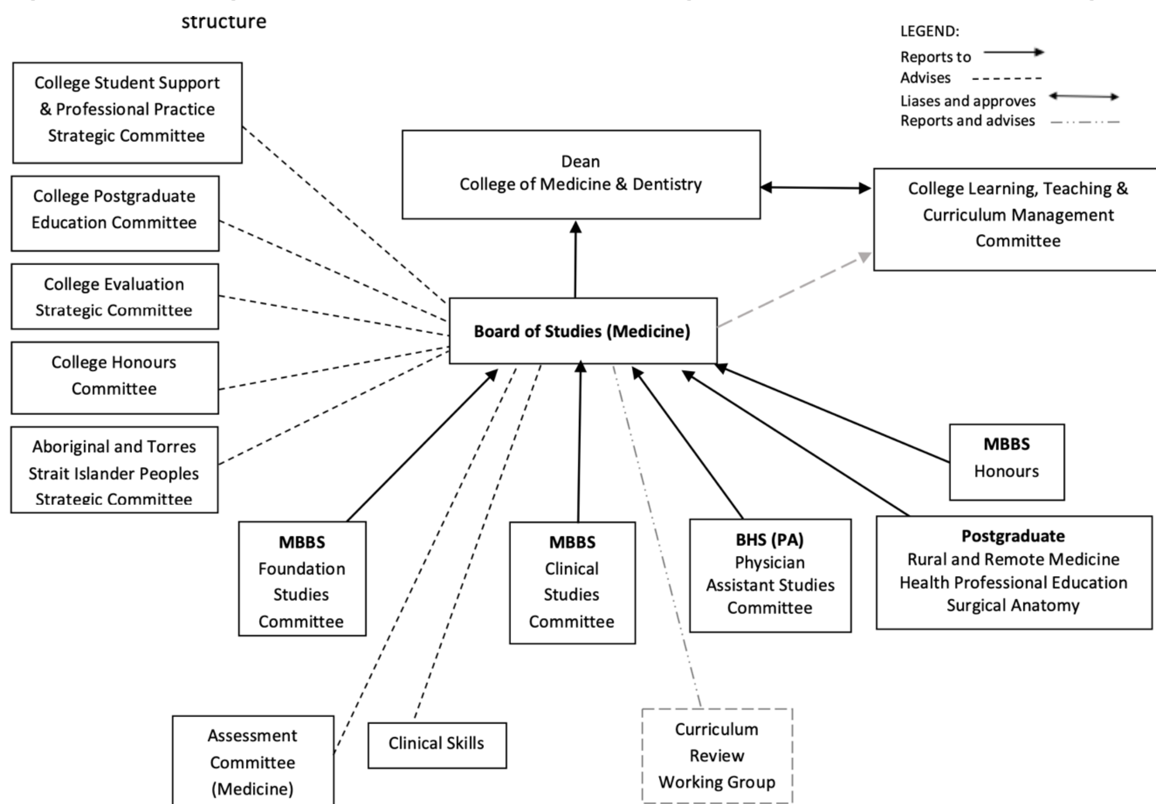
The College, like all other colleges, includes a leadership structure below the Dean, of an Associate Dean of Research (ADR), Associate Dean of Research Education (ADRE) and Associate Dean of Learning and Teaching (ADLT). In addition to this, the College of Medicine and Dentistry has an Associate Dean of Students. The University-proscribed College Leadership roles of Academic Head and Course Coordinator were combined in 2020, creating the single role of the Head of Medical Education. The principal accountabilities of these roles, including the new combined position, are well-described. The College has staff who are representatives on a variety of University-wide committees.

The Dean of the College reports to the DVC of the DTHM, who in turn reports to the Provost, and in turn to the Vice Chancellor (VC). Of note, the VC is due to retire, and a search is underway for her replacement.

The College's governance structures for the Program are complex (see Figure 1); however, they appear to function well, albeit with significant levels of informal pathways of communication and

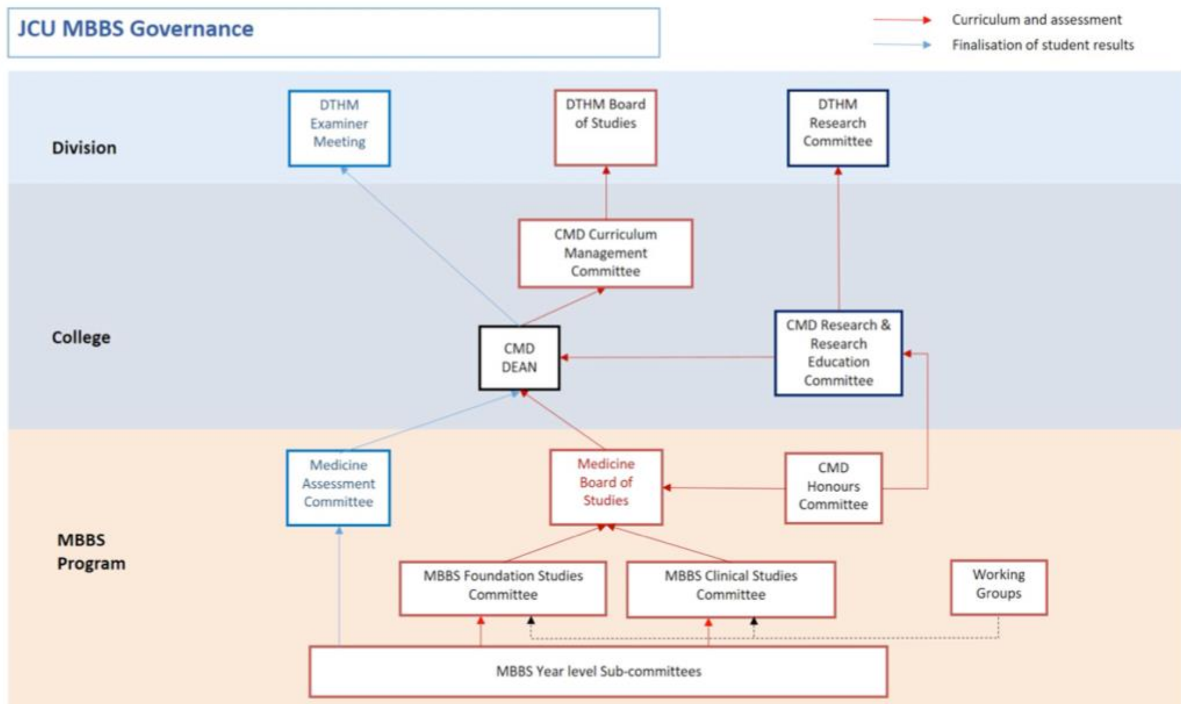
decision making. The 'open-door' approach to problem solving is very much in keeping with that of the regional culture, one that is personable and informal. The structure seems to work well, albeit with some risk. All interviewed about the governance structures acknowledged the value of the flexibility, while also being aware of the importance of the formal structures and the need to use them to deal with disruption such as occurred during the COVID-19 pandemic in 2020.

Figure 1 Organisational structure of the College relevant to the medical program



The Board of Studies (Medicine) is a central decision making committee of the College and is responsible for the medical, physician assistant, health professional education, rural and remote and surgical anatomy courses. Specific to an MBBS perspective, it includes representation from the MBBS Course Coordinator, Director of Foundation Studies, Director of Clinical Studies, Head of Clinical Skills, and two students (though not necessarily MBBS students). Reporting to the Dean, it is also charged with referring well-defined major decisions to the College Learning, Teaching and Curriculum Management Committee (CCMC) chaired by the Associate Dean of Learning and Teaching, a committee which also has the Dean as a voting member. On paper, there is a degree of uncertainty in the decision making responsibilities between the Dean and the CCMC, as decisions and reporting lines of the CCMC are to the Division Board of Studies (DBoS), of which the Dean is also a member, however, the Chair of CCMC sits beneath the Dean in terms of reporting lines. However, staff members understood the structure, felt that it was robust and fit for purpose. Of note, the Provost has recently undertaken a review of the overall governance structure of the University, however, recommendations from this review will not be implemented until the new Vice Chancellor is appointed. The potential changes were therefore outside the scope of this assessment and would need to be submitted separately to the AMC for consideration of their impact on the Program's accreditation, once confirmed.

Figure 2 Medical Program Governance Chart



The governance of the MBBS structure is divided into Foundation Studies (Years 1 to 3) and Clinical Studies (Years 4 to 6), with each part having year coordinators, and site coordinators for the clinical years. Site directors and year coordinators are clear in their perception of the Medical School working well as one entity of healthy collaboration, with opportunities for all involved to raise any problems, and trusting that the existing organisational structure responds well.

Overall, the Terms of Reference (ToR) of the various college committees were clear and inclusive, with membership constructed to meet the needs of the committee, except in a few instances where the functions could be enhanced by increased representation from the student body. For the Foundation years, there was significant teaching load delivered by the academic staff from the two other colleges within the Division, CPHMVS and CHS. This was delivered in a collaborative fashion, with staff teaching into and out from the College both at the University campus in Townsville, and also in other clinical sites.

The Program is delivered over a broad geographic footprint, with the foundation years (Years 1 to 3) being largely based on the Townsville campus, and the clinical years based across the three main hospital-based sites of Cairns (Years 4 to 6), Townsville (Years 4 to 6) and Mackay (Years 5 to 6), along with the Rural Clinical Training sites across northern Queensland, including the Atherton Tablelands Clinical School (Short rural placements Years 2, 4 and 6, Murtupuni Centre for remote health in Mt Isa and extended integrated rural placements in Year 6). Each of the clinical sites has an assigned head of program, although this position in the Rural Clinical Training Sites is unfilled at present though a recruitment process is underway.

1.2 Leadership and autonomy

1.2.1 The medical education provider has autonomy to design and develop the medical program.

1.2.2 The responsibilities of the academic head of the medical school for the medical program are clearly stated.

The College has almost complete autonomy in the design and development of the curriculum and its implementation. Substantial changes to curriculum that affect information in the University handbook (such as changes in learning outcomes or assessment weightings) require approval by the College Curriculum Management Committee. These changes are well-defined in committees' terms of reference.

The reporting relationships and key responsibilities of the Dean of the College to the DVC DTHM and to the University administration are clear. The Dean's roles and responsibilities are clearly articulated under the university statutes. The Head of Medical Education reports to the Dean in their role as head of the MBBS program, and also has clearly defined roles and accountabilities in the operationalisation of the program.

1.3 Medical program management

1.3.1 The medical education provider has a committee or similar entity with the responsibility, authority and capacity to plan, implement and review the curriculum to achieve the objectives of the medical program.

1.3.2 The medical education provider assesses the level of qualification offered against any national standards.

The responsibility to plan, implement and review the curriculum to achieve the objectives of the Program sits largely with the Board of Studies (Medicine) (BoS (Med)). It is the central committee responsible for authority and decision-making on the learning, teaching and assessment, and related policies and guidelines in the medical program. Minor changes to teaching, curriculum and assessment are managed by the BoS (Med), with significant curriculum change proposals (well described in the TORs of both committees) approved by the College Learning, Teaching and Curriculum Management Committee (CCMC).

The BoS (Med) has broad representation from a number of committees across the Program, and other postgraduate programs (see Figure 1), and reports directly to the Dean of College. It is clear that the distributed course delivery model requires careful and ongoing coordination to assure alignment with the curriculum while allowing for flexibility in local delivery.

The CMCC has a broader range of responsibilities across the other academic units of the College, namely Dentistry, Pharmacy and the postgraduate Australian General Practice Training (AGPT), and reports to the DVC DTHM.

The College's Aboriginal and Torres Strait Islander Peoples' Strategy Committee has responsibility for advice and oversight of curriculum matters relating to how the health issues of Aboriginal and Torres Strait Islander peoples is delivered into teaching programs across all of the College's academic units. This committee is chaired by a lecturer in Indigenous Health, and provides advice to the BoS (Med) on curriculum and assessment.

The College indicated that the Medical Program meets the Australian Qualifications Framework (AQF) level seven requirements for a Bachelors qualification. The MBBS (Hons) meets the AQF level eight requirements for an Honours qualification.

1.4 Educational expertise

1.4.1 The medical education provider uses educational expertise, including that of Indigenous peoples, in the development and management of the medical program.

The College's approach to strengthening its educational expertise, with the merging of the roles of Academic Head and Course Coordinator in 2020 and the appointment to the new role of Head of Medical Education, is impressive. The obvious passion for clinical education and research exhibited by the staff is inspiring. The governance structure includes clear pathways for curriculum and assessment review.

The College networks with a number of senior Aboriginal and Torres Strait Islander academics, largely through the Indigenous Education and Research Centre. This leadership, combined with the growing numbers of Indigenous academic staff at the Murtupuni Centre for Rural and Remote Health in Mt Isa, demonstrates growing capacity in the development and delivery of an integrated Indigenous health curriculum. The College has broad committee representation by the University's Indigenous academic staff members.

1.5 Educational budget and resource allocation

1.5.1 The medical education provider has an identified line of responsibility and authority for the medical program.

1.5.2 The medical education provider has autonomy to direct resources in order to achieve its purpose and the objectives of the medical program.

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

The Medical Program has a single budget with revenue from a number of sources. The University's Budget Allocation Model (BAM) allocates funds based on projected student numbers and research income on an 'as-earned' basis. In addition to the operational funding, the Medical Program receives monies from a number of external grants, including Commonwealth and State Health Department funds under several programs.

The Dean of the CMD, through the DVC DTHM negotiates the College's budget on an annual basis, with current COVID era budgets of shorter duration than the normal triennial arrangement. The Dean has the authority and autonomy to then determine budget distribution across the medical program. Overall, the Program receives funding from the University and from the Commonwealth Government's Rural Health Multidisciplinary Training (RHMT) Program grant funding, split roughly 2:1, respectively. The Program has well defined financial reporting requirements with the College, with regular 'budget to actual' reviews performed throughout the year. This allows the central finance team, together with the College Manager, to ensure delivery of all courses within the budget allocation, and to the standard required. There are strict reporting requirements for the Commonwealth grants, with specific deliverables and targets to be met. Regular 'budget to actual' reviews of the College and individual Disciplines is performed throughout the year. Monthly forecasts are updated using information from the actual results to date as well as updates from the Colleges/Disciplines on any changes that will impact their planned activities and costs. The central finance team, in conjunction with the College Manager, refines cost estimates and forecasts to ensure the portfolio of courses are delivered at the prescribed standard and within the funding available.

The summary income and expenditure statements and supplementary financial information were provided. Net zero budgets realised for 2018-2020.

The 2021 budget was forecast assuming business operations will continue across the same level as 2020, guaranteeing continuity for staff salaries across all Divisions, with a deficit budget approved to achieve operational stability. The University has commenced the development of a Strategic Asset Management Plan, aimed at managing the whole of University capital expenditure needs, to improve budgetary management in the future.

The College has the financial resources and financial management capacity to implement the Program, with some degree of uncertainty and risk related to the financial pressures created by the loss of international medical students due to the COVID-19 pandemic.

1.6 Interaction with health sector and society

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.

In delivering the Program, the College is to be commended on ongoing strong partnerships with the clinical sites at the three health services that the Team visited, as well as the multiple rural and remote health services, and Aboriginal Community Control Health services who host student placements. This is of particular note in the delivery of the rural and remote program, where multiple stakeholders and health services are engaged to deliver a geographically dispersed Program. There was evidence of formal agreements underpinning these relationships.

1.7 Research and scholarship

1.7.1 The medical education provider is active in research and scholarship, which informs learning and teaching in the medical program.

The College has a rich and robust track record in research focusing on its graduate outcomes that underpin its mission and purpose. There is also an embedded nature of research-informed teaching. The recently incorporated Tropical Australian Academic Health Centre (TAAHC), a formal collaboration between James Cook University, the AITHM, all five of the northern Queensland Hospital and Health Services, the Northern Queensland Primary Health Network, and the Queensland Aboriginal and Islander Health Council, recently received accreditation from the National Health and Medical Research Council (NHMRC) as a Centre for Innovation in Regional Health. TAAHC represents enormous opportunity to build important collaborations with Health providers, and research capability both within the College and the University as a whole.

As discussed further under standard 3.2, there is an opportunity for the College to focus on expanding an authentic research program for students that will in turn benefit the Program. The College is further encouraged to continue to develop relationships in building research opportunities with the health services that will provide benefits to the local communities.

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.

1.8.3 The medical education provider actively recruits, trains and supports Indigenous staff.

1.8.4 The medical education provider follows appropriate recruitment, support, and training processes for patients and community members formally engaged in planned learning and teaching activities.

1.8.5 The medical education provider ensures arrangements are in place for indemnification of staff with regard to their involvement in the development and delivery of the medical program.

The College has academic staff in the combined Program, rural training hubs, research and General Practice training. A number of these appointments were conjoint, representing mixed staffing responsibilities. Nonetheless, there was consensus among the staff members that there were a number of essential staff necessary to deliver the Program. The Program is supported by approximately 70 professional and technical staff. Academic Services, Clinical Training Services, Administrative Services and MedTech support are provided by these staff members. There was a commitment by the University to preserve all staff appointments for 2021, which was an important decision in the otherwise uncertain times of the COVID-19 pandemic.

The University has a well-developed Aboriginal and Torres Strait Islander leadership group in the form of the Indigenous Education and Research Centre. This initiative has allowed the development of a leadership team of senior Indigenous academics with broad community connections and influence. The College has the ability to draw on this expertise with two Level C appointments, one Level B appointment and four Aboriginal staff members within GP training. The College is to be commended for the success in recruitment and development of a growing group of Indigenous academic and professional staff at the Murtupuni Centre for Rural and Remote Health in Mt Isa, achieving greater-than-population parity representation. It is noted that there is also an increasing network of Aboriginal and Torres Strait Islander research officers and fellows employed across the distributed networks of the College.

There are a number of initiatives that appear to be in development to promote the recruitment of Indigenous staff across the broad footprint of the College, in particular, the Cairns Clinical School and the Mackay Clinical School. The School is encouraged to further utilise the initiatives that have been noted in the JCU Reconciliation Action Plan to improve the active recruitment and training of Indigenous staff.

The College has a predominantly informal process for recruiting patients and community members into planned teaching and learning activities. Volunteers and patients reported good levels of training and support, opportunities to provide feedback to the College on their experiences, and appreciated the Annual Volunteer Celebration days that the College conducts.

University staff members are indemnified for relevant activities in the development and delivery of the MBBS as per the University Indemnity, Insurance and Legal Claims policy, which was provided for review.

1.9 Staff appointment, promotion & development

1.9.1 The medical education provider's appointment and promotion policies for academic staff address a balance of capacity for teaching, research and service functions.

1.9.2 The medical education provider has processes for development and appraisal of administrative, technical and academic staff, including clinical title holders and those staff who hold a joint appointment with another body.

The College has a full suite of policies for appointment and promotion of academic staff that address a balance of capacity for teaching, research and service functions. The College also has robust

processes for development and appraisal of all staff, including those with joint clinical appointments.

From 2020, processes for approving all new JCU staff appointments were modified due to the COVID-19 pandemic. Approvals were centralised rather than at the College level. Although this did not result in reduced staffing, there were delays in appointments and additional workloads for College staff. Although the College has processes and policies in place for appointment, promotion and development of staff, there remain a number of senior positions that are awaiting appointment, impacting the College's overall progress. The College is encouraged to work with University HR to improve the efficiency of recruitment processes for staff appointments to these positions. Throughout the visit, staff work ethic, engagement and enthusiasm to improve the quality of teaching, learning and student outcomes is impressive.

2 The outcomes of the medical program

Graduate outcomes are overarching statements reflecting the desired abilities of graduates in a specific discipline at exit from the degree. These essential abilities are written as global educational statements and provide direction and clarity for the development of curriculum content, teaching and learning approaches and the assessment program. They also guide the relevant governance structures that provide appropriate oversight, resource and financial allocations.

The AMC acknowledges that each provider will have graduate attribute statements that are relevant to the vision and purpose of the medical program. The AMC provides graduate outcomes specific to entry to medicine in the first postgraduate year.

A thematic framework is used to organise the AMC graduate outcomes into four domains:

1 Science and Scholarship: the medical graduate as scientist and scholar.

2 Clinical Practice: the medical graduate as practitioner.

3 Health and Society: the medical graduate as a health advocate.

4 Professionalism and Leadership: the medical graduate as a professional and leader.

2.1 Purpose

2.1.1 The medical education provider has defined its purpose, which includes learning, teaching, research, societal and community responsibilities.

2.1.2 The medical education provider's purpose addresses Aboriginal and Torres Strait Islander peoples and/or Māori and their health.

2.1.3 The medical education provider has defined its purpose in consultation with stakeholders.

2.1.4 The medical education provider relates its teaching, service and research activities to the health care needs of the communities it serves.

The College's purpose and mission, in delivering a fit-for-purpose workforce to serve the communities of North Queensland is clearly stated and evident in all of its strategic objectives and activities. It is a clearly recognised part of the College's culture by external stakeholders.

The statement of purpose for the College is: To promote health and strengthen healthcare for communities of tropical Australia and beyond through excellence in socially accountable health professional education, research, service, partnerships, advocacy and leadership.

The College's mission clearly identifies the importance of the recognition of the local Aboriginal and Torres Strait Island cultural heritage, with a clear commitment to closing the gap between Aboriginal and Torres Strait Islander health outcomes and non-Indigenous health outcomes, uniquely offering postgraduate integration with rural General Practice training as a means to address the maldistribution of medical practitioners in rural and remote North Queensland.

The College relates its teaching, service and research activities to the health care needs of the community it serves. The College's work is guided by the College-wide Program Logic, which aims to concisely represent the desired priorities and actions, mapped to intended outcomes (short, medium and long term) in order to meet the objectives of its intended outcomes – a future where individuals and families can be confident of good health and equitable access to high quality health care in remote, rural, regional and tropical locations, in Aboriginal and Torres Strait Islander communities and across the wider region.

The College's activities are informed from community advocacy to develop a workforce that suits the needs of the broader community. The College has the benefit of close links with the Indigenous Education and Research Centre, and a number of significant senior Aboriginal and Torres Strait

Islander leaders who are well connected across the region, and are active in seeking community input into the work of the College and University as a whole, and, particularly through the Murtupuni Centre for Rural and Remote Health in Mt Isa, to enrich the Program. Their leadership has resulted in growing numbers of Aboriginal and Torres Strait Islander applicants to the Program, increased the range of programs, and the support of scholarship overseen by the University's Indigenous Education and Research Centre.

While acknowledging the role of the annual College Summit, where the College reviews its purpose and strategic priorities, attended by key stakeholders including local hospital and health service executives, defined systematic and formal processes by which community stakeholders are regularly invited to contribute input on the College's Program are difficult to identify. Such inputs are usually gained from informal and opportunistic encounters with community volunteers at the College's various teaching sites. The College is encouraged to develop formal and systematic processes for coordinating and mapping community consultation to further inform the activities of the medical program.

2.2 Medical program outcomes

A thematic framework is used to organise the AMC graduate outcomes into four domains:

1. *Science and Scholarship: the medical graduate as scientist and scholar.*
2. *Clinical Practice: the medical graduate as practitioner.*
3. *Health and Society: the medical graduate as a health advocate.*
4. *Professionalism and Leadership: the medical graduate as a professional and leader.*

2.2.1 The medical education provider has defined graduate outcomes consistent with the AMC Graduate Outcome Statements and has related them to its purpose.

2.2.2 The medical program outcomes are consistent with the AMC's goal for medical education, to develop junior doctors who are competent to practise safely and effectively under supervision as interns in Australia or New Zealand, and who have an appropriate foundation for lifelong learning and for further training in any branch of medicine.

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 College's graduate outcomes are well defined, and consistent with the AMC's graduate outcomes for medical education. There was good evidence of equivalence of outcomes across the Program, underpinned by a governance structure supporting a single College approach to learning and teaching.

The University's medical graduates are recognised for their work readiness, their commitment to remote and rural health, and for their understanding of the issues and needs of the North Queensland communities. The graduates are valued and welcomed by the local health services. Of note, the size and acuity of the two largest health service teaching sites (Cairns and Townsville) were sufficiently capable in providing experiential learning appropriate for practice as interns anywhere in Australia or New Zealand. The College's integrated rural immersion program in rural and remote North Queensland, with successful collaborations with remote health services, including those serving Aboriginal and Torres Strait Islander communities is commendable.

The Program is delivered consistently across all instructional sites, as evidenced by the use of psychometric tools to compare the assessment results in each discipline across sites. The completion and wide availability of the online curriculum management system the Database of

Curriculum, Teaching and Assessment (DoCTA) will further support this inter-site consistency. The College also seeks feedback from students at all instructional sites, although the robustness of the systems for analysing and acting on this information fluctuate across disciplines and sites. The committee structure is adequate in ensuring equivalence in outcomes across all sites and disciplines, in both regional and rural settings.

3 The medical curriculum

3.1 Duration of the medical program

The medical program is of sufficient duration to ensure that the defined graduate outcomes can be achieved.

The medical program is a six year MBBS degree, and the duration of the program is sufficient to ensure that the defined graduate outcomes can be achieved.

3.2 The content of the curriculum

The curriculum content ensures that graduates can demonstrate all of the specified AMC graduate outcomes.

3.2.1 Science and Scholarship: The medical graduate as scientist and scholar.

3.2.2 Clinical Practice: The medical graduate as practitioner.

The curriculum contains the foundation communication, clinical, diagnostic, management and procedural skills to enable graduates to assume responsibility for safe patient care at entry to the profession.

3.2.3 Health and Society: The medical graduate as a health advocate.

The curriculum prepares graduates to protect and advance the health and wellbeing of individuals, communities and populations.

3.2.4 Professionalism and Leadership: The medical graduate as a professional and leader.

The curriculum ensures graduates are effectively prepared for their roles as professionals and leaders.

The curriculum content is based around four themes which align with the four AMC domains. There are no specific theme chairs although there are identified champions for each of the themes who attend key meetings concerning the curriculum.

Science and scholarship

The Foundation Years 1 to 3 are made up of systems-based units of study. Anatomy teaching in Years 1 and 2 appears to be taught with limited clinical context and is revisited during an Emergency Medicine term in year 3 and with a small number of sessions in Year 4 focused on clinically-oriented anatomy and pathology. There is a selective in anatomy in Year 3 which is highly sought after involving dissection. Students expressed some concerns about the adequacy of anatomy teaching.

Evidence-Based Medicine (EBM) is introduced in Year 1 with a focus on epidemiology in Ecology of Health. There is further formal teaching in Years 2 and 3 on epidemiology in Rural, Remote, Indigenous Health, Tropical Health, and Preventative Health and Addiction studies. There are also many assessments where students are required to perform literature searches and provide summary of best practice. In Year 6, students complete an EBM presentation based on a clinical case supported by an influential paper contributing to the evidence for management of a medical condition. Year 6 students also develop a research proposal for a project with considerable feedback from experienced researchers. The students expressed a desire to actually complete a research study/audit rather than a simulated research proposal during their last year. Inequity in access to EBM resources across sites was also raised in the student report as the 'UptoDate' database is not available to students placed at Mackay. The College advises the point of care information resource Dynamed Plus is available to all students.

Students reported that they feel that they do not have sufficient skills in research methodology to critically appraise a research article. While there are reasonable foundation activities in EBM, the students' lack of confidence in critical appraisal was of concern. This appeared at odds with the strong scholarly approach to medical education within the College. There is an opportunity for the College to work with students to develop a formal Evidence-Based Medicine framework to signpost skill acquisition and to enhance teaching so that students feel confident in research methodology, science and scholarship.

Clinical Practice

Clinical skills is formally taught via a specific module in years 1 to 3, with clinical placements from Year 1 with nine hours of general practice and 70 hours in a health elective placement. Clinical placement increases to 1,600 hours in Year 4, which is clinically immersive. Emphasis on the importance of communication is highlighted right from Year 1, including effective communication styles in the Aboriginal and Torres Strait Islander context. The students undertake the majority of their initial history taking and examination skills learning in Years 1 to 3 with practice of history taking and examination across years 4 to 6. Generally, students are very satisfied with the amount and quality of clinical teaching.

Year 4 includes five rotations in a range of settings including rural, public, private, community and clinical intensive. The clinical experience in this year is fairly self-directed, with students not clearly attached to a team, resulting in a reported feeling of lack of clear direction for their bedside learning. Although self-directed learning skills are important to develop, the early clinical activities may benefit from improved briefing of students and supervisory support or more formal attachments to clinical teams.

Students are required to demonstrate competency in core procedural skills in a simulated environment before they proceed to Year 5.

Year 5 is comprised of specialty blocks, medicine and surgery as well as general practice that are well structured to develop communication, clinical, diagnostic and management skills. The final year is a pre-internship, fully immersed with the teams including a rural intensive and clinical elective. Students feel confident that Year 6 provides the experience to ensure they are prepared for internship. This was certainly reflected in the joint AMC-MBA Preparedness for Internship Survey, where the University's graduates scored very highly. There is a significant placement component, approximately 3,500 hours across the course, more heavily weighted toward the later part of the degree, which is impressive for a medical program.

Health and Society

Health advocacy is a strength of the Program and is taught both directly and indirectly throughout the course with multiple assessments, allowing constant revision of concepts. Tropical medicine, Indigenous health and rural medicine, which are central to the purpose of the University and stated outcomes of the Program are covered across the six years.

Professionalism and Leadership

Development of professionalism and leadership appear to be emphasised throughout the Program. There are Home Groups, which assist in the development of a professional identity and discussions of scenarios representing challenges to professionalism. Students reported that by the time they reached clinical years, they have a strong understanding of professional requirements.

Students complete a continuing professional development portfolio in Year 6 with the requirement to have acquired 100 points or more of continuing professional development points, which is a

requisite for graduation. This will eventually become part of the Professionalism, Education and Leadership e-Portfolio (PEAL).

The Professionalism, Education and Leadership e-Portfolio (PEAL) was introduced in 2019 with a single e-portfolio system for students using Pebblepad+ which will be progressively introduced across the six years. In conjunction with a senior leadership working group, coordinators have developed workbooks and templates to progressively include as students progress through the course. A number of PEAL assessment items in Years 1 to 3 have been redeveloped with better alignment to domain learning outcomes. The students expressed some discontent with both the platform and the number of reflective tasks required. They voiced the desire for more group discussions and debriefing sessions around professional behaviour rather than personal reflection, while recognising the importance of reflection. Students had identified important opportunities for the PEAL portfolio to enhance student learning about professional behaviours in action.

Importantly, with respect to professional identity, students reported that there is a culture which admonishes overt competitiveness, endorses collaborative learning, and creates cohorts in which most students form close professional relationships. Students expressed a sense of sincere pride and gratitude to the College. This is an excellent foundation for positive professional relationships in team-based health service environments.

3.3 Curriculum design

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

There is evidence of purposeful curriculum design and clear articulation with medical intern training. There are opportunities to improve the vertical integration within the curriculum.

The curriculum structure is described as an 'overlapping wedge' model (see Figure 3.1) of clinical and professional skills, with foundation knowledge weighted towards the early years and clinical/professional skills weighted towards the later years. In Years 1 to 3 the curriculum is largely organised into a blend of organ systems-based modules, population, social and community health modules, and clinical skills experiences supplemented by clinical placements. Although clinicians do provide teaching with clinically focused content, some students reported that the foundation content tended to be learnt by rote due to insufficient clinical contextualisation and understanding of relevance to clinical medicine.

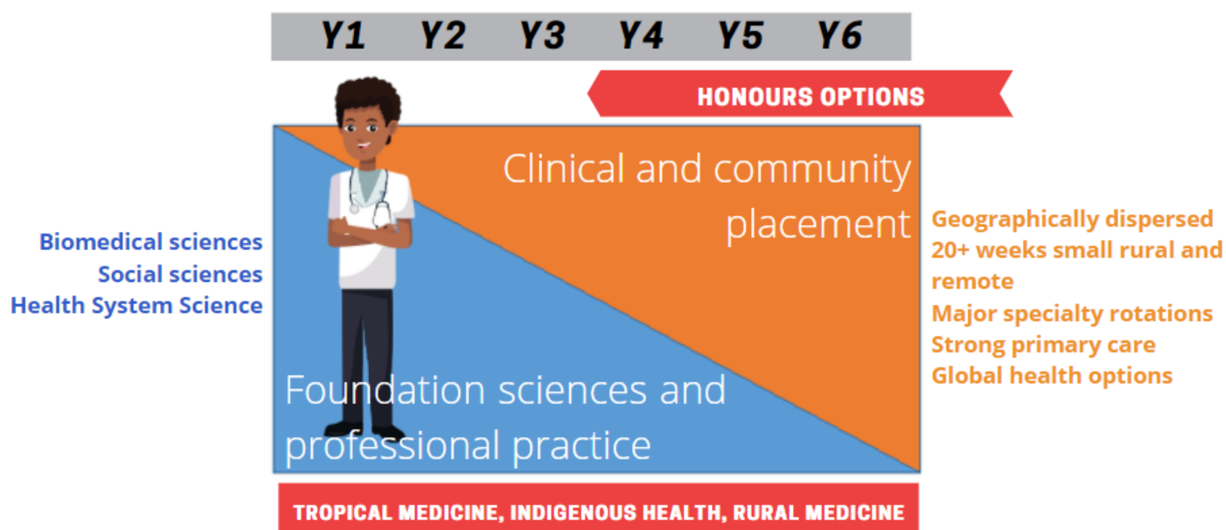
Year 4 is the link from the foundation science teaching in Years 1 to 3 to the multidisciplinary clinical Years 5 and 6, and is delivered to cohorts in Cairns and Townsville. The year is centred around a series of integrated Clinico-Pathological teaching sessions to consolidate and apply the basic science learning of Years 1 to 3. Although these sessions appear very valuable to student learning, the majority of pathology teaching appears to occur relatively late in the course and results in a lack of contextual learning of clinical skills and other biomedical sciences in Years 1 to 3.

Overall, based on student feedback and curriculum documentation, there appears to be siloing of biomedical sciences without clear vertical integration between the foundation studies years and clinical studies years. Increasing clinical contextualisation of biomedical sciences in the early years and revisiting these concepts in a systematic fashion in later years would enhance the vertical integration of biomedical sciences.

The College has an established Program that has successfully produced graduates who feel and are regarded as being well prepared for medical intern training.

However, a review of curriculum delivery, particularly during the first three years, with improved integration of the biomedical sciences around a clinical scenario is needed. This would enhance the experience of Year 4 as a transitional year to clinical practice, consolidating clinical reasoning, investigations and clinical skills in preparation for the immersive clinical years of Years 5 and 6.

Figure 3 JCU curriculum outline



3.4 Curriculum description

The medical education provider has developed and effectively communicated specific learning outcomes or objectives describing what is expected of students at each stage of the medical program.

The curriculum is informed by an overarching set of Course Learning Outcomes (CLOs) that reflect the global attributes of graduates of the University. These are based on the expectations of medical graduates in Australia and are contextualised to apply to the University's mission. Under these CLOs sit a suite of Year Learning Outcomes (YLOs) which have been prepared for each year of the course.

Using an Excel mapping system named HALO (Harmonising Assessment and Learning Outcomes) YLOs have been mapped against MBBS CLOs and also to the assessment items in each year. The YLOs have also been mapped against the AMC Graduate Outcome statements to demonstrate how the content delivered across the Program ensures that graduates are able to achieve all of the specified outcomes. This is used by Faculty to demonstrate mapping of Learning Outcomes and assessment, but is not available to the students. The DoCTA database is a bespoke curriculum tool housing the curriculum, teaching and assessment. This appears to be populated in Years 1 to 4, but has not been fully developed for Years 5 and 6. Students described some concerns about learning outcomes lacking detail with unclear expectations in the latter years. Further attention to these learning outcomes and subsequent collaborative work with students on the outcomes and expectations is required.

3.5 Indigenous health

The medical program provides curriculum coverage of Indigenous health (studies of the history, culture and health of the Indigenous peoples of Australia or New Zealand).

The Indigenous Health curriculum at the College was used to inform the Committee of Deans of Australian Medical Schools Indigenous Health Curriculum Framework, which has in turn influenced the design and development of Indigenous Health curricula at other schools. The fact that the

College's MBBS graduates rank first nationally for preparedness to provide care for Aboriginal and Torres Strait Islander peoples reflects the success of the Program.

The curriculum is integrated across the six years and delivered via lectures, guided learning sessions and clinical placements in Years 4 to 6. Cultural awareness is introduced early in the course through a cultural immersion experience (not held in 2020 due to COVID-19).

In Year 2, there is a module on Rural, Remote, Indigenous and Tropical Health that has a strong focus on working with individuals, families and groups in Aboriginal and Torres Strait Islander context and exploring models of health care delivery. Appropriate on-course assessments and reflective diaries are utilised.

In Year 4, students undertake an Aboriginal and Torres Strait Islander health placement as part of their six-week rural clinical rotation. This is in an Aboriginal Community Controlled Health Service (ACCHS) or other related government health service. Year 6 students complete a capstone Aboriginal and Torres Strait Islander Peoples' Health Assignment, which requires students to integrate their learning across all previous years, focusing on populations with chronic diseases.

The work of the Aboriginal and Torres Strait Islander Peoples' Strategy Committee was recognised with a LIME award in 2019 for 'Excellence in Community Engagement' for the Year 2 Rural, Remote, Indigenous and Tropical Health module. The clinical placements available to all students in an Aboriginal or Torres Strait Islander Health Centre are impressive. The current curriculum includes Indigenous health status and important topics for the health of Aboriginal and Torres Strait Islander Peoples. Staff and students are also taught to reject deficit framing, victim-blaming and stereotyping. However, over time and with changing staff, some students now report that stereotyping and deficit messages about Indigenous people have crept into the clinical teaching. The inappropriateness of this is recognised and a review of the Indigenous Health curriculum, overseen by the Aboriginal and Torres Strait Islander Peoples' Strategy Committee is planned for 2021/22. The curriculum review will need to be supported by staff induction and training to ensure the delivery of the curriculum is as intended. The College is expected to report to the AMC on the review recommendations and its responses in monitoring reports, given this will be a significant development for the curriculum.

3.6 Opportunities for choice to promote breadth and diversity

There are opportunities for students to pursue studies of choice that promote breadth and diversity of experience.

The College offers multiple opportunities for students to pursue studies of choice at various time-points across the course.

In Year 3, students take a three credit point elective subject offered by any discipline across the University. The most popular units are Tutoring in Health; Introductory Bioethics; Alternative Dispute Resolution; Advanced Anatomy by Dissection and Building Research Skills in Medicine. These units enrich the skills of the students and it is encouraging to see that teaching skills and bioethics are so highly sought after by the students.

There is also a clinical elective which is a ten-week block in the final year of the Program, which can be in an area of choice (Clinical or Research) either in Australia or internationally (pre-COVID-19). Most students select a clinical elective, with emergency medicine as the most popular choice, followed by general medicine, paediatrics and general practice. Years 5 and 6 students can also apply to undertake part of one of their core rotations in Fiji, Solomon Islands or Sri Lanka funded by the new Colombo Plan.

There are Extended Integrated Rural Placements available for Year 6 students, which are 20 weeks duration and incorporate the Rural Internship rotation and Adult Health rotation. Between 13 and 20 students have taken up this placement in the last four years. The Longitudinal Integrated Clerkship allows a small number of students to complete almost the entire Year 6 in a Northern Queensland rural community. Only one to two students take up this opportunity each year.

High-achieving students can opt to take on a concurrent degree (overload study) such as a Masters of Public Health and Tropical Medicine. There are criteria such as the need to have a prior degree or have completed Year 3 of the MBBS. Students are limited to three credit point subjects per semester and must be high achieving students (D or HD) and maintain at least a credit average. Applications are assessed on a case-by-case basis against these criteria.

An Honours program can be undertaken via three different pathways including Bachelor of Medical Science with Honours that involves taking a year out of the MBBS between Years 3 and 4 or Years 4 and 5; an embedded Honours that involves a two year part-time overload program; Honours (end-on), which is a part-time overload in Year 6 of the MBBS and postgraduate Year 1 or a one year full-time at any time up to Postgraduate Y5. The embedded program is most popular with between 10 to 20 students involved in the Honours program (less than 10% of the cohort). Honours is restricted to higher-performing students (credit or above across Years 4 and 5). The majority of students are focused on their MBBS studies, and may negotiate opportunities to do smaller 'ad hoc' research activities with individual clinicians or academics. Students expressed the desire to undertake a more substantial audit or research project rather than a research proposal in Year 6. The Queensland Health research governance system has presented an obstacle for students undertaking patient audits requiring access to patient records (IEMR). The research academics at the College expressed hope that this could be overcome.

4 Learning and teaching

4.1 Learning and teaching methods

The medical education provider employs a range of learning and teaching methods to meet the outcomes of the medical program.

The College utilises a wide range of learning and teaching methods underpinned by sound pedagogy to meet the outcomes of the medical program.

A structured program of campus-based learning and teaching activities is delivered Years 1 to 3. In the 'sample week' provided (see Figure 4.2 below) there are 25 contact hours comprising a mixture of whole-cohort teaching activities and small group teaching activities. Much of the new content is presented live to the whole cohort in a traditional didactic format. Guided Learning Sessions are delivered in a large flat-space teaching area and provide students with the opportunity to work through the lecture content and other interactive content, with access to teaching staff. Other learning activities in the pre-clinical years include Synthesising Sessions and Integrative Sessions that are delivered in a lecture theatre setting. While there have been attempts to increase the interactivity of the delivery of this content with various Student Response Tools, opportunities to refresh the delivery of some content to align with modern, student-centred adult learning pedagogy were observed.

Figure 4 Example of a typical student week in MBBS Years 1-3

MD2011	Mon	Tues	Wed	Thur	Fri
			week begins		
8-9am				lec (module 4)	
9-10am	GLS (module 1)	SS (module 2)	lec (module 1)	clinical skills	GLS (module 3)
10-11am		SS (module 3)			
11am-12pm			lec (module 2)		
12-1pm			lec (module 3)		
1-2pm		SS (module 4)		GLS (module 2)	GLS (module 4)
2-3pm	SS (module 1)	Integrative session			
3-4pm					
4-5pm		home group			

Abbreviations: lec = lecture; GLS = guided learning session; SS = synthesising session

Although clinical placements take place from Year 1, Year 4 represents a transition point for students from campus-based teaching and learning, to more immersive teaching and learning in a clinical environment. A mixture of structured, self-directed and clinical activities are offered including further didactic lectures, tutorials and laboratory sessions. Simulation as a teaching and learning method features prominently in Year 4. To support the transition to the clinical environment, there are specific teaching sessions dedicated to the interpretation of clinical investigations as well as clinical reasoning. Clinical placements across a variety of health settings in Year 4, including the six-week public and six-week private medicine rotations, provide experiential learning opportunities for students. During these clinical attachments, although students are not formally embedded in a clinical team, they have opportunities to participate in ward rounds, grand rounds and bedside teaching.

One of the key teaching and learning activities in Year 4 is the weekly small group Clinico-Pathological Case (CPC) sessions. While learning outcomes for the weekly CPCs cases are provided, students expressed a strong desire for more guidance around expectations regarding depth of learning as well as greater academic oversight of their self-directed learning. Students reported

that their perception is that this feedback has been provided repeatedly but has not yet been adequately addressed by the College. Communication with students to address this is encouraged.

In Years 5 and 6, learning and teaching methods are based on immersion in clinical attachments supplemented by structured learning activities. In Year 5, attachments in medicine, surgery and general practice are complemented by tutorials, and self-directed and online learning activities such as the online NPS MedicineWise Prescribing Curriculum. Learning in the clinical environment is standardised during 'Base Weeks' where a program of lecture-based and tutorial teaching is delivered. The College's ongoing work to improve the 'Base Week' program, taking into account student feedback is noted.

During clinical placements in Year 6, students are fully immersed as 'student interns' (community and hospital based), in multidisciplinary teams, medical and surgical specialities, critical care and emergency medicine. Learning in the clinical environment in Year 6 is supplemented by whole of year sessions with a pre-intern focus. Additionally, all students undertake a 10-week Rural Internship in their final year that clearly addresses the Program outcomes related to preparedness for practice in remote, rural and regional environments.

4.2 Self-directed and lifelong learning

The medical program encourages students to evaluate and take responsibility for their own learning, and prepares them for lifelong learning.

The support provided to students in developing as self-directed, life-long learners, for example through the Home Group program in Years 1 to 3, was evident. The implementation of the Continuing Professional Development portfolio, which includes reflective activities, is an authentic example of students taking responsibility for their own learning. Students acknowledged a strong focus on self-directed learning that has increased as they progressed towards graduation, and while they indicated their receptivity to this mode of learning, they called for more guidance around expectations and depth of learning required, particularly in Year 4.

Students are prompted to reflect on their learning experiences extensively throughout the Program, including by way of written reflection in the Individual Learning Profile. The perceived burden associated with the volume of written reflective activities reported by students may mitigate the value of the learning experiences.

Students are provided with opportunities to gain an appreciation of the importance of Evidence-Based Medicine (EBM) and critical appraisal of research from early in the Program, including through formal structured Integrative sessions in Year 1 Study Period 1 that introduce students to concepts such as hypothesis testing and critiquing journal articles. There are opportunities for students to put these concepts into practice later in the Program, such as the MBBS Journal Club and the Year 3 selective subject 'Building Research Skills in Medicine' are opt-in for students, with modest attendance reported. The formalisation of the EBM curriculum may help to ensure all graduates are adequately prepared in this regard.

4.3 Clinical skill development

The medical program enables students to develop core skills before they use these skills in a clinical setting.

Clinical skills are introduced early in the Program and are scaffolded well, with an increase in complexity as students progress from Year 1 to 6. For example, basic clinical skills such as hand washing are taught in Year 1 and more complex clinical skills such as insertion of indwelling catheters in Year 3. In the foundational years of the program, clinical skills are taught largely in a simulated environment, parallel with and integrated with the corresponding body system content.

While this curriculum structure aids learning, further attention could be given to clinical contextualisation of skills teaching from earlier in the Program. Students reported difficulty understanding the relevance of some of the skills they were being taught, such as physical examinations, explaining that at times it felt like they were rote-learning checklists.

Students are required to demonstrate competence in the performance of select procedural clinical skills prior to undertaking these on patients. Attainment of competence is tracked in a logbook. Students reported that they feel generally feel well prepared to demonstrate core skills when they enter the clinical environment. Furthermore, students commented that they felt confident in their understanding of their scope of practice, largely due to teaching in the social science subjects in the pre-clinical years.

That the clinical skills simulation has been developed to the point of a simulated ward in the Acute Care Clinic workshop in Year 4 is impressive.

Year 5 students on the General Practice Rotation attend simulated GP clinics (simGPclinic). Small groups of 2–3 students undertake a series of consultations with simulated patients presenting with a variety of presenting complaints commonly seen within General Practice. Feedback is provided by the simulated patients, a fellow student and an observing GP academic. This innovative development was evaluated positively by students and provides an authentic opportunity for students to build skills in clinical consultation in a standardised way.

4.4 Increasing degree of independence

Students have sufficient supervised involvement with patients to develop their clinical skills to the required level and with an increasing level of participation in clinical care as they proceed through the medical program.

The supervised involvement with patients with an increasing level of participation in clinical care as students proceed towards graduation is a clear strength of the Program. The total hours of clinical placements across the six years of the Program exceeds that of many other medical programs. Students recognise this to be a key factor in their self-rated preparedness for internship, which was evident in the joint AMC-MBA Preparedness for Internship Survey from 2018/2019 which saw the College's graduates rank their preparedness highly across a range of domains. Stakeholders, including the local health services, also recognise the preparedness of the College's graduates for internships, particularly in the remote, rural and regional settings of northern and far northern Queensland.

Although students are not formally embedded in clinical teams in Year 4, their transition to the clinical environment is supported through the Clinical Facilitator model in the public and private hospital placements, which has been observed to be working very well, although potentially dependent on individual facilitator engagement and enthusiasm.

Students raised concerns about unequal exposure to some specialities in the clinical years across the various sites in the University footprint. In response, there have been significant efforts to standardise learning opportunities through structured teaching programs such as Base Weeks, which are designed to complement learning in the clinical environments.

4.5 Role modelling

The medical program promotes role modelling as a learning method, particularly in clinical practice and research.

Early access to role models is provided through the Home Group program that commences in Year 1. Students described that the home group facilitators act as mentors and positive role models.

Additionally, in Year 1, students undertake observational general practice placements which focus on identifying and learning from positive behaviours of supervisors such as patient centred approach, empathy, compassion and respect. Furthermore, many examples of senior students acting as role models for junior students, including through the Clinical Skills program and the Guided Learning Sessions were noted.

There were efforts by staff to role model through teaching, specifically in Year 4, through the recent revision of clinical cases to ensure principles such as inclusivity and cultural safety are incorporated.

Students outlined that overall, they felt there was sufficient exposure to high quality academics and clinicians who role model good behaviour across the Program, however, they expressed that opportunities to learn via role modelling could be made more explicit.

While there are several active researchers who teach into the Program and act as role models for students, students indicated that they experienced difficulty in accessing supervisors and opportunities for research projects, particularly at the peripheral sites. This deserves further investigation by the College.

The Year 4 Aboriginal and Torres Strait Islander health experience, largely conducted within Aboriginal Community Controlled Health Centres, as well as the rural placement in Year 6 provide opportunities for role modelling culturally safe clinical practice to students. During these placements, cases are used to illustrate clinical presentations and highlight opportunities to provide advocacy.

Two assessment activities make formal reference to role modelling as a learning method: the first, an essay in Year 2 where students are asked to write about a role model; and the second through the PEAL portfolio where students are asked to upload a reflection about a standout role model.

4.6 Patient centred care and collaborative engagement

Learning and teaching methods in the clinical environment promote the concepts of patient centred care and collaborative engagement.

There are numerous examples of the ways in which patient centred care is demonstrated to students. The importance of patient centred care is impressed on students early in the course through the Ecology of Health and Global Health Modules. The fundamental concepts of patient centred care and the importance of good communication are taught through role play, for example, difficult scenarios and in simulated history taking where students are taught to clarify, reflect and summarise.

Later in the course, students are further educated about patient centred care largely through the role modelling of clinical supervisors. Numerous examples of the ways in which patient centred care is championed in the clinical environment during placements were described by enthusiastic and dedicated clinical supervisors. The focus on patient centred cared is supported by College graduates who had the highest self-ratings in Australia in six of the seven patient centred skills profiles in the AMC and Medical Board of Australia Preparedness for Internship Surveys in 2018 and 2019.

The College promotes scholarship in this area, with a study currently underway to investigate student and staff attitudes in Medicine and other courses towards patient centred care.

As noted under Standard 1.8, there is also a robust volunteer program where volunteers act as simulated patients, providing a safe space for students to practice clinical skills and providing feedback from the patient perspective, which is evidence of successful and enduring collaborative engagement with the community.

Further evidence of community collaborative engagement is the extent to which Aboriginal and Torres Strait Islander communities have input into the curriculum. Staff reported that the CPC facilitator program is routinely oversubscribed, largely by University alumni which demonstrates strong collaborative connections in this area too.

4.7 Interprofessional learning

The medical program ensures that students work with, and learn from and about other health professionals, including experience working and learning in interprofessional teams.

Opportunities for interprofessional learning (IPL) are provided across all six years of the Program. These opportunities are largely for students to learn from other disciplines, rather than alongside students of other disciplines. One notable exception to this is the Year 3 drug audit conducted with pharmacy students. Opportunities for students to learn from other disciplines occur formally, such as through the Year 1 Allied Health elective, Community Health Expo, the nurse shadowing experience and Multidisciplinary Case Conferences. Opportunities for informal IPL occur when student are embedded in functioning clinical teams in the latter part of the Program including at the Murtupuni Centre for Rural and Remote Health where students undertake formal clinical learning activities with students from multiple health disciplines.

The College's plans to review the IPL curriculum and create a formal IPL framework were noted as an important step, as without a formal framework, the sustainability of the current IPL teaching is a risk. In this review, the College could consider incorporating further opportunities for medical students to learn alongside students from other health-related disciplines.

5 The curriculum – assessment of student learning

5.1 Assessment approach

5.1.1 The medical education provider's assessment policy describes its assessment philosophy, principles, practices and rules. The assessment aligns with learning outcomes and is based on the principles of objectivity, fairness and transparency.

5.1.2 The medical education provider clearly documents its assessment and progression requirements. These documents are accessible to all staff and students.

5.1.3 The medical education provider ensures a balance of formative and summative assessments.

All levels of assessment and teaching undertaken by the College adhere to the key principles of ensuring that the assessment tasks are an authentic representation of the course outcomes, the assessments are transparent and fair, the criteria for assessments are clearly stated and the awarded grades to students are based on performance to a set criteria and standard.

The Program's assessment guidelines follow the broad principles of the University's Learning Teaching and Assessment (LTA) policy and procedures. The University's LTA policy was recently reviewed, and changes came into effect on 1 January 2021. The new LTA policy and procedures are aligned to the Tertiary Education Quality and Standards Agency and the Higher Education Standards Framework.

The Foundation Studies Committee (FSC) and the Clinical Studies Committee (CSC) are responsible for planning, implementing and evaluating assessments for Years 1 to 3 and Years 4 to 6, respectively. These committees also facilitate the planning and evaluation cycle for assessment and make recommendations on curriculum, assessment, and examinations reform and structure. These committees make recommendations to the BoS (Med), which is the central decision making and policy forum for academic and student matters. The BoS (Med) has delegation to approve minor changes to assessment. Decisions on significant changes to curriculum or weighting of summative assessment or the assessment tools used can only be endorsed by the College Dean. Substantial changes to curriculum and assessment that affect the course and subject information in the University Handbook require approval by the CCMC, in accordance with the University Curriculum Approval, Monitoring, Review and Improvement procedures. Final approval of significant amendments to curriculum such as the structure of a course are made at the DBoS.

MBBS progression rules have recently been modified and are evolving further to include professional behaviours across all years of study. The College commenced a programmatic approach to professionalism assessment in 2017. Students are given specific feedback on professionalism during each year of the Program. All staff and students undertake an online educational program yearly to ensure compliance and continued understanding of expectations relating to academic integrity. Regular 'talk back sessions' are organised by subject coordinators in each year of study to provide students with relevant information on assessment and progression requirements. All subject outlines and the Program assessment guidelines documents are available to staff and students via the University's Blackboard Learning Management System (LearnJCU) and other relevant webpages on the University website.

The College has ensured alignment between teaching, subject and course learning outcomes, and assessment with the AMC Graduate Outcome Statements. The curriculum aligns with assessment tasks for each year of the Program in HALO Maps.

Assessments within the Program include both formative and summative tasks. Course curriculum is blueprinted and includes both formative and summative assessments. Professional behaviours and reflective practice are present in each year of study.

The teaching team in each year level, led by the Year Academic Coordinator, peer-reviews the assessment plan (blueprint) prior to the start of the academic year for content and suitability of the suite of proposed assessment tasks, and ensures their appropriateness for both supporting and measuring learning within the year of study.

Details of the assessment schedule for each year of study are documented in the Subject and Year Outlines. Progression rules are explained in the MBBS Assessment Guideline. These are available for staff and students. Students and staff reported that information about assessment methods and progression rules is clear.

5.2 Assessment methods

5.2.1 The medical education provider assesses students throughout the medical program, using fit for purpose assessment methods and formats to assess the intended learning outcomes.

5.2.2 The medical education provider has a blueprint to guide the assessment of students for each year or phase of the medical program.

5.2.3 The medical education provider uses validated methods of standard setting.

The College assesses students throughout the Program using a variety of methods to assess learning outcomes. These include: written examinations (multiple choice questions (MCQ), extended matching questions, short answer questions, essay questions, and clinical investigation exams); practical exams (clinical skills, mini-clinical evaluation exercise (mini-CEX), multi-station assessment task (MSAT), and objective structured clinical examination (OSCE)); extended written assignments; oral assessment (such as interviews, handover assessment, and CPC assessments); and workplace-based assessments during clinical attachments. These summative assessments include both weighted assessments and non-weighted threshold assessments. Year 5 students undertake a high stakes exam at the end of the year that contributes 70% of the total mark. Both students and faculty are aware of the pressures associated with such an assessment, however, feel that Year 5 assessments are working well. Recognising staff and student satisfaction with the current exam, the College could consider assessment throughout Year 5 rather than a high stakes exam at the end of the year, which would enable multiple perspectives on student performance over time to inform pass/fail decisions. It could also support the development of more authentic assessments embedded in clinical practice settings. The University's contribution to the Australian Collaboration for Clinical Assessment in Medicine (ACCLAiM) is significant and commendable.

The Assessment Committee introduced a basic sciences retention feedback and evaluation exam that does not contribute towards the overall mark and course progression. This online assessment comprises of 60 MCQs undertaken in Years 2, 4 and 6. Students receive individualised feedback on their performance. There appears to be a disconnect in the role and rationale for this assessment between the College and the students. While the need to assess the retention of basic sciences knowledge and application to clinical context through the Program is acknowledged, students reported concern about the value of the test as an assessment tool, as it does not contribute to students' marks.

Each year of the Program is blueprinted to guide the students. The blueprint is developed at three levels. The first level involves curriculum mapping in which the course and subject learning objectives are weighted against and linked to the assessment tasks. The second level aids the development of appropriate assessments at the subject level. This allows for balance in the sampling of subject matter because it aids selection of the assessment instruments that best assess the defined competencies. The third level provides a global view of areas covered in the written and clinical examinations. This approach helps to improve content validity and identify gaps in assessment.

The determination of pass marks is based on various validated methods of standard setting. The Hofstee method is used for written assessments while the borderline regression method is used for the assessment of clinical performance in the OSCE assessment. The choice of methods is based on feasibility, credibility and suitability of examiners.

5.3 Assessment feedback

5.3.1 The medical education provider has processes for timely identification of underperforming students and implementing remediation.

5.3.2 The medical education provider facilitates regular feedback to students following assessments to guide their learning.

5.3.3 The medical education provider gives feedback to supervisors and teachers on student cohort performance.

The College ensures appropriate assessment feedback is provided in a timely and constructive manner to students as per clause three of the LTA policy which was updated on 1 January 2021. Students are notified that the nature and construct of feedback for assessment tasks are stated in the subject outlines and Program assessment guideline documents. Feedback is in the form of both individualised and general cohort approaches, and is delivered verbally, in written form, and electronically.

For written assessment items, students are provided with feedback via a criterion referenced marking sheet, as well as personalised written feedback provided in a variety of ways, most commonly using online annotation tools within LearnJCU. For oral presentations and workplace-based assessments, students are provided with both verbal and written feedback. Individualised feedback includes a breakdown of each student's performance across all modules and disciplines in the examination as well as the cut-off marks and standard error of measurement. Staff reported that this process of individualised feedback allows the identification of underperforming students.

Students can request a review of any assessment item or their final grade under the Finalisation and Publication of Student Results procedure as documented on the University website. Students requiring special consideration are able to do so as per University procedures.

Weekly feedback can occur with Home Group supervisors and this is a friendly forum for students to discuss their academic progress.

Students reported that they received relevant and timely feedback, but individualised information with greater detail would be more beneficial in guiding their learning.

The COVID-19 pandemic caused difficulties in providing consistent depth of feedback across assessors for some assessment items. In addition, some of the functionality of the LearnJCU tool and delays in staff contracts have impacted on feedback for some assessment items. Due to this, in 2021, markers for written assignments will use a 'live' online spreadsheet for marking within Microsoft Teams, and academic staff have been trained in the use of online annotation tools.

Supervisors and teachers are provided feedback on the student cohort performance and assessment items via the Remark exam management software. Item analysis is conducted for each assessment by computing the difficulty index, discrimination index, item-total score correlation coefficients and Kuder–Richardson 20 (KR-20) reliability index using classical test theory. Psychometric data on individual MCQs and the whole examination are available to staff on a shared intranet site. The College feels that all trainers do not engage with the feedback report due to the complexity and detail of the psychometric analysis report. As such, the College has held regular exam writing workshops for staff and teachers to foster collegiality and engagement to write high quality assessment tasks, especially in the pre-clinical years.

5.4 Assessment quality

5.4.1 The medical education provider regularly reviews its program of assessment including assessment policies and practices such as blueprinting and standard setting, psychometric data, quality of data, and attrition rates.

5.4.2 The medical education provider ensures that the scope of the assessment practices, processes and standards is consistent across its teaching sites.

The Foundations Studies Committee (FSC) (Years 1 to 3) and the Clinical Studies Committee (CSC) (Years 4 to 6) along with the year subcommittees review the performance of existing assessment items each year. Assessment coordinators review overall performance, mark distributions, compare assessor marks, and review feedback provided by students.

The College's examination formats and progression rules have had minimal changes since the previous AMC review. Changes to assessment, however, have included professionalism index rating scores in the pre-clinical years, the clinical reasoning assessment task in Year 4 and revision of the PEAL assessment throughout the course.

Student representation and contribution towards assessment planning occur on the FSC, CSC, and BoS (Med).

This year, following the Clinical Curriculum Conference, a working group that reports to CSC has been established to review the weighting and mix of assessment methods, standard setting procedures and progression rules in Years 4 to 6. This group will meet monthly in 2021 and make recommendations for implementation in 2022.

The College has established protocols that ensure the consistency of assessment across teaching sites. In 2017, a review of the Clinical Investigations Exam (CLIX) was undertaken as this exam had been delivered at various time points across the three teaching sites. An exam bank was created, the blueprint revisited, and the questions graded easy, moderate and difficult. The exam was then constructed following a formula with evaluation of the process and student results in 2019. It was evident that results and student performance had become more consistent across training sites.

To ensure consistency of marking exams, assessor training across sites is undertaken at the start of the academic year or just before commencement of marking. For both written and oral presentation tasks, assessors meet prior to marking and review past exam papers or pre-recorded videos of oral presentation to test mark. Oral presentations are examined by two examiners: one senior and one junior. Failing-level written exams are double marked. Furthermore, consistency across sites is ensured with examiners videoconferencing during marking.

6 The curriculum – monitoring

6.1 Monitoring

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.

6.1.2 The medical education provider systematically seeks teacher and student feedback, and analyses and uses the results of this feedback for monitoring and program development.

6.1.3 The medical education provider collaborates with other education providers in monitoring its medical program outcomes, teaching and learning methods, and assessment.

There is a substantial volume of monitoring and evaluation of the Program including contributions to national surveys of graduates, central university surveys, and routine and targeted evaluation activities within the College. There is an important focus on evaluation of course outcomes, innovative strategies and graduate performance. Many of these demonstrate high quality educational scholarship and have resulted in numerous peer-reviewed journal publications for which the College should be commended.

The University has a Curriculum Approval, Accreditation, Monitoring, Review and Improvement policy that specifies the principles for appropriate review of courses in line with the Higher Education Standards Framework. There is an expectation of annual course reviews (Course Performance Reports (CPR)), Division Academic Program Reports and comprehensive internal reviews every five to seven years. Section 11 (monitoring, review and improvement) of the procedures related to this policy has many elements in common with AMC Standard 6.

The Academic Course Review procedure describes the operationalisation of the annual and comprehensive reviews in more detail. The Academic Head of the Program completes the annual CPR as a summary of issues, achievements and action plans for the Program. Included data encompasses issues that have arisen from evaluation information, Quality Indicators for Learning and Teaching (QILT) survey results, accreditation status and equity group participation rates. The CPR is submitted for information and review to the BoS (Med), the Dean, CMD, the DTHM Director Academic Quality and Strategy and thereafter, up to the University Education Committee as part of a Divisional Report.

The University-based Student Experience of Learning and Teaching (SELT) obtains evaluation data from an institutional survey instrument (YourJCU) and learning analytics in the Learning Management System. These data are received by Divisions and Colleges to monitor staff teaching performance and student satisfaction for all subjects. Student SELT feedback is collected after every study period, and evaluation of teaching staff is expected to occur at least yearly. Likert-scale results and free text are available through this method. Results are sent to the Dean, the Academic Head, the Associate Dean of Learning and Teaching, and the Academic Coordinator of the individual subject. Aggregated data is considered by the appropriate committee, including the FSC or CSC.

The College Evaluation Strategy Committee reports to the Dean and Cabinet through the BoS (Med) and is responsible for leading a College-wide approach to evaluation. This Committee acts as a 'community of practice' to support evaluation activities. Other responsibilities include staff development, promoting collaboration, development of a strategic evaluation framework, dissemination of findings, and benchmarking of evaluation processes. The Committee includes the Academic Lead, Evaluation and Assessment, and the Evaluation Coordinator. There is no student representative on this committee.

College-wide Evaluation priorities identified by the Evaluation Strategy Committee include the following, derived from the Program Logic framework:

- Lead in high quality patient and community centred health professional education that is efficient, geographically distributed and technologically enabled.
- Build profile and influence by systematically assessing, communicating and advocating the College's impact and intent.
- Strengthen community and industry partnerships in research, training and transformation of healthcare.
- Deepen international connections with reciprocal benefit, in the region and across the tropical world.
- Diversify and expand funding sources and drive efficiency.

This framework describes high level strategic outcomes and does not appear to address systematic evaluation of the operationalisation of the Program.

A further College Evaluation Framework developed by the Evaluation Strategy Committee (figure below) was provided which also appears to be a mixture of high level strategic and quality improvement goals. There is insufficient detail for this framework to be operationalised and the framework was not recognised or referenced in discussions with staff and committees about evaluation activities.

Figure 5 College of Medicine and Dentistry Evaluation Framework

COLLEGE OF MEDICINE & DENTISTRY EVALUATION FRAMEWORK

Our Goal STRATEGIC INTENT →	How? ACTIVITIES/STRATEGIES →	What do we want? OUTPUTS →	Why? OUTCOMES →	 IMPACT
The CMD has a participatory approach to prompting health and strengthening healthcare for communities of tropical Australia and beyond through socially accountable health professions education, discoveries, partnerships, advocacy and leadership	▪ Identify critical elements of work readiness and build these into the selection process ▪ Identify critical elements of work readiness and better match the curricula to deliver these elements ▪ Continuously review and refine learning outcomes and assessment tools/methodology ▪ Actively engage in research programs based around tropical community health for rural, remote and marginalised populations	▪ Student selection principles and processes that address NQ health workforce needs ▪ Targeted academic system that encourages and supports geographically, socially and culturally disadvantaged students ▪ Curricula tailored to foster patient centred health professionals who are capable of addressing local community needs ▪ Increased recruitment and retention of health workforce in targeted communities ▪ Established networks and partnerships with all stakeholders across Northern Australia	▪ CMD graduates recognised for being work-ready through the best possible learning and training experience ▪ CMD graduates are global health practitioners who are able to operate in resource-scarce environments ▪ CMD graduates are transformative scholars and leaders in healthcare	▪ Strengthened reputation as leaders in the delivery of innovative health professions education, research and advocacy to deliver health workforce to meet the needs of rural, remote and marginalised communities ▪ Strong and sustainable recruitment and retention of health workforce in rural, remote and marginalised communities

The recent evaluation activities conducted through the Evaluation Strategy Committee described by the College are categorised into the following domains:

- Assessment
- Academic Support
- Innovative Learning and Teaching
- Health Workforce

- Patient Centred Care and Community Engagement.

For each of these, a list of important evaluation activities is described, which have led to substantial changes to the Program, including Professionalism assessment, basic sciences retention examination, student wellbeing initiatives, cross-College support roles and producing a shared vision of College staff. These activities do not seem to be consistent with evaluation frameworks and it is unclear how evaluation activities are prioritised across the Program.

The BoS(Med) has monitoring and evaluation activities as part of its Terms of Reference. However, curriculum evaluation activities are delegated to lower level curriculum committees, particularly the CSC and FSC. These committees regularly review student guidelines, curriculum content, quality of teaching, assessment and student progress. There is student representation on these committees but their input into the governance of evaluation activities appear to be minimal. These committees meet regularly (generally on a monthly basis) to ensure a quick response to any issues that may arise. Students who have been involved in some of the committees have been impressed by the commitment of the College to active monitoring, and continual revision and improvement of the Program.

The roles, frameworks, processes and priorities of the Evaluation Strategy Committee, and evaluation conducted within other curricular committees, are unclear and disconnected from student and other stakeholder input. There seem to be ad-hoc evaluation activities without an overarching framework, including at the different clinical schools. Although the delegation of evaluation activities to curriculum committees is empowering for staff in those committees, this exposes the Program to risk in the quality management of the program, duplication and inefficiencies, difficulties in evaluation of integrative practices, or lack of evaluation for important elements of the program. Topics that are indirectly related to curriculum committee governance seemed to have separate evaluation processes, such as student selection or student support. A clear and coordinated approach to systematic monitoring and evaluation across the Program should be developed and implemented.

Although students may be involved in the process of identifying areas for evaluation, they are not involved in assisting to devise solutions for the identified problems. It was surprising that student surveys are discouraged due to ethical constraints. Furthermore, students gave examples of previous student suggestions for improvement in the Program that they believe have not been acted upon.

Talk back sessions, which are held every study period, include discussion about changes to modules in response to previous student feedback. The students reported that the academics' responses were not entirely receptive during the talk back sessions in response to student feedback.. Students believe that these sessions could be more productive if staff members were more receptive to constructive feedback. The student body was also concerned that feedback provided at the clinical sites other than Townsville is not acted upon. There are also concerns regarding the ease to which students would provide potentially sensitive feedback at some of the smaller sites during the clinical years.

Formal pathways for feedback to and from staff are also difficult to identify, with many staff unaware of mechanisms to provide feedback or to receive feedback. The feedback process appears informal which may bias information being received by the College. No recent staff surveys have been performed although other less formal consultations have taken place. The review of evaluation processes, including feedback pathways, would benefit from active involvement of student representatives and broader input from staff and external stakeholders.

With respect to collaborations with other education providers, the University-based ACCLAiM assessment collaboration is an important benchmarking activity with a visiting examiner process in place. In addition, internal staff members act as Quality Assurance examiners and provide formal reports that are tabled at relevant committee meetings. However, it is unclear if other collaborations are in place to assist in benchmarking activities. While the College has advised it has utilised many external visiting examiners, it could consider further external collaborations and benchmarking exercises for other areas of curricular design and function.

There is evidence of clear, rigorous and often impressive evaluation based on outcomes data that led to demonstrable changes and continuous improvement of the Program. However, the overarching frameworks were not well understood and evaluation activities appeared disparate across the Program. Teaching staff were unclear about the mechanisms for capturing their feedback or how the evaluation frameworks were operationalised. While there are a range of mechanisms for capturing student feedback, students did not consider that their feedback was responded to, particularly if they were placed in clinical sites other than Townsville and some examples of this were identified through the assessment.

6.2 Outcome evaluation

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.

6.2.2 The medical education provider evaluates the outcomes of the medical program.

6.2.3 The medical education provider examines performance in relation to student characteristics and feeds this data back to the committees responsible for student selection, curriculum and student support.

The University takes part in the QILT Student Experience Survey, Course Experience Survey and Graduate Outcome Survey. For medicine, their results are consistently above average in almost all domains compared to other medical programs. In the joint AMC-MBA 2019 Preparedness for Internship Survey, the University's Program was significantly above the national average (ranked third in Australia) – ranked second in preparedness for prescribing, and ranked first for preparedness to providing care for Aboriginal and Torres Strait Islander peoples.

In addition, the Evaluation Coordinator administers an exit survey each year to Year 6 students seeking feedback on preparedness for internship, and perceptions of the utility of some aspects of the Program. These reports are considered by the BoS (Med) and feedback provided to Academic Coordinator to assist with continuous quality improvement and completion of the CPR.

The College has evaluated the practice outcomes of rurally bonded students, early career outcomes and future practice intentions of international students, and intentions for rural practice of final year students. Senior staff are also aware of the performance of rural origin students, international students, and Aboriginal and Torres Strait Islander peoples within the Program, particularly with regard to enrolment numbers, progression difficulties, attrition, and rates of graduation.

6.3 Feedback and reporting

6.3.1 The results of outcome evaluation are reported through the governance and administration of the medical education provider and to academic staff and students.

6.3.2 The medical education provider makes evaluation results available to stakeholders with an interest in graduate outcomes, and considers their views in continuous renewal of the medical program.

Feedback regarding outcome evaluation processes is provided to students in a number of ways including regular meetings with the student association, talk back sessions, and attendance at key meetings including the BoS (Med), FSC and CSC. Each subject outline has a paragraph describing the process of receiving student feedback on the subject, through the use of the LearnJCU survey. Some explanation of recent changes from student feedback is included in these sections of the subject outline documents.

Regular meetings are held with JCUMSA where any concerns can be raised by staff or students through the JCUMSA President and Academic Vice President. While the students report that the College shares most evaluation results to students, these results are often difficult to locate and it would be beneficial for the College to develop a process to more actively communicate evaluation results back to the entire student body.

The annual College Summit, where the College reviews its purpose and strategic priorities is an important forum for engaging with key stakeholders, including local hospital and health service executives, and student representatives. However, there do not appear to be defined systematic and formal processes by which community stakeholders are regularly invited to contribute input on the College's Program. Such inputs are usually gained from informal and opportunistic encounters with community volunteers at the College's various teaching sites. In addition, while the results of outcomes evaluation are included in the annual CPR documentation it is unclear how information is fed back to relevant stakeholders, particularly outside the committee structures.

7 Implementing the curriculum – students

7.1 Student intake

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.

7.1.2 The medical education provider has defined the nature of the student cohort, including targets for Aboriginal and Torres Strait Islander peoples and/or Māori students, rural origin students and students from under-represented groups, and international students.

7.1.3 The medical education provider complements targeted access schemes with appropriate infrastructure and support.

The cohort size of the Program is around 200 domestic enrolments into Year 1, annually. The Program has a number of targeted admission schemes: it aims to recruit about 65% of the cohort from Australian Statistical Geographical Classification – Remoteness Area (ASGC-RA) categories two to five (ie, RA-2 Inner regional, RA-3 Outer regional, RA-4 Remote and RA-5 Very remote), and generally meets this target – well above the expectations of the RHMT Program; it recruits a minimum of five Aboriginal and Torres Strait Islander students and is currently recruiting seven to eight students per year; it aims to recruit international students to make up about 15 to 20% of the cohort. Students who are enrolled via targeted pathways are provided with specific and additional support.

In an attempt to increase the number of Indigenous applicants, innovative work is being done by the Indigenous Education and Research Centre, reaching out and engaging with Aboriginal and Torres Strait Islander high school students about tertiary education and subsequent career opportunities, including those in medicine.

Like other programs, challenges were encountered in 2021 with an increased proportion of offers converted to enrolments despite predictions otherwise because of COVID-19. This increased number has been offset by fewer international admissions. The College is aware that this issue will need to be actively managed as the cohort moves into clinical years.

7.2 Admission policy and selection

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.

7.2.2 The medical education provider has policies on the admission of students with disabilities and students with infectious diseases, including blood-borne viruses.

7.2.3 The medical education provider has specific admission, recruitment and retention policies for Aboriginal and Torres Strait Islander peoples and/or Māori.

7.2.4 Information about the selection process, including the mechanism for appeals is publicly available.

The selection processes for the Program aim to support the strategic intent to improve health outcomes in the rural and Indigenous communities on the University footprint. Therefore, the processes seek to identify students with appropriate academic ability, background, personal qualities and intention to serve these communities. The selection policies and processes are under the governance of the College Selection Advisory Committee.

Prospective students with appropriate academic prerequisites are required to apply in writing to the College. These applications are assessed by an experienced team of reviewers. Those rated as

suitable are then ranked based on academic scores (predicted or actual). Scores for applicants who attended schools in rural and remote settings are awarded some recognition of the associated social and educational disadvantage. For the 2021 intake, initially, 800 students were invited to interview and an additional group was added once academic results were confirmed.

The interviews usually take place in-person in Townsville for domestic students, and electronically for international students. Interviews are with a three-person team that includes an academic, a clinician and a community member. Applicants are rated independently in the interview then given an overall score based on both the interview and academic achievements.

While these processes are clear and have worked well for the Program to date, consideration of the role and implementation of the interview in the context of the reproducibility and reliability of the selection processes would be beneficial. It is noted that these selection processes have been in place since the beginning of the Program and are currently under review led by Professor Peter Crampton, from the University of Otago. The review is due to report by the end of 2021.

The University and College support the rights of individuals to pursue tertiary education to attain personal and professional career objectives, but in doing so, consider the inherent requirements of the course and the profession. This is important for students who live with disability or who have blood-borne viral infections. Therefore, in addition to and independent from the admissions process, the College advertises and promotes to current and prospective students, its policy on the inherent requirements necessary to complete the Program. There is room for reasonable adjustments to aspects of the course in discussion with AccessAbility service staff as long as the integrity of the program is not fundamentally changed.

There is also a separate but aligned selection process for Aboriginal and Torres Strait Islander applicants that was designed in collaboration with the Australian Indigenous Doctors' Association (AIDA) and key Indigenous stakeholders. This process is also under review.

Indigenous applicants provide confirmation of Aboriginality and if they meet minimum academic standards the top 24 are shortlisted for interview. A minimum of five are selected each year, and in 2021, eight were admitted into the Program. The pathway for selection for Aboriginal and Torres Strait Islander applicants serves also to introduce them to the Indigenous social, cultural and academic support structures and groups both within the University and the College.

While there is clear information about the application process in handbooks and publicly on websites, the process for appeals regarding selection decisions, is not similarly transparent.

7.3 Student support

7.3.1 The medical education provider offers a range of student support services including counselling, health, and academic advisory services to address students' financial, social, cultural, personal, physical and mental health needs.

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.*

7.3.3 The medical education provider offers appropriate learning support for students with special needs including those coming from under-represented groups or admitted through schemes for increasing diversity.

7.3.4 The medical education provider separates student support and academic progression decision making.

The College has provided evidence of the range of student support services that it provides both directly and through the University. The University Student Support Services provide access to academic support, including personal tuition, general practice services, support for Aboriginal and Torres Strait Islander students, and personal support including for students living with disabilities.

AccessAbility services are free, confidential and provide information and practical advice about support available for all registered JCU students, who identify as having a short or long term disability, injury, illness or health condition. The University has an Infection Control procedure that seeks to minimise the risk of infectious diseases by advising on immunisation requirements necessary for different professional programs, and by supporting and counselling students who have infectious diseases including blood-borne viruses.

For students enrolled in the Program, student support is governed through the Student Support and Professional Practice Strategy Committee that is chaired by the Associate Dean of Students. This committee provides strategic advice to the College Cabinet and the Dean on priorities and emerging issues, and links with a network of Academic Advisors. The Associate Dean of Students, together with the Academic Lead, Student Support, head this team of academic advisors, where one is allocated to each year of the Program, including at each of the clinical schools at Cairns, Mackay and Townsville.

Academic advisors are academic staff who are trained in pastoral care and mental health first aid. They follow-up with students who are at academic risk in the Program as well as students who may have attendance issues and can recommend further clinical or psychological care as required. Students can self-refer to their advisor via an online booking system or they can be referred by concerned staff or student colleagues. Academic advisors are not involved in the assessment of students of the year that they advise but may be involved in assessment of other cohort years.

In addition, other resources are available to students such as: online student support resources folder within LearnJCU; a program outlining orientation and transition to university, networking and developing collegial relationships through the Home Group program; a Health Professional Self-care program; student-led activities; and an external Queensland Doctors' Health program.

There are dedicated mentoring programs to provide additional support to international, rural and Aboriginal and Torres Strait Islander students. The Aboriginal and Torres Strait Islander student mentor program is also student led, and supported and resourced by the College and the University's Indigenous Education and Research Centre. The DTHM Associate Dean Indigenous Health developed the program with Indigenous student representatives from both JCU Medical Students Association and the Australian Indigenous Doctors Association. Indigenous students reported that they welcomed the support provided from admission, tutoring, study and cultural space, cultural activities and scholarships.

The program reported, through the AMC's COVID-19 monitoring report process, on the adaptions required to support students who were dislocated from their families and international students who were not able to enter Australia, earlier in the year.

Recently, the College has made changes to student support and there is evidence that this new system is utilised by students. However, there was significant feedback from students that this system and its strategies were not working for them. It is important for the College to work with students to address these concerns.

7.4 Professionalism and fitness to practise

7.4.1 The medical education provider has policies and procedures for managing medical students whose impairment raises concerns about their fitness to practise medicine.

7.4.2 The medical education provider has policies and procedures for identifying and supporting medical students whose professional behaviour raises concerns about their fitness to practise medicine or ability to interact with patients.

Included in the guidelines and policies for students is a Code of Conduct and policies for dealing with misconduct, including academic misconduct, general misconduct and professional misconduct. Further, the College provided evidence of functioning policies and procedures to manage important issues including academic progression, unsatisfactory academic progress and a student's suitability to continue in the Program.

Members of staff, student colleagues or a member of the public can report issues relating to a student's fitness to practise to the College. Initially, where appropriate, these would be managed informally. However, if informal processes do not lead to resolution, or if they are of a serious nature, formal processes are instigated.

In these cases, a small panel is convened, usually consisting of at least three people with membership including: an academic staff member who is the panel Convenor; at least one member who is a medical practitioner external to the Program; and where appropriate, a medical or psychological professional and an Indigenous person.

Students enrolled in the Program can be required to attend a review if there are concerns about issues such as health concerns, inappropriate behaviours, including criminal behaviour, and issues of professionalism. In the last four years, the College reported that it has held eight reviews with one still pending.

With respect to other unprofessional behaviours, staff reported that the embedded plagiarism prevention tool SafeAssign in the Learning Management System was not effective at identifying academic integrity issues.

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.

The College has formal monthly meetings between members of the JCUMSA executive, and academic and support staff of the College where issues can be raised and discussed. JCUMSA leaders and executives are also invited to participate in the annual College Summit.

Students have formal representation on a number of governance committees of the Program including the College Council, BoS (Med), FSC and CSC, however, as noted under Standard 6, they are not involved in the evaluation activities associated with the Program.

Separately, the College also provides opportunities for students to participate in a range of University and College clubs and further, the Maggie Grant Leadership Event is held to develop a wide range of leadership skills among students.

7.6 Student indemnification and insurance

7.6.1 The medical education provider ensures that medical students are adequately indemnified and insured for all education activities.

The College has comprehensive indemnity insurance for students in the Program that covers a broad range of activities while on campus, in clinical placements, and associated travel.

8 Implementing the curriculum – learning environment

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 University has provided purpose-built facilities for the College and the Program. On the University Townsville campus, five buildings house large lecture theatres, smaller, flexible teaching and tutorial spaces, study group spaces and specialist spaces for activities such as human anatomy, laboratory work and clinical skills. These facilities are of good standard and there is an ongoing program of construction and maintenance to support staff and students in pursuit of their educational objectives.

At the clinical school sites, there are a mix of University facilities and those shared with the local health service. These spaces include offices, teaching, research and study spaces. At some clinical sites, there is competition for space between the College and the health service due to the expansion of health services. This issue has been amplified with COVID-19. However, building and maintaining strong, collaborative and enduring relationships between the College and health service providers was seen as important and needed to be underpinned by long-term planning to ensure the future requirements of both service expansion and education needs were being accommodated

Students reported that they appreciate having access to a range of student accommodation at different locations and reported feeling safe around campus.

8.2 Information resources and library services

8.2.1 The medical education provider has sufficient information communication technology infrastructure and support systems to achieve the learning objectives of the medical program.

8.2.2 The medical education provider ensures students have access to the information communication technology applications required to facilitate their learning in the clinical environment.

8.2.3 Library resources available to staff and students include access to computer-based reference systems, support staff and a reference collection adequate to meet curriculum and research needs.

The College and the University continue to demonstrate their commitment to information technology systems, the developing technological trends in teaching, learning and communication, and have invested in information technology resources including MedTech staff on campus and at clinical learning sites. Further, the University provides wireless connectivity to staff and students via Eduroam across all campuses and clinical teaching sites. Staff and students reported that they valued the information technology infrastructure and efforts made to ensure connectivity during the restrictions from COVID-19.

The University uses a platform called LearnJCU, which is based on the Blackboard Learning Management System, within which each subject has its own 'site'. Recently, LearnJCU transitioned to Blackboard Ultra, which is more agile on mobile devices. Other platforms such as Talis, PebblePad and Pebble+ are also utilised for specific purposes within the Program.

The College has excellent library support, and significant physical library resources are available to staff and students at campuses in Cairns and Townsville. In addition, staff and students have 24-hour access to a wide range of online medical databases and clinical references. The library also provides additional learning support for specific projects such as research.

The University's medical students at clinical schools in Cairns, Mackay and Townsville have access to the hospital and health service library spaces and facilities during their placements. Students in Mt Isa also have this access. In Cairns, students reported that sometimes there were insufficient spaces in the health service libraries, so they may need to return at different times to access clinical notes and, for example, write up their case studies.

8.3 Clinical learning environment

8.3.1 The medical education provider ensures that the clinical learning environment offers students sufficient patient contact, and 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.

A commendable feature of the Program is its commitment to ensuring students have early, continued and comprehensive patient contact across a wide variety of clinical and geographical settings, starting in Year 1. Students rotate through many settings including private and public hospitals, the community, and a rural placement, and are taught by a range of health professionals. The nature and location of these clinical opportunities, including 20 weeks of rural practice during the Program, are well aligned with the values and mission of the College.

There is a Disaster Management Plan in place, which has been enacted to respond to, for example, flood events and cyclone preparation that are common in Northern Queensland. These plans place a priority on student safety and well-being, with a secondary consideration around how to address any missed curricular time or experiences.

There was some rearrangement of the clinical placement timetable (particularly Year 5) as a mitigation strategy for further restrictions due to the COVID-19 pandemic. The International Elective placements were cancelled and some Year 2 and 4 students had reduced rural placement time. These are unlikely to have a substantial impact on student learning across the curriculum. Essential face-to-face workshops were re-scheduled and other learning activities were provided electronically. Although these adjustments resulted in increased staff workload, there was no significant impact on student clinical contact time or other learning activities. For 2021, most learning activities have reverted to pre-pandemic formats.

The Program provides extensive experience to students to participate in culturally competent care for Aboriginal and Torres Strait Islander peoples. A range of teaching and learning experiences are stair-cased over the length of the Program and include theoretical, practical and clinical experiences mentored by Indigenous academics, elders and community members. Some of the experiences are in Aboriginal and Islander Community Controlled Health Services and sometimes led by Indigenous graduates of the Program. In the 2019 Preparedness for Internship Survey, more than 95% of Year 6 students of the Program declared themselves well prepared or very well prepared to provide care to Aboriginal or Torres Strait Islander peoples.

8.4 Clinical supervision

8.4.1 The medical education provider ensures that there is an effective system of clinical supervision to ensure safe involvement of students in clinical practice.

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.

8.4.4 The medical education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the medical program and the responsibilities of the medical education provider to these practitioners.

It is a College philosophy that teaching medical students is an expected part of the role for those involved in health services that host students. These expectations are moderated through clinical contracts with these health services. Most services and clinicians recognise the importance of inspiring future health practitioners and generally they embrace this task with enthusiasm. Teaching, mentoring and supervising students and junior staff is further reinforced by most of the Speciality Training Programs. However, the College cannot compel staff employed by these health services to engage in teaching and learning activities for students. Rather it relies on the development of mutually beneficial relationships that can be maintained over time.

These relationships are supported by embedding academic staff within the health services through a variety of mechanisms that in turn may assist with the recruitment and retention of clinical staff within the health service. Academic staff positions include Clinical Deans at clinical schools, research professors and their research teams as well as adjunct appointments (some classified as Full Academic Title Holders). These staff are seen to be beneficial for both organisations and these staff can then participate in College activities for instance on admission interviews or college committees such as BoS (Med) and Examination Boards.

Each of the main clinical teaching hospitals have Clinical Schools with Heads of Schools and Clinical Deans who supervise academic and clinical teaching staff. Clinical teaching staff are generally adjuncts (mostly Full Academic Title Holders) or have fractional appointments. All teaching staff are vetted for appropriate qualifications and suitability. The Clinical School Deans and Heads of Clinical Schools meet regularly with the senior executives and clinicians of the hospitals in which the schools are embedded to discuss strategic and operational issues including allocated time for teaching.

The College engages with a network of enthusiastic and committed clinical supervisors who are also offered training that features a mix of theoretical and practical skills in teaching, learning, assessment and feedback. They are invited to participate in assessment activities and selection interviews, and monitored through student feedback and from that of their colleagues. Training is given on 'Teaching on the Run' and materials are provided on how to provide feedback to students. These resources are based on materials developed for the University Health Professional Education offerings.

Tutors have access to induction training modules and are encouraged to undertake postgraduate training in medical education. A suite of programs for Graduate Certificate, Graduate Diploma and Masters in Health Professional Education (medical education) has been developed, with current student enrolment numbers around 80. The 2020 reduction in fee structure resulted in more than a quadrupling of student numbers in the four Graduate Certificate of Health Professional Education subjects.

Supervisors and academic staff reported that they appreciated the range and the quality of medical education training opportunities provided. However, while these opportunities were available, there was limited evidence that participation by tutors and clinical supervisors was monitored by the College. Further, supervisors reported that they received limited feedback on their performance and would welcome this, and it is recommended that the College develop mechanisms to provide feedback to clinical supervisors on their performance to support their development as medical educators.

The opportunities for medical education training have increased with the University leading the postgraduate training in general practice and rural medicine. College staff delivered a series of 'teach-the-teacher' workshops across the region for undergraduate and postgraduate clinical teachers in general practice. Locations included Cairns, the Atherton Tablelands, Townsville, Mackay, Rockhampton, Wide Bay, Sunshine Coast, Emerald and Mt Isa. There were over 200 participants in these workshops each year from 2016-2019 (i.e. pre-COVID), with new and different content developed each year.

In 2020 the College developed online formats to support clinical teachers due to COVID-19. Online Zoom sessions were offered and recorded for later viewing. There was an additional webinar as part of the JCU Series: "Teaching tips for time poor clinicians". Tutor training moved to an online format and a series of professional development sessions for the College's cohort of academic registrars was delivered by Zoom, on topics including principles of learning and teaching; bedside teaching and planning a teaching session; making time to teach – the one minute preceptor; the trainee in difficulty; principles of assessment; and introduction to research methods.

There is an opportunity to enhance supervisor development as the supervisors reported limited feedback on their performance and expressed an appetite for more.

Appendix One Membership of the 2021 AMC Assessment Team

Professor Tony Celenza (Chair) MBBS, MClinEd, FACEM, FRCEM
Head, Division of Emergency Medicine, The University of Western Australia

Professor Papaarangi Reid (Deputy Chair) DipComH, BSc, MBChB, DipObst, FNZCPHM
Tumuaki and Head of Department of Māori Health, Faculty of Medical and Health Sciences, The University of Auckland

Professor Jane Bleasel MBBS PhD MHPE FRACP
Director, Sydney Medical Program and Academic Education, School of Medicine, Faculty of Medicine and Health, The University of Sydney; Senior Staff Specialist, Rheumatology Department, Royal Prince Alfred Hospital

Associate Professor Anil Keshava MB BS(Syd) FRACS, MS (Colorectal Surgery)
Clinical Program Head, Surgery & Gastrointestinal Program, Macquarie University Clinical Associates, Macquarie University; Colorectal Surgeon, Concord Hospital, Sydney

Professor Robyn Langham MBBS (Hons), PhD, FRACP, GAICD, FAMA
Chair, Human Research Ethics Committee, Royal Children's Hospital, Melbourne; Chair, Specialist Education Accreditation Committee (SEAC) and Director, Australian Medical Council

Dr Nicola Wood BMed, BMed Sci (Hons)
Lecturer, College of Medicine and Public Health, Flinders University

Mr Alan Merritt RN, BN, MHSc (Education)
Manager, Medical School Assessments, Australian Medical Council

Ms Georgie Cornelius
Program Administrator, Australian Medical Council

Ms Chloe Chuah
Accreditation Programs Assistant, Australian Medical Council

Appendix Two Groups met by the 2021 Assessment Team

Meeting	Attendees
Tuesday, 25 May 2021	
James Cook University	
Overview of assessment week	Dean, Medicine and Dentistry Head, Medical Education
Oversight of the medical program	Dean, Medicine and Dentistry Deputy Vice Chancellor, Division of Tropical Health and Medicine (DTHM) Director, Academic Quality and Strategy, DTHM Director, Divisional Operations, DTHM Manager, College Operations Head, Medical Education
Management of the medical program	Chair, Board of Studies and Chair, Assessment Committee Chair, Clinical Studies Committee Chair, Foundation Studies Committee and Chair, MBBS1 Sub-committee Dean, Medicine and Dentistry Associate Dean, Learning and Teaching, and Chair, College Curriculum Management Committee Team Leader, Academic Services Assessment Lead, MBBS4 Sub-committee Assessment Lead, MBBS5 Sub-committee Chair, MBBS2 Sub-committee Chair, MBBS3 Sub-committee Chair, MBBS4 Sub-committee Chair, MBBS5 Sub-committee Chair, MBBS6 Sub-committee Head of Clinical School (Cairns) Head of Clinical School (Mackay) Head of Clinical School (Townsville)
Aboriginal and Torres Strait Islander Strategy, engagement with community, program delivery and development and students	Pro Vice Chancellor, Indigenous Education and Strategy Senior Lecturer and Associate Dean, Indigenous Health, DTHM

Meeting	Attendees
	Indigenous Health Academic Associate Professor, Remote Indigenous Health and Workforce
Program purpose and outcomes	Vice Chancellor
Budget and finance	Chief Financial Officer Director, Divisional Operations, DTHM Manager, College Operations
Wednesday, 26 May 2021	
James Cook University	
Governance of University	Deputy Vice Chancellor, Students Chair, Academic Board Director, Academic Quality and Strategy, DTHM Dean, Medicine and Dentistry Associate Dean, Learning and Teaching, and Chair, College Curriculum Management Committee Head, Medical Education
James Cook University Medical Students' Association (JCUMSA) executives	President Academic Vice President
College research strategy	Director, Research Development, DTHM Associate Dean, Research Education, College of Medicine and Dentistry Associate Dean, Research MBBS Honours Coordinator
Student support	Associate Dean, Students, College of Medicine and Dentistry Manager, Student Equity and Wellbeing Senior Lecturer, Medical Education, Student Support and Professional Practice Student Support (Cairns) Student Support (Mackay) Student Support MBBS5 and MBBS6 (Townsville) International Manager, International Student Support

Meeting	**Attendees**
Assessment	Associate Dean, Learning and Teaching, and Chair, College Curriculum Management Committee Manager, Academic Services Head, Medical Education Chair, Clinical Studies Chair, Foundation Studies Committee and MBBS1 Academic Coordinator Assessment Lead MBBS4 Assessment Lead MBBS5 MBBS2 Academic Coordinator MBBS3 Academic Coordinator MBBS6 Academic Coordinator
Thursday, 27 May 2021	
James Cook University	
Curriculum oversight	Head, Medical Education Associate Dean, Learning and Teaching, and Chair, College Curriculum Management Committee Chair, Clinical Studies Chair, Foundation Studies Committee and MBBS1 Academic Coordinator MBBS2 Academic Coordinator MBBS3 Academic Coordinator MBBS4 Academic Coordinator MBBS5 Academic Coordinator MBBS6 Academic Coordinator
Teaching and learning	Chair, Foundation Studies Committee and Chair, MBBS1 sub-committee Head, Medical Education Head, Anatomy and Pathology, MBBS1 Head, Pathology MBBS1 to MBBS3 Clinical Skills Coordinator MBBS2 Associate Professor, Ecology of Health MBBS2 Rural, Remote, Indigenous and Tropical Health Coordinator MBBS4 Academic Coordinator (Cairns)

Meeting	Attendees
	MBBS4 Senior Lecturer, Clinical Investigations (Cairns) MBBS4 Senior Lecturer, Preventive Medicine and Addiction Studies MBBS5 Adult Health Medicine Coordinator Research Scientist and Senior Lecturer, Genetics and Health Professor, Health Professional Education, General Practice Associate Professor, Infection, Inflammation and Immunology Senior Lecturer, Paediatrics Senior Lecturer, Public Hospital and Clinical Skills Adult Health 2 Academic Coordinator (Cairns) Child and Adolescent Health Academic Coordinator Clinical Elective Coordinator Clinical Pathology Curriculum Coordinator Home Group Coordinator, and Professionalism Education and Leadership (PEAL) Coordinator PEAL Coordinator Rural Internship Coordinator Rural Internship Supervisor Rural, Remote, Indigenous and Tropical Health Coordinator
Evaluation	Associate Dean, Learning and Teaching, and Chair, College Curriculum Management Committee Evaluation Coordinator Head of Clinical School (Townsville)
Student selection	Chair, Selection Advisory Committee Dean, Medicine and Dentistry Deputy Vice Chancellor, DTHM Director, Academic Quality and Strategy, DTHM Selection Coordinator, DTHM
Clinical Schools	Head of Clinical School (Cairns)

Meeting	Attendees
	Head of Clinical School (Mackay) Head of Clinical School (Townsville)
Professional and technical staff	Manager, College Operations Manager, Academic Services Team Leader, Academic Services Team Leader, Academic Services Manager, Regional Medical Training (Atherton) Manager, Regional Medical Training (Cairns) Manager, Regional Medical Training (Mackay) Manager, Communications and Administrative Services Team Leader, Clinical Training (Townsville) Team Leader, Laboratories and Technical Support – MedTech (Townsville) Team Leader, Laboratories and Technical Support – Human Anatomy and Pathology Clinical Training Support Coordinator (Atherton) Clinical Training Support Coordinator (Cairns) Clinical Training Support Coordinator (Mackay)
Wednesday 2 June 2021	
Townsville Clinical School	
Overview of clinical school	Head of Clinical School (Townsville) Clinical Dean, Townsville Clinical School Team Leader, Townsville Clinical School Clinical Facilitator Program Manager, Northern Queensland Regional Training Hubs Regional Medical Training Coordinator
Clinical teachers and supervisors	Head of Clinical School (Townsville) MBBS4 Lecturer, Clinical Investigations Tutor and Private Rotation Coordinator MBBS5 Subject Coordinator and Adult Health 1 Coordinator Senior Lecturer, General Practice and Rural Medicine

Meeting	Attendees
	Senior Lecturer, Mental Health Adult Health 2 Coordinator Child & Adolescent Health Coordinator Clinical Facilitator (Two) Reproductive and Neonatal Health Coordinators Director, Palliative Care, Townsville University Hospital
Students (Townsville)	(Four) Students
Townsville University Hospital (TUH) executives	Acting Executive Director, Medical Services Clinical Dean, Townsville Clinical School Director, Clinical Research Director, Medical Services and Workforce
Atherton rural placements leadership team	Senior Lecturer, General Practice and Rural Medicine Manager, Regional Medical Training Rural Placement Facilitator (Atherton) Clinical Training Support Coordinator
Students on rural placement	(Six) Students (from different hospitals)
Murtupuni Centre for Rural and Remote Health	Director, Centre for Rural and Remote Health Associate Professor, Remote Indigenous Health and Workforce
Clinical teachers, supervisors and professional staff from Mackay Clinical School	Academic Advisor Adult Health 1 Coordinator Adult Health 5 Coordinator Child and Adolescent Health Coordinator Clinical Training Support Coordinator GP Coordinator Manager, Regional Medical Training
Cairns Clinical School	
Cairns and Hinterland Hospital and Health Service executives (CHHHS)	Chief Executive Officer Executive Director Head of Clinical School (Cairns) Clinical Dean, Cairns Clinical School
Overview of clinical school	Academic Coordinator

Meeting	Attendees
	Head of Clinical School (Cairns) Manager, Regional Medical Training (Cairns) Regional Medical Training Coordinator
Clinical teachers and supervisors	Adult Health Academic Co-ordinator, Cairns Adult Health 1 Academic Co-ordinator, Cairns Adult Health 2 Academic Co-ordinator, Cairns Child and Adolescent Health Academic Co-ordinator, Cairns GP Academic Co-ordinator, Cairns Reproductive and Neonatal Health Academic Co-ordinator, Cairns MBBS4 Academic Co-ordinator, Cairns MBBS4 Clinical Facilitator, Cairns MBBS4 Senior Lecturer, Clinical Investigations, Cairns MBBS4 Clinical Skills Academic Co-ordinator, Cairns MBBS4 Private Clinical Facilitator, Cairns Senior Lecturer, Child and Adolescent Health, Cairns Senior Lecturer, Mental Health, Cairns
Students, Year 4 to Year 6 (Cairns)	(11) Students
Thursday 3 June 2021	
College of Medicine and Dentistry, Townsville, Bebegu Yumba campus	
Overview and tour of campus – including anatomy laboratories, basic science teaching, clinical skills teaching, library, teaching and learning spaces.	(Seven) Students Associate Professor, Clinical Skills Head, Anatomy MBBS4 Tutor, Clinico-pathologic case studies and Clinical Investigations MBBS4 Lecturer, Clinical Investigations Tutor and Private Rotation Coordinator (Four) Lecturers, Clinical Skills Senior Lecturer, Clinical Skills Senior Lecturer, Medical Education Senior Lecturer, Paediatrics Senior Liaison Librarian Team Leader, Laboratories and Technical Support – MedTech

Meeting	**Attendees**
Students, Year 1 to Year 3	(11) Students
Demonstration of teaching and learning tools and platforms – Portfolio, DoCTA and HALO	Head, Medical Education (Two) PEAL Coordinators
General practitioners	Dean, Medicine and Dentistry, and Associate Professor, JCU Health Director, JCU GP Training Principal Medical Educator, JCU GP Training Professor, General Practice Professor, Health Professional Education General Practitioner, Cranbrook Medical
Aboriginal and Torres Strait Islander Strategy	Associate Professor, Ecology of Health, MBBS2 Associate Professor, Remote Indigenous Health and Workforce Senior Lecturer and Associate Dean, Indigenous Health, DTHM Indigenous Health Academic
Indigenous students	(Three) Students
Townsville Clinical School, Mater Campus	
Tour of Clinical School	Head of Clinical School (Townsville) Clinical Facilitator, Private Rotation MBBS4 Lecturer, Clinical Investigations Tutor and Private Rotation Coordinator Senior Lecturer, Clinical Skills Team Leader, Townsville Clinical School
Volunteers	(Six) Volunteers
Students	(19) Students

Appendix Three Teaching and facilities observed by the 2021 Assessment Team

Date	Teaching session
Thursday, 3 June 2021	Year 4 Clinico-pathologic case study discussion (CPC), Douglas campus
	Year 4 Clinical Investigations teaching (CLIX), Douglas campus
	Year 4 Clinical Skills teaching on Volunteer Simulated Patients, Mater campus
Wednesday, 2 June 2021	Townsville Clinical School, Townsville University Hospital
	James Cook University Bebegu Yumba Campus
	Cairns Clinical School, Cairns Hospital
Thursday, 3 June 2021	James Cook University Bebegu Yumba Campus
	James Cook University Health GP Clinic
	Townsville Clinical School – Mater Campus, Mater Hospital