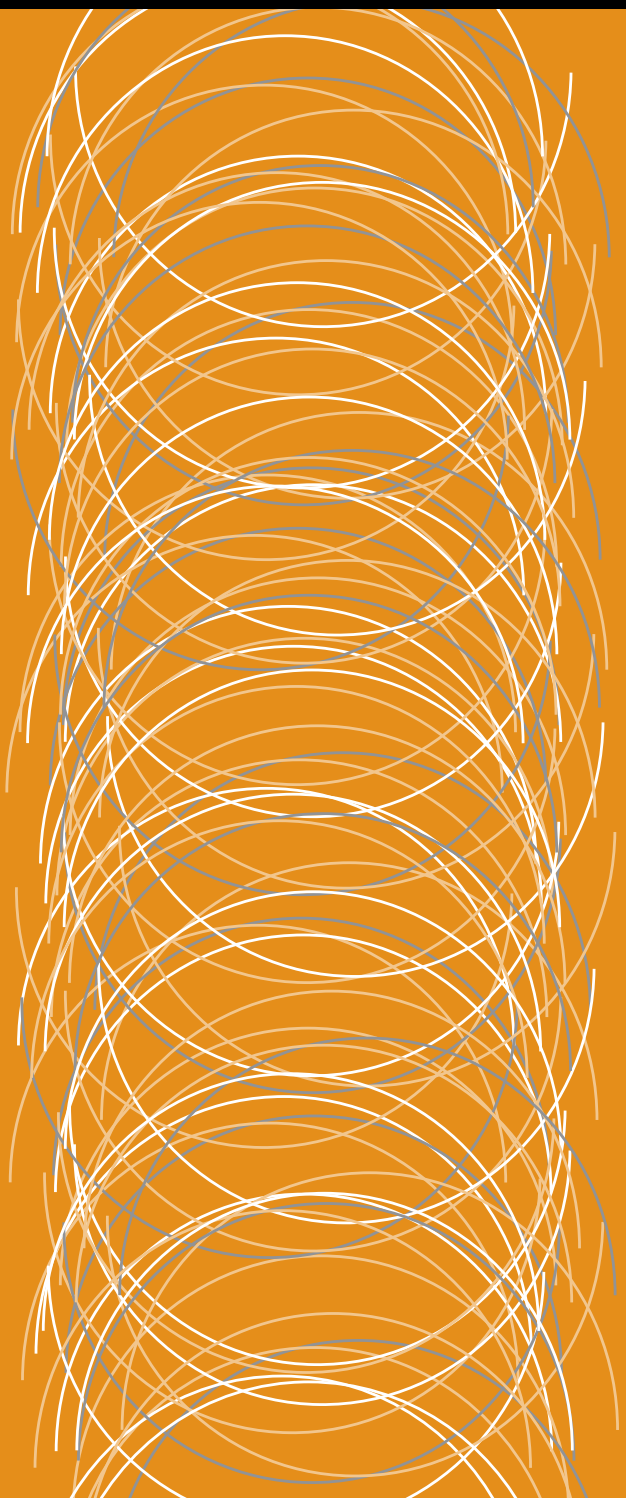
Australian Medical Council Limited

Accreditation of University of Queensland Faculty of Medicine

AMC



Medical School Accreditation Committee
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Acknowledgement of Country

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

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

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

Executive summary 2022

Accreditation process

According to the AMC's *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2022,* 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.

Accreditation of The University of Queensland (UQ), Faculty of Medicine's medical program expires on 31 March 2023.

The AMC reaccreditation of the current MD program and accreditation of MD Design, UQ's new MD program assessment was conducted by a Team which reviewed the Faculty's submission and the student report, and visited UQ and associated clinical teaching sites in the week of 9 May 2022.

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 2022*, section 5.1, the accreditation options are:

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

AMC Directors at their 15 September 2022 meeting resolved that:

(i) the four-year Doctor of Medicine (MD) medical program of the University of Queensland, Faculty of Medicine meets the accreditation standards

(ii) accreditation of the four-year Doctor of Medicine (MD) medical program of the University of Queensland, Faculty of Medicine be granted for six years, to **31 March 2029** and:

(iii) accreditation of the program is subject to meeting the following conditions and to meeting the monitoring requirements of the AMC, and a visit to review progress on the curriculum development and new pathways.

Condition	*To be satisfied by 2023*
1	Develop formal agreements with the University of Southern Queensland (UniSQ) and the Central Queensland University (CQU) to facilitate the introduction of the Darling Downs and South West Medical Pathway. (Standard 1.6.1)
2	Define strategies to ensure adequate support for the Aboriginal and Torres Strait Islander health leadership roles to reduce the risk associated with the significant breadth of responsibilities held by the two leads and enable increased engagement with local communities as the medical program is run in its entirety in the regions. (Standards 1.8.2 and 1.8.3)
4	Articulate strategies communicating to students how the teach out of the existing program or transition to the new program will be managed when students are unable to progress or intermit their studies. (Standard 3.1)

Condition	*To be satisfied by 2023*
5	Demonstrate that the quality of the learning and teaching into the current MD program (particularly lectures and Case Based Learning (CBL) sessions) is maintained as it is being taught out. (Standard 4.1)
6	Demonstrate that staff teaching into Year 1 at all sites have been trained in the new teaching and learning methods that support the program e.g. team-based learning (TBL) before the commencement of Semester One, 2023. (Standard 4.1)
7	That there be clear evidence of the enactment of the partnership arrangements between the partner Universities (Central Queensland University and University of Southern Queensland) with regard to academic arrangements including assessment and progression. (Standard 5.1)

Condition	*To be satisfied by 2024*
9	Progress reporting of student support during the teach-out of the current MD program is required in accordance with the Quality Improvement and Evaluation Framework (2019) and The University of Queensland Medical Student Aspirations and Support Strategy 2021-2023. (Standard 7.3)
10	There is a clear need to confirm access and formalise planning to a range of clinical placements across different disciplines in MD Design for all students in the different pathways and training sites. In particular the university has identified potential placement pressures in paediatrics and women's health during the transition. (Standard 8.3)
11	The increasing complexity of the delivery environment is generating a growing need for the development and implementation of an overarching IT Strategic Plan to guide the development of ICT systems in coming years to support the MD program. ICT support for curriculum mapping, eOSCE and support for ExamSoft is seen as a priority. (Standard 8.2)

Condition	*Report annually*
3	The School is required to provide an annual report detailing progress of how the detail of the MD Design curriculum under development will align with the AMC Graduate Outcomes. (Standard 3.2)
8	The School is required to provide an annual monitoring submission of the monitoring and review process relating to implementation of MD Design against the nine Program Domains within the Quality Improvement and Evaluation Framework (2019). (Standard 6.1)

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	**Substantially Met**

Standards 1.6 and 1.8 are substantially met

Conditions

1 Develop formal agreements with the University of Southern Queensland (UniSQ) and the Central Queensland University (CQU) to facilitate the introduction of the Darling Downs and South West Medical Pathway. (Standard 1.6.1)

2 Define strategies to ensure adequate support for the Aboriginal and Torres Strait Islander health leadership roles to reduce the risk associated with the significant breadth of responsibilities held by the two leads and enable increased engagement with local communities as the medical program is run in its entirety in the regions. (Standards 1.8.2 and 1.8.3)

Recommendations

A Further refinement of roles and responsibilities of the Medical School (the School) and Faculty senior leadership Team may help mitigate risks associated with critical personnel management. (Standard 1.1)

B Explore opportunities to increase engagement with Aboriginal Community Controlled Health Organisations within the geographic areas covered by the two planned Medical Pathways in the regions (Central Queensland and Wide Bay as well as Darling Downs and South West Queensland) to support the development and delivery of the medical program. (Standard 1.6.2)

C The School has set itself a goal to recruit an additional 60-100 general practices, to achieve a total of 200-250 general practices, across the Greater Brisbane area to provide clinical supervision in Years 2 and 4 of MD Design. An annual update regarding progress in recruiting new practices would be beneficial to ensure sufficient placements are available for MD Design. (Standard 1.6.2)

Commendations

The School leadership Team and staff demonstrated very strong and positive relationships. Numerous examples of collaboration and staff participation were cited during the visit across all aspects of the program and its management and delivery. (Standard 1.1)

The clear project governance arrangements and significant stakeholder engagement supporting the development of MD Design. (Standard 1.1)

The commitment to and the strength of relationships with a wide range of external stakeholders. Queensland Health, local Hospital and Health Services, partner universities and other Queensland universities with medical programs all reported mature and effective working relationships with the School. (Standard 1.1)

2. The outcomes of the medical program	**Met**

Recommendations

D The School should monitor the exposure of rural-based students in MD Design and the Medical Pathways in the regions to sub-specialty medicine and the potential loss of rural medicine exposure and opportunities for the city-based students. (Standard 1.6.2)

Commendations

There is a clear and strong alignment between the Faculty and School strategic intent, goals, and program delivery, student experience and stakeholder engagement.

3. The medical curriculum	**Substantially Met**

Standards 3.1 and 3.2 are substantially met

Conditions

3 The School is required to provide an annual report detailing progress of how the detail of the MD Design curriculum under development will align with the AMC Graduate Outcomes. (Standard 3.2)

4 Articulate strategies communicating to students how the teach out of the existing program or transition to the new program will be managed when students are unable to progress or intermit their studies. (Standard 3.1)

Recommendations

E Identify how the teach-out of the current program can be improved through the work on MD Design and communicate these plans to students. (Standard 3.2)

F While graduate attributes and staged learning outcomes have been developed and aligned to the six vertical themes of the new program, further work is required to detail more specific learning outcomes for courses as learning session content is developed. These will need to be provided in a timely manner to guide staff who are developing or delivering courses later in the program regarding the knowledge and skills required of the students. (Standard 3.4)

G Consider providing central coordination to better support students, in the current program, requesting to change their placement in order to reduce the reliance on the UQMS facilitated swap process. (Standard 3.6)

Commendations

The extensive work that has been done over recent years by the Associate Dean (Indigenous Engagement) and the Coordinator, Indigenous Health Education in the current MD program, which is valued highly by staff and students. (Standard 3.5)

4. Teaching and learning	**Substantially Met**

Standard 4.1 is substantially met

Conditions

5 Demonstrate that the quality of the learning and teaching into the current MD program (particularly lectures and CBL sessions) is maintained as it is being taught out. (Standard 4.1)

6 Demonstrate that staff teaching into Year 1 at all sites have been trained in the new teaching and learning methods that support the program e.g. team-based learning (TBL) before the commencement of Semester One, 2023. (Standard 4.1)

Recommendations

H Review the method of delivery of anatomy learning in the current program. (Standard 4.1)

I The School is encouraged to review and look at ways to improve communication from the School to students regarding the delivery of learning and teaching of Years 1 and 2 in the current program. (Standard 4.1)

J The School is encouraged to keep developing opportunities for Interprofessional Learning education in the current program at Queensland metropolitan sites. (Standard 4.7)

K The School is encouraged to seek more opportunities to embed Interprofessional Learning across all sites in MD Design. (Standard 4.7)

Commendations

The commitment to and significant number of innovative activities to embed concepts of patient centred care in the program delivered at rural sites in Queensland and in New Orleans.

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

Standard 5.1 is substantially met

Conditions

7 That there be clear evidence of the enactment of the partnership arrangements between the partner Universities (Central Queensland University and University of Southern Queensland) with regard to academic arrangements including assessment and progression. (Standard 5.1)

Recommendations

L Consider simplifying access to information regarding assessments and progression so that it is more easily identifiable on the Learning Management System for the courses within the teach out MD program. (Standard 5.1)

M The Learning Communities aim to promote good assessment practice across sites. This is however dependent on the development of infrastructure to manage large data sets and assessment information. It will be important for the University to monitor the effectiveness of Learning Communities as a mechanism to support good assessment practice across the curriculum. (Standard 5.1)

N Blueprinting for the teach out MD, which consists of 29 separate courses, should be available to all students and staff until its completion. (Standard 5.2)

O Articulation of assessment activities to the learning outcomes within each course is needed and should be developed for the MD Design program. (Standard 5.2)

P The assessment blueprint for MD Design should be aligned with the global curriculum and be accessible to students and staff including Academic Title Holders. (Standard 5.2)

Commendations

The quality and commitment of the academic leadership in assessment within the Academy for Medical Education is noted and recognised by the Academic Board of the University. (Standard 5.1)

Professional encouragement for clinicians to be involved in the assessment process was clearly noted. This encourages a culture of quality improvement, and also provides a point of contact for clinician participation in the MD program. (Standard 5.4)

6. The curriculum – monitoring	**Substantially Met**

Standard 6.1 is substantially met

Conditions

8 The School is required to provide an annual monitoring submission of the monitoring and review process relating to implementation of MD Design against the nine Program Domains within the Quality Improvement and Evaluation Framework (2019). (Standard 6.1)

Recommendations

Q Whilst the MD program participates in a range of University and Faculty evaluation activities it is encouraged to develop a framework for a whole of MD program evaluation, including outcome evaluation, and include a transparent process to disseminate information to stakeholders. (Standard 6.3)

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

Standard 7.3 is substantially met

Conditions

9 Progress reporting of student support during the teach-out of the current MD program is required in accordance with the Quality Improvement and Evaluation Framework (2019) and The University of Queensland Medical Student Aspirations and Support Strategy 2021-2023. (Standard 7.3)

Recommendations

R Continued close monitoring and reporting of student demographics of each cohort, especially students with low socioeconomic, rural and regional and Aboriginal and Torres Strait Islander backgrounds, will be important to ensure that any unintended consequences of admission changes (e.g. pre-requisites) are addressed in a timely manner. (Standard 7.2)

S Monitor student feedback on the provision of student support across all three clinical schools, and via the Medical Student Support Team (MSST) especially for students outside Brisbane. (Standard 7.3)

T Prioritisation of Aboriginal and Torres Strait Islander students accessing on-country placements where peer support is available should be considered. (Standard 7.3)

Commendations

The growth in Aboriginal and Torres Strait Islander student enrolments is commendable and signals important pathways into the program are operational. (Standard 7.1)

The commitment to achieve (and exceed) enrolments of students from a rural background. (Standard 7.1)

Student representation is a strength of the program. (Standard 7.5)

The development and application of the Medical Student Aspirations and Support Strategy 2021-2023 is considered a strong student-focused strategy to support quality in the student experience.

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

Standard 8.2 and 8.3 are substantially met

Conditions

10 There is a clear need to confirm access and formalise planning to a range of clinical placements across different disciplines in MD Design for all students in the different pathways and training sites. In particular the University has identified potential placement pressures in paediatrics and women's health during the transition. (Standard 8.3)

11 The increasing complexity of the delivery environment is generating a growing need for the development and implementation of an overarching IT Strategic Plan to guide the development of ICT systems in coming years to support the MD program. ICT support for curriculum mapping, eOSCE and support for ExamSoft is seen as a priority. (Standard 8.2)

Commendations

The Team commends the support for Education Registrar positions across clinical unit sites at the Greater Brisbane Clinical School. (Standard 8.4)

The Team commends the access to clinical supervision in all rural sites participating in the program. The quality of clinical supervision is a strength of the program and one that is valued by the students. (Standard 8.4)

Introduction

The AMC accreditation process

The AMC is the national standards body for medical education and training in Australia. Its principal functions include assessing Australian and Aotearoa 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 Medical Deans 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. This visit may take a week. 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 2022*. 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 monitoring submissions 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 University of Queensland (UQ) was founded in 1909. It is governed by a 22 member Senate established by The University of Queensland Act (1998). The primary role of the Senate 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 allocated to individuals in accordance with their role.

The University's academic business is overseen by the Academic Board established by The University of Queensland Act (1998).

In 2021 UQ had 56,278 student enrolments. The MD program had a student load of 1,084 Equivalent Full-Time Student Load (EFTSL) with 435 students commencing in 2022.

The University is organised into six faculties. The Faculty of Medicine includes the following schools:

- School of Biomedical Sciences
- Medical School
- School of Public Health.

The University consists of three campuses, study centres, field stations, and research hubs. The Medical School consists of three Clinical Schools – Greater Brisbane Clinical School, the Rural Clinical School with sites at Toowoomba, Rockhampton, Bundaberg and Hervey Bay, and the Ochsner Clinical School located in Louisiana, USA and the Academy for Medical Education.

In 2021 the medical program had in total 79.1 full-time equivalent (FTE) academic staff, 64.1 FTE Administrative staff distributed across the sites. By function there were 13.1 FTE Teaching and Research staff, 16 FTE Research focused staff, 27.8 FTE teaching focused and 14.9 FTE Clinical Academic staff.

There are 4,330 Academic Title Holder (ATH) appointments supporting the medical program across the three clinical school sites and within the Medical School.

The current Doctor of Medicine (MD) program commenced in 2015. It is a four-year, full-time graduate-entry program (AQF 9 Extended Masters) leading to the qualification of Doctor of Medicine, accredited by the Australian Medical Council (AMC). The program consists of 160 weeks of timetabled learning activities across the four years, including orientation and introductory weeks, revision weeks and assessment/examination weeks.

The current program structure is divided into a "pre-clinical" phase for Years 1 and 2, with a focus on classroom and laboratory learning in the basic sciences, followed by Years 3 and 4 which are entirely clinically based and involves learning in a variety of clinical settings under supervision. The current MD program curriculum is structured around the AMC Graduate Outcome Statements and key learning domains. Other key influences of the curriculum include the Australian Curriculum Framework for Junior Doctors, the Medical Deans Australia and New Zealand (MDANZ) Competencies, and The University of Queensland Graduate Attributes.

Years 1 and 2 comprise 76 weeks of teaching and learning with an additional Observership period (required for UQ-Ochsner students, optional for Onshore students from 2021). Each semester is 16 weeks duration in addition to orientation (one week in semester 1 only), a revision period

(one week) and an end-of-semester examination period (two weeks in Semester 1 and one week in Semester 2).

In Years 3 and 4, students are expected to participate in the clinical placements which may include afterhours shifts and weekend shifts as required by each course. Students participate in at least 25 to 30 hours of learning in the clinical environment each week under direct clinical supervision. At least eight hours of this time should be under direct consultant supervision. Year 3 is structured as an introductory week (standardised one-week program) and then clinical teaching (18 weeks) for each semester. Clinical teaching occurs as either nine-week blocks or six-week blocks. There is also a revision and examination period of two weeks each semester. Recently the timing of the Objective Structured Clinical Examination (OSCE) was altered so that it is now held at the end of Year 3, rather than in Year 4.

Year 4 is structured as an introductory week (standardised one-week program) and then clinical teaching (18 weeks) for each semester. Clinical teaching occurs as six weeks blocks. There is also a revision and examination period of two weeks each semester.

Vertical integration between the preclinical Years 1 and 2 and clinical Years 3 and 4 is promoted as teachers from the clinical years are invited to teach and give lectures in Years 1 and 2. Students are encouraged via the mentorship program to build links with students in later years.

Horizontal integration occurs between the four courses each semester in Year 1 by using a modular 'body system' structure where activities in clinical sciences and clinical practice are aligned. A high level of horizontal integration is achieved through the Integrated Clinical Studies course (MEDI7212) in Semester 2, Year 2, when what has been learnt in the first three Semesters by Year 1 and 2 students, with respect to the biomedical sciences and body systems taught in the Clinical Science courses, is integrated with knowledge from clinical, public health and research disciplines. MEDI7212 now provides a rich integration of Clinical Science, Public Health and Research to better prepare students for Year 3 and 4 and their future medical career. This Integrated Clinical Studies course was implemented in 2019 and was evaluated via a Scholarship of Teaching and Learning project grant.

There are slight differences in the order of clinical placement courses in Years 3 and 4 between the Onshore MD program and the UQ-Ochsner MD program.

In Year 3, Onshore students undertake Medicine, Surgery, Mental Health, General Practice and Rural & Remote Medicine/Medicine in Society; while UQ-Ochsner students undertake Medicine, Surgery, Mental Health, Obstetrics & Gynaecology and Paediatrics & Child Health.

In Year 4, Onshore students undertake Obstetrics & Gynaecology and Paediatrics & Child Health, Personalised Learning Course, Medical Specialties, Surgical Specialties and Critical Care; while UQ-Ochsner students undertake General Practice, Medicine in Society, Personalised Learning Course, Medical Specialties, Surgical Specialties and Critical Care.

UQ-Ochsner students generally undertake all Year 3 and 4 clinical placement courses in the Ochsner Health System, with the exception of one six-week placement in Year 4 where, in accordance with AMC requirements, they are required to undertake clinical placement in Australia. This placement may include Emergency Department, Orthopaedics, Medical Specialties, Medicine in Society, Intensive Care, Ophthalmology, Anaesthetics, or Elective (clinically based placement only).

In addition to the four-year MD program, students can combine their qualifications in the areas of research through the Clinician Researcher Track (CRT). This offers students a research-intensive pathway whereby eligible students can incorporate a Higher Degree by Research (HDR), either a PhD or MPhil, through an intercalated model. The Clinician Researcher Track involves students interrupting their MD program, after completion of Year 2, to undertake full-time research, then return to complete their MD to graduate with an MD-PhD or MD-MPhil. The

MD-PhD requires three years interruption to the MD program, while the MD-Phil requires one year interruption.

While the current MD is well established and graduates succeed in their internships and medical careers, the MD program is currently under review in accordance with quality review principles. A programmatic re-design of the MD (aka MD Design) has been underway since May 2019 with the new program due to commence in 2023 subject to AMC approval.

MD Design development

Stage 1 (May 2019 – December 2020) included significant stakeholder engagement with almost 50 workshops held across Queensland and in Louisiana. External stakeholders such as professional colleges, hospital and health services and alumni were invited to contribute. Best practice from around the world was reviewed along with a comprehensive literature review. Stage 1 culminated with a high-level design including a vision for the new program, the graduate attributes, an agreement on vertical themes, and an overall program outline.

Stage 2 (January 2021 – September 2021) involved the formation of Theme Working Groups which focused on the development of Staged Learning Outcomes for each year of the program that would enable students to meet the graduate attributes. A key achievement of Stage 2 was the endorsement of the high-level design of the new program by the University's central committees and ultimate approval by the Vice Chancellor in August 2021.

Stage 3 (October 2021 – implementation) provides the detailed design and implementation plans for the five courses of the new program. The Steering Committee that oversaw Stages 1 and 2 has been superseded by a School-led Project Board. The MD Design and Operations Project Board is chaired by the Dean of the Medical School and has membership appropriate for both the educational and logistical aspects of the new program. The purpose of the Board is to advance the detailed plans for implementation of the new program and transition arrangements for the current program.

The School is planning to introduce the redesigned MD program in 2023.

Accreditation Background

The AMC first assessed the MBBS delivered by UQ, Faculty of Medicine in 1988 and the Faculty was granted accreditation for five years until 31 June 1993. A follow up assessment visit was conducted in 1990, after which the AMC granted accreditation until 31 June 1998.

In 1997 the School implemented a major change to its four-year graduate entry program and, following an accreditation assessment, the AMC granted accreditation to 31 December 2001. Accreditation was extended to 31 December 2002, after a follow up assessment visit in 1998.

Following the School's submission of a comprehensive report in 2001, the AMC granted a further extension to 31 December 2005.

The reaccreditation of the four-year MBBS program took place in 2005 and the School was then granted accreditation for a period of six years, to 31 December 2011.

In 2008 the Faculty proposed a major change which involved offering the medical program offshore through the Ochsner Clinical School for up to 120 fee-paying students and to incorporate the UQ-Ochsner cohort and to implement Years 1 and 2 at Ipswich. In 2010, an AMC Team completed an assessment of the new arrangements, which included visits to the three university campuses associated with the MBBS program and the then 10 Clinical Schools (including the Rural Clinical School, Ochsner (Louisiana) and Brunei. Following this assessment, the AMC granted the program accreditation until 31 December 2016, subject to satisfactory reports on conditions and a follow up assessment in 2014.

In 2012, the School notified the AMC of plans to introduce a Doctor of Medicine (MD) in place of its MBBS from 2015. The AMC Medical School Accreditation Committee determined that the change to the program was not a material change and that transition should be assessed as part of the 2014 follow up assessment.

Based on the 2014 follow up assessment by an AMC Team, the AMC confirmed the period of accreditation remained six years, until 31 December 2016.

The Faculty submitted a further comprehensive report in 2015 and the AMC granted an extension of accreditation of the program until 31 March 2021.

In March 2020, the AMC granted a further extension of accreditation of the program, until 31 March 2023, to enable the Faculty to progress its plans for curriculum review before reaccreditation.

In 2020 and 2021, the Faculty provided both satisfactory monitoring submissions reports and appropriate information on the impacts of the COVID-19 pandemic on the program and students.

The MBBS program concluded in 2020 and is no longer an active program. Its accreditation expired 31 March 2022.

This report

This report details the findings of the 2022 reaccreditation assessment of The University of Queensland, Faculty of Medicine's program.

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

The members of the 2022 AMC Team are at **Appendix One**.

The groups met by the AMC Team in 2022 in Queensland are at **Appendix Two**.

Appreciation

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

1 The context of the medical program

1.1 Governance

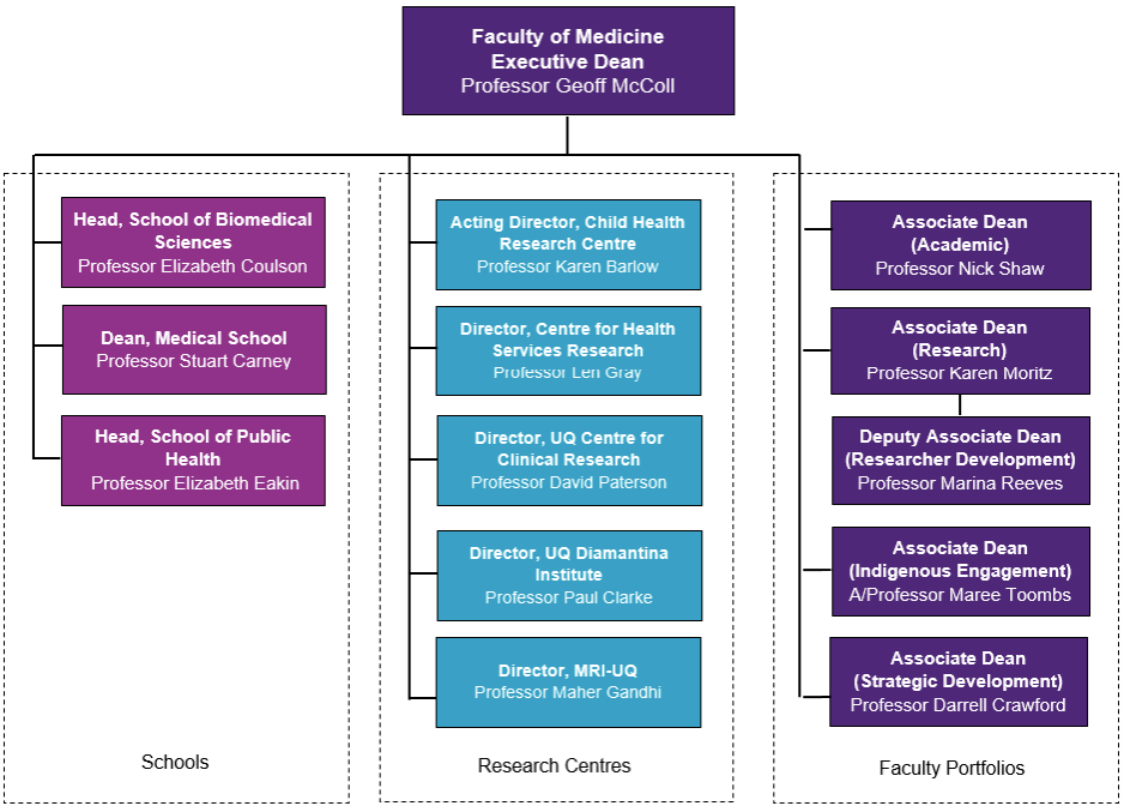
1.1.1 The medical education provider's governance structures and functions are defined and understood by those delivering the medical program, as relevant to each position. The definition encompasses the provider's relationships with internal units such as campuses and clinical schools and with the higher 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 Medical School sits within the Faculty of Medicine together with the School of Biomedical Sciences and the School of Public Health. Significant collaboration between the Schools is evident, including teaching in to the MD program, as well as with other UQ organisational units, the Faculty of Health and Behavioural Sciences, and the Faculty of Science with the School of Chemical and Molecular Biology. See Figure 1.

Figure 1 Faculty of Medicine Structure



The Medical School, previously known as the Medical Dean Portfolio, and the new organisational structure, was formally established in January 2022 and includes the Greater Brisbane Clinical School, the Rural Clinical School, the Ochsner Clinical School, each of the Mayne Academies, and the Academy for Medical Education (formerly the Office of Medical Education).

The academic and corporate governance structures and functions of The University of Queensland, the Faculty of Medicine and the Medical School, while complex, are commensurate

with the size of the School and are clearly defined and well described in the submission. These structures were understood by the staff the AMC Team met with.

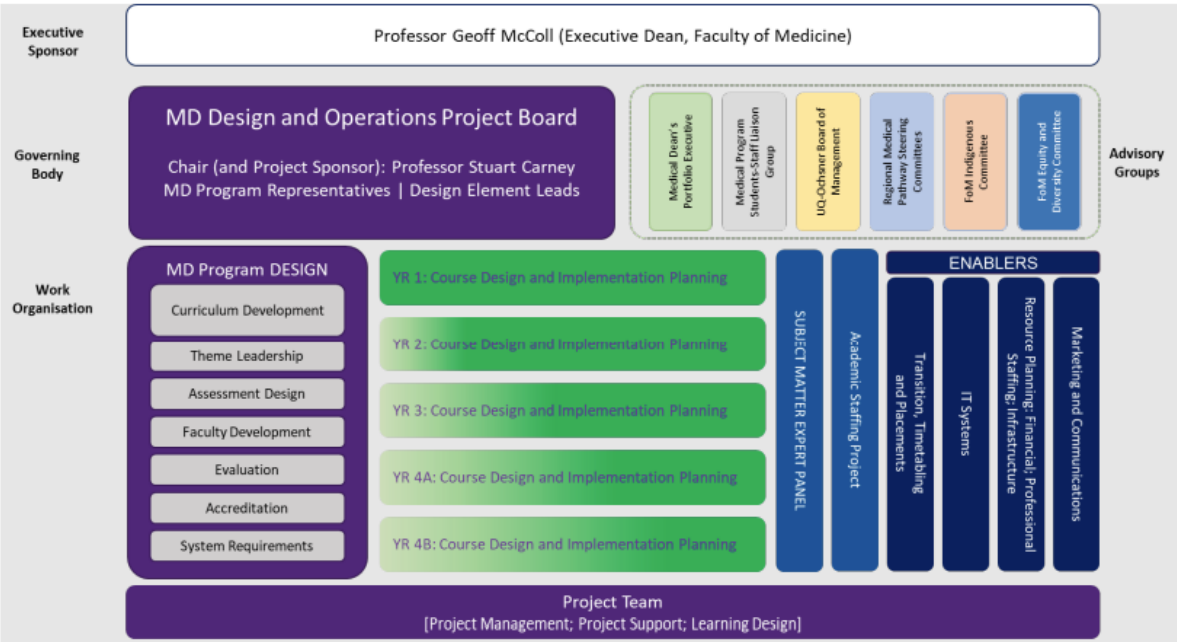
The governance structures for each of the committees responsible for the Medical Program clearly set out the terms of reference, composition and reporting relationships. All relevant groups are well represented in decision making, and this was confirmed during site visits and consultations held between the AMC Team and the constituent elements of each of the clinical schools.

The working relationship between the Executive Dean and the Dean of the Medical School is constructive and focused. Further refinement of roles and responsibilities within the Faculty and Medical School may help mitigate risks associated with critical personnel management. Similarly, the working relationships between the leadership Team and Medical School staff is very positive.

The consultations held by the AMC Team with relevant groups, including Queensland Health and the Hospital and Health Services, as well as the leadership of the teaching hospitals within each of the clinical schools' regions (including those in the Greater Brisbane Clinical School, the Rural Clinical School and the Ochsner Clinical School), confirmed the quality and comprehensiveness of consultations on key issues related to the MD program, including the initial planning for MD Design. The Team notes that the intention for the MD Design working group is to merge this into current governance structures. The Team also noted that there are policies and procedures throughout the governance structures which provide guidance on how discussions about change are conducted.

A well-articulated project governance structure has been defined for the governance of the MD Design project that was understood by staff and is serving the governance requirements of the School. See Figure 2.

Figure 2 MD Design Project Governance



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 School has the autonomy to design and develop the medical program within the governance framework of the Faculty of Medicine and UQ.

The responsibilities of the Dean of the Medical School, as the academic head of the medical program, are clearly stated, and include overall responsibility for the MD program, the MD Design, as well as the chair of the Medical School Leadership Committee and the School Board.

The responsibilities of the Dean of the Medical School include academic leadership, governance and management of human resources, budget and infrastructure, and maintenance of effective external relationships.

The relationship between officers of the leadership Team is constructive and supportive. The Team noted a strong personal connection between Team members. Whilst this is considered a major strength it poses some potential risk in the event of staff turnover. Some further consideration of risk management strategies may assist in mitigating for critical personnel risk.

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 current MD program is overseen and managed by the MD Program Committee (MDPC), chaired by the Program Convenor. The MDPC membership comprises the Chairs of the Advisory Groups and student representatives. Several advisory groups, each with their own Terms of Reference, report to the MDPC. This structure assists in ensuring that the planning, provision and evaluation of the Medical Program are regularly reviewed and monitored. The MDPC reports through the Medical School Teaching and Learning Committee.

The School Teaching and Learning Committee is chaired by the Director of the Academy for Medical Education, who is also the Director of Teaching and Learning in the School, and who is responsible for ensuring that the MD program meets national accreditation standards.

MD Design illustrates the autonomy of the School with an approval process involving the School and its Teaching and Learning Committee and the Faculty Board of Studies. It is noted that proposals for significant change require approval from the Medical School and its Teaching and Learning Committee, the Faculty Board of Studies, the University's Committee for Academic Programs and Policy, and the Academic Board. These approval processes ensure that there is alignment with the University policies and procedures, and also that the level of qualification being offered through the MD program meets the national standards of the Australian Qualification Framework of the Tertiary Education Quality and Standards Agency.

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.

There is a high level of educational and medical educational expertise within the Medical School, Mayne Academies, clinical schools and the Academy for Medical Education (formerly the Office of Medical Education). A key role of the Academy for Medical Education is curriculum oversight of both the current MD program and MD Design. The Faculty of Medicine has an Associate Dean

Academic and an Associate Dean (Indigenous Engagement), both of whom actively support the medical program.

An impressive number of Academic Title Holders (ATH) have postgraduate qualifications in Health Professional Education. The creation of Education Registrar positions in several of the clinical units in the Greater Brisbane Clinical School will further grow capacity and enhance the clinical teaching and education expertise of future clinician leaders.

There is clear and active engagement of the Faculty of Medicine Associate Dean Indigenous Engagement, and the Coordinator of Indigenous Health Education which ensure ongoing development of the Indigenous Health curriculum within the MD program.

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 Dean of the Medical School has delegated responsibility from the Executive Dean of the Faculty of Medicine, for the resourcing allocated to the MD program and has delegated autonomy to direct resources to achieve the agreed purposes and the objective of the program.

The University has the financial resources and financial management capacity to sustain its medical program and provides sufficient financial support to assure the ongoing development and implementation of MD Design, the roll out of the two four-year Medical Pathways in the regions, in partnership with the Central Queensland University (CQU) and the University of Southern Queensland (UniSQ), and the continuation of the UQ-Ochsner MD Program. The educational budget and resource allocation arrangements also contribute to the two other Schools within the Faculty of Medicine that provide academic services to the Medical School.

MD Design development work receives financial support from Mayne Trust disbursements. This is a positive strategy that avoids use of funds that would otherwise be required for current program management.

Resources are dedicated to the planned "teach out" of the current MD program, although this will require monitoring as MD Design is simultaneously implemented.

The University has been operating an expenditure budget during the COVID-19 pandemic, which has created some challenges for discretionary expenditure but has not impeded the expenditure required to support the ongoing development of MD Design. The University advised that work has commenced on the development of a new budget model that will be more closely tied to revenue and expenditure drivers. This new budget model is planned to operate in parallel to the Expenditure Only model in 2023, with full transition to the new model in 2024. This implementation timeframe may be subject to change given the size and complexity of the undertaking.

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.

The Medical School maintains strong and committed working relationships with a broad range of external bodies including Queensland Health and the three other Queensland universities that deliver medical programs (Bond University, Griffith University and James Cook University). This relationship is managed through the Queensland Medical Schools Liaison Committee, which brings together the current four Queensland university medical schools and Queensland Health. The relationship with these bodies is active in both the current MD program and planned MD Design development.

Metropolitan and Regional Hospital and Health Services are actively involved in clinical placement, teaching and supervision of students. Regional Hospital and Health services actively contribute to the planned Central Queensland and Wide Bay Regional Medical Pathway, and the Darling Downs and South West Medical Pathway.

The Medical School maintains clear and positive working relationships with its two partner universities in the planned Medical Pathways in the regions, being CQUni and the UniSQ. A formal agreement between CQU and UQ was executed on 26 October 2020 to formalise the Central Queensland and Wide Bay Regional Medical Pathway. There is a need to develop a similar agreement between UniSQ and UQ to facilitate the introduction of the Darling Downs and South West Medical Pathway.

The UQ-Ochsner MD Program delivered in partnership with Ochsner Health continues to be a strong and positive relationship within the Medical School. UQ-Ochsner graduates rank very highly in the United States of America (US) resident match rankings. The Team met with the Ochsner Health leadership Team who confirmed the strength of the positive partnership with colleagues at UQ, and who outlined plans for further expansion of clinical supervision opportunities across Louisiana. The COVID-19 pandemic had disrupted the regular opportunity of face-to-face visits in both Queensland and Louisiana.

There are constructive working relationships with teaching hospitals within the Greater Brisbane Clinical School, the hospitals within the Medical Pathways in the regions, General Practice, and Rural and Remote Medicine. The Medical School has set itself a major challenge to recruit an additional 60-100 general practices to achieve a total of 200-250 general practices across the Greater Brisbane Area to provide clinical supervision in Years 2 and 4 of MD Design.

Opportunities were also identified to engage more strongly with Aboriginal Community Controlled Health Organisations (ACCHOs) within the geographic areas covered by the two planned Medical Pathways in the regions (Central Queensland and Wide Bay as well as Darling Downs and South West). Updates regarding the progress and success of recruiting additional general practices and engagement with ACCHOs would be beneficial.

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 Academy for Medical Education (formerly the Office of Medical Education) was established in early 2022 and is incorporated into the governance structure of the Medical School. The Academy brings together expertise from across the School in learning and teaching, assessment and evaluation, as well as providing a strong focus for scholarship in medical education.

Research is a core component of the curriculum of the existing MD program and the new MD Design. UQ is a research-intensive university, and the Faculty of Medicine comprises three

research intensive Schools as well as five hospital-based research centres and Institutes: University of Queensland Centre for Clinical Research, Child Health Research Centre, Centre for Health Services Research, University of Queensland Mater Research Institute, and University of Queensland Diamantina Institute. Whilst the AMC Team did not meet with representatives of all the research institutes, it did meet with the Head of Research for the Rural Clinical School, the newly appointed Head of the Child Health Research Institute, and other research staff to explore the extent of integration with the MD program. The challenges of the scale of the MD research program are well understood. The School has good experience and expertise in delivering the research component of the MD program. New partnerships are being explored with other universities and Hospital and Health Services to ensure continued innovation.

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 Medical School has the staff and associated resources necessary to manage and deliver the current medical program and plans are well advanced to ensure that the staffing for MD Design and the Medical Pathways in the regions is sufficient.

In addition to continuing and fixed term academic staff, there are over 4,300 Academic Title Holders affiliated with the Medical School, as well as many clinicians employed in hospitals, community and private practice settings involved in teaching who do not have academic status.

The current Aboriginal and Torres Strait Islander academic and professional staff employed within the Faculty of Medicine have significant workloads. In addition, delivery of the Indigenous Health curriculum is principally coordinated by one staff member located at Toowoomba. The AMC Team noted plans to recruit, train and support more Indigenous staff across the Faculty of Medicine, which is aligned with the wider University strategy to increase Aboriginal and Torres Strait Islander staff numbers. It will be important that these plans are enacted successfully to reduce the risk associated with reliance on the two key leads for the Faculty and School.

University of Queensland staff (full-time, part-time, and casual) are indemnified for all University associated teaching and research, and the University maintains a comprehensive portfolio of insurance arrangements to provide financial protection to staff, students and others who assist in the conduct of its business against liabilities arising from insurance risks.

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.

UQ has policies and procedures for recruitment, appointment, professional development and promotion of staff, including Academic Title Holders (ATH). Access to these formal support mechanisms is less apparent for the many clinicians involved in the Medical School education programs who do not hold ATH status.

Given the planned pathway programs with CQUni and UniSQ it will be important to review the interaction of specific policies and procedures to ensure transparency and functionality between the universities in areas such as application and admission, student appeals, and progression.

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 Faculty's purpose, as outlined in the Faculty of Medicine's Strategic Intent 2019-2021 is to:

"save lives and improve human health in material and lasting ways through the education we provide and the research we conduct in our medical, biomedical and public heath endeavours".

In line with the Faculty of Medicine's purpose the MD program objective is:

"designed to produce graduates who are safe and effective from the first day of their internship/residency, and able to adapt to changing healthcare needs throughout their careers. We strive to train future medical practitioners who are representative of the populations they serve, and who are distinctive as being critical scientific thinkers, socially accountable, patient centred and global leaders in health care".

The vision/purpose of MD Design is:

"To nurture and educate future medical graduates who are clinically capable, Team players, kind and compassionate, serve responsibly and are dedicated to the continual improvement of the health of people and communities in Queensland, Australia and across the globe".

The enacting of the vision is demonstrated in the substantial evidence of extensive consultation with partnering universities, key stakeholders and Hospital and Health Services in the ongoing delivery of the current program and in the development of MD Design. One clear example is the regular meeting of the four Queensland universities and aligned Hospital and Health Services. This forum provides great opportunities for inter-agency collaboration. The School pays particular attention to community needs in the design and development of the current MD

program and the proposed curriculum of the new MD Design. The strategic intent particularly around First Nations health education and student experience is clear.

2.2 Medical program outcomes

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.

There is good alignment between the defined graduate outcomes of both the existing MD program and new MD Design with the AMC Graduate Outcome Statements.

The School is undertaking work to improve intern readiness, including specific changes in the MD Design curriculum to support transitions to Queensland medical internship programs.

Current students appear comfortable about the upcoming transition to internship. Recent graduates indicated that they were well prepared for internship, with no apparent concerns when comparing their experience with graduates from other universities.

With the development of MD Design and the Medical Pathways in the regions, there was concern expressed by some staff about the level of exposure to sub-specialty medicine in some rural sites and, as a corollary, the potential loss of rural medicine exposure and opportunities for the city-based students. It is acknowledged that this is a complex, long term, systemic dynamic between health workforce planning, specialty training and the medical education clinical supervision. However, these are areas to carefully consider in the design and change process.

For current students, it seems the predominant mechanisms for broadening the experience during electives was through student-co-ordinated "swaps". Thus, there is a significant ad-hoc element to ensuring a broad exposure for some students. For rural students, the significant costs (particularly related to accommodation) associated with gaining a city-based specialty exposure is noted.

It was clear from the evaluation of outcomes that geographical and pathway-related differences in student experience did not significantly impact the overall educational quality of experience of the students or their intern-preparedness.

Students can combine their MD with either a PhD or MPhil through an intercalated model.

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 4-year duration and structure of both the current MD and new MD Design enables students to achieve the graduate outcomes.

Students can combine their MD with either a PhD or MPhil through an intercalated model. Students who follow the Clinician Researcher Track interrupt their MD program at the end of Year 2 to undertake full time research. This requires an additional 3 years for students undertaking a PhD and 1 year for students undertaking a MPhil.

The School has developed a teach-out plan for the current MD program as they transition to the new MD Design during the period 2023-2027. It will be important for the School to clearly articulate to students how the teach out of the existing program or transition to the new program will be managed when students are unable to progress or intermit their studies.

Exit awards are available for students who complete 1 (Graduate Diploma in Medical Studies) or 2 (Master of Medical Studies) years of the program and discontinue.

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 current MD program consists of a pre-clinical phase (i.e. Years 1 and 2) and a clinical phase (i.e. Years 3 and 4). The program is delivered as a modular course-based curriculum across eight semesters. Students have indicated that at times this structure creates challenges with consistency of the learning experience across the multiple courses. Workplace Learning Portfolio courses (Years 3 and 4) and a Personalised Learning course (Year 4) were introduced in 2019. In addition, the Integrated Clinical Studies course (MEDI7212) was introduced into Semester 2 / Year 2 in 2019, replacing the Clinical Science 4, Health and Society, and Research courses, and an elective course introduced. It will be important for the School to continue to seek improvements to the model as the remaining students progress through the existing program.

There are slight differences in course structure for Onshore and UQ-Ochsner cohorts of the MD program, with the latter cohort having time allocated in Semester 2 / Year 2 to prepare for the United States Medical Licencing Exam (USMLE). This preparation time is largely well received by the students.

MD Design will maintain this mapping but seek to simplify and improve the structure of the program and increase emphasis in a number of areas, including Indigenous Health and intern preparedness.

MD Design will consist of year-long courses in Years 1-3 with each year level containing 16 units. The final year of the program will retain the two-semester structure with 8 units in each semester. There has been a significant reduction in the number of courses compared to the existing program in order to enhance the student learning experience. The new program will include earlier clinical experience with 20% and 40% of Years 1 and 2, respectively, allocated to clinical learning. Year 3 will consist of five 8-week clinical placements for students based in a metropolitan setting or possibly a longitudinal integrated clerkship for rural/remote students. One day per week in Year 3 has been allocated for structured learning. The new structure has resulted in some disciplines apparently increasing their duration while other disciplines have been slightly decreased. While some concerns have been expressed by staff involved in the delivery of disciplines where the duration of the placement has decreased, most discipline leads are satisfied with the allocation of time. Semester 1 / Year 4 will include 20 weeks of clinical learning. Important changes have been made to key transition points. The program will include an extended 4-week transition to the MD period at the start of Year 1 and a capstone course at the end of Year 4 with the final 8-week pre-internship placement being undertaken, where possible, in the clinical unit where the graduating students commence their internship.

UQ-Ochsner students undertake Years 3 and 4 of the MD program in the Ochsner Health System (USA), except for one 6-week placement in Year 4 which is undertaken in Australia.

The vision for MD Design is clear and well-articulated, and the Team looks forward to the further development of the detail of the program. The School will need to retain a strong focus on the paediatric and women's health placements given the change in this teaching from Year 4 of the current MD program to Year 3 in MD Design. There will be a challenging period in 2025 when these year levels overlap.

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 clear evidence of purposeful curriculum design of the current MD program and the forthcoming MD Design. The School has acknowledged that the modular structure of the current MD program presents challenges for integration. This has been confirmed by the AMC Team following discussion with various stakeholders across sites. The addition of the Integrated Clinal Studies course in Semester 2 / Year 2 has improved the integration of phase 1 (Years 1 and 2) and phase 2 (Years 3 and 4). Further work on the content and delivery of case-based learning tutorials has enhanced integration.

MD Design is being planned to enhance vertical and horizontal integration. This is intended to be achieved by a reduction in the number of courses across the program and the introduction of Learning Communities. The Learning Communities are intended to strengthen relationships between students and their supervising Teams through greater continuity and connection. There will be a strong focus on transition to practice in the final year. The AMC will wish to monitor the development of the program and strategies to address current structural concerns. There were some anxieties expressed by students and supervisors about the value and the potential unintended consequences of the introduction of Learning Communities. It will be important the School monitors the effectiveness of this strategy as it is implemented.

The Learning Communities will be integral to promoting good assessment practice across sites. This is, however, dependent on the development of infrastructure to manage large data sets across the Academy for Medical Education (AME) and multiple clinical and teaching sites.

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.

Specific learning outcomes for the current MD program are clearly articulated through the Electronic Course Profiles (ECPs). Students have access to the ECPs through the MD program Current Students webpage and links to the ECPs are also available via LearnUQ the learning management system.

Specific learning outcomes for MD Design will be released to students when they commence each course. While graduate attributes and staged learning outcomes for each year of the program have been developed and aligned to the six vertical themes of the new program, further work is underway to detail more specific learning outcomes for courses as the learning session content is developed. These will need to be provided in a timely manner to guide staff who are developing or delivering courses later in the program regarding the knowledge and skills required of the students.

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 commences in Year 1 of the MD program with content embedded in MEDI7101 (Year 1). This includes three modules presented by First Nations academics. Aspects of these modules are re-visited in Year 2 (MEDI7201) over two weeks. In Year 3, the health of First Nations peoples is addressed in a number of courses with a strong focus in Rural and Remote Medicine (MEDI7315). Students and staff were very positive regarding the extensive work that has been done over recent years by the Coordinator of the Indigenous Health and History Curriculum in the current MD program.

In the new MD Design, the Indigenous Health curriculum is being developed to provide early core knowledge followed by a longitudinal integrated curriculum. The plans to enhance the Indigenous Health curriculum are commendable, but there is concern regarding the workload on existing staff. A strategy for professional and academic staffing is required to support the increased emphasis in the curriculum.

Attention should also be given to increasing the Indigenous Health content for students who will be in teach out.

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.

There are a variety of opportunities for breadth and diversity of experience in the current MD program including a summer block observership at the end of Year 1 (optional for Onshore students and mandatory of UQ-Ochsner students), selectives in Semester 2 of Year 2, and Year 1 or 2 longitudinal observerships (for UQ-Ochsner students). A self-arranged Personalised Learning Course in Year 4 of the MD program was introduced in 2019 and provides additional choice. To an extent, students' opportunity to pursue areas of interest in the Year 4 Medical Specialties course depends on their clinical unit allocation and ability to swap their allocation

with another student facilitated by the UQMS. Some students reported this to be challenging and there appears to be an opportunity for the School to support students by coordinating this process.

MD design will offer choices for students in Years 2-4 of the program. However, planning around the nature of these activities is ongoing and will need to be completed with sufficient time for students to identify opportunities aligned with their interests.

The Clinician Researcher Track is available in both the current MD program and planned MD Design.

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 current MD program utilises a wide range of established, well validated teaching and learning methods applied throughout the varied contexts and distributed settings of the program

Methods used in Years 1 and 2 of the current MD program include case-based learning tutorials (CBLs), practical sessions of biomedical sciences (gross anatomy, histology, pathology, physiology) and multidisciplinary integrated practicals using flipped classroom and blended learning approaches; formal lectures, multidisciplinary clinical plenaries; procedural skills workshops and clinical practice masterclasses, clinical coaching in small groups, and communication skill sessions run by clinical psychologists. These offerings are supported by online resources on the Blackboard site, learning tools for practicals including An@tomedia, BEST Network and Slice, extension reading and multimedia materials, and a discussion board for student feedback.

Learning and teaching methods in Years 3 and 4 of the current program consist of immersive clinical placements at sites located in the Greater Brisbane Clinical School, Rural Clinical School and Ochsner Clinical School based in Louisiana. Teaching in these years occurs using established methods, workplace-based learning on placements (singly or in pairs), bedside tutorials, role modelling, completion of workbooks, and use of online resources. Learning activities are developed by each course coordinator who reports to the appropriate Mayne Academy Head and works in collaboration with the Year 3 and 4 Academic Lead.

The value of case-based learning tutorials in providing students with a small group learning, peer support environment was evident. However, the Team noted concerns regarding consistency and quality of CBL tutorials in Years 1 and 2 of the current program, and the depth and focus of lectures (as a delivery model) and guest lecturers (pedagogical expertise). The method of delivery of anatomy learning in the current program was raised by several students as challenging. The Team also noted a systemic issue with communication from the School to students regarding the delivery of learning and teaching of Years 1 and 2 in the current program.

It will be important the school ensures that consistency and quality of the learning and teaching in the current MD program (particularly lectures and cased based learning sessions) is maintained as it is being taught out.

The impetus for the new MD Design was to simplify the current program and provide a more cohesive and coherent learning experience, resulting in enhanced workforce readiness and smoother transition to internship. The change involves a philosophical shift from teaching to facilitating learning. Learning and teaching methodologies planned for MD Design are similar to the current program although a move from CBL to Team-Based Learning (TBL) in Year 1.

In Year 1 of MD Design students will have four days per week of structured learning experiences including TBL, 'lectorials', practical sessions, clinical and professional learning small group sessions, masterclasses, interactive seminars, reflective practice and symposia, such as clinical plenaries and workshops. Involvement of clinicians, community and patients will be encouraged where possible. Year 2 will continue to include weekly case-based sessions to enable application of knowledge to clinical scenarios and development of clinical reasoning, building upon the knowledge concepts and basic clinical skills gained in Year 1. Teaching of clinical and professional practical skills will take place in classroom, skills simulation labs and in wards and clinics averaging two days per week across the year. Formal structured teaching seminars will continue to be used to prepare UQ-Ochsner students for Step 1 of the USMLE. Year 3 of MD Design will require 4 days per week in clinical immersion and one day per week structured teaching at the

students' home base of their Learning Community with an additional requirement for team scholarly project work. This will be complemented by informal teaching on clinical placements. Year 4 is focused on clinical immersion with a structured core teaching program one day a week at the Learning Communities, complemented by opportunistic teaching on the wards or in the clinic.

The Team noted that staff at clinical sites desired further information and training on the delivery of TBLs. The implementation of MD Design will require staff development to ensure all staff teaching and working in TBL environments have received appropriate training.

Feedback from students in the current program noted variation in the quality of clinical supervision and clinical coaching at some sites including that provided by Academic Title Holders.

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 current MD program encourages students to take responsibility for learning from Year 1 of the program, with increasing opportunities for autonomy as they progress. During Years 1 and 2, students have predominantly formal structured teaching in biomedical sciences with direct supervision by appropriate academic staff. Opportunities for self-directed learning in later years of the current program are provided through Workplace Learning Portfolio courses (Years 3 and 4) and a Personalised Learning course (Year 4).

Lifelong learning practices, autonomy and responsibility to learning is further developed in Years 3 and 4 during the clinical immersion placements. During these years, students are under supervision of medical Teams, often residents and registrars. They are encouraged to develop autonomy through clinical skills and reflection on their capability through a range of reflective learning activities.

The shift to facilitated learning and teaching methods from teaching in MD Design is intended to strengthen development of self-directed learning across all years of the new program. The self-directed learning activities introduced into the current program in 2019 will continue in MD Design.

4.3 Clinical skill development

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

The current MD program enables students to develop clinical skills in Years 1 and 2 through clinical plenaries, procedural skills workshops, clinical coaching, clinical practice masterclasses, and communication tutorials. The MD program has a strong focus on teaching of clinical skills across the sites that participated in the assessment. These are supplemented by innovative online resources that were developed during the COVID-19 pandemic and include digital technology to enhance feedback by tutors. During Year 1, clinical instruction occurs in the classroom, with simulation-based learning activities to ensure appropriate learning outcomes. Years 3 and 4 of the current program also use simulation sessions to develop clinical skills before using them in clinical placements.

MD Design plans to continue this graduated approach to developing skills in simulated settings before implementing them in real life settings, from earlier in the course.

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.

Both the current MD program and new MD Design encourage progression from supervised clinical skill development to placements with medical Teams.

In the current program, students progress from practising communication and examination skills with peers in Year 1, to clinical coaching in small groups (5 or 6 students) in hospital settings and clinics in Year 2 with real patients, to supervision by medical Teams on wards during clinical immersion placements in hospitals and clinics in Years 3 and 4. Clinical skill development sessions at rural clinical sites were facilitated by other health professionals and were greatly valued by students.

There is a strong focus on teaching of clinical skills across all sites. Onshore and UQ-Ochsner graduates reported that they were well prepared by clinical instruction in Years 1 and 2 before encountering patients in clinical settings.

MD Design plans to utilise the same approach to increasing supervised clinical skills but will introduce these opportunities at a greater range and amount of community sites and subpopulations in Year 2.

4.5 Role modelling

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

The current program provides opportunities for role modelling from clinicians of all health professions in structured teaching sessions and during clinical immersion in the workplace. This role modelling occurs particularly in Years 3 and 4 of the program but also occurs by the provision of clinical coaches during Years 1 and 2 and during small group, CBL sessions, clinical plenaries and lectures.

For UQ-Ochsner students, Years 3 and 4 provide role modelling by medical practitioners and other health professionals in the American health system by faculty based at Ochsner Health. The current program also provides role modelling of clinician researchers through student research projects, student research symposia and seminars, although access to clinician research models varied with geographic site.

MD Design is intended to provide increased opportunities for role modelling by general practitioners and other community primary care health professionals through the expanded community placements in Year 2, and the extended duration of the general practice clinical immersion in Year 4.

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.

The current MD program has a strong emphasis on patient centred care and collaborative engagement commencing in Year 1 and extending throughout the program. The School has introduced a number of innovative activities to embed concepts of patient centred care. The Vulnerability in Medicine (ViM) element of the Medicine in Society course (MiS) in Year 3 is predominantly for international students to debrief and reflect on challenges in the workplace and in doctor patient relationships. The ViM won a Vice Chancellor's excellence in teaching award

in 2021. The UQ-Ochsner MD program has community volunteer led groups that focus on patient experience in community that students and staff participate in. The Ochsner Clinical School and student volunteer led clinic in Haiti is one of many examples of patient centred care.

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.

The School partners with the Faculty of Health and Behavioural Sciences to deliver Interprofessional Learning (IPL) from Year 1 in the current program through a joint IPL committee. The MD Program Convenor has expertise in IPL.

There are numerous examples of exemplary IPL at the School and within Rural Clinical School sites (RCS). These include Silver Q at RCS, multidisciplinary simulation activities at RCS and Ochsner Clinical School, interprofessional Advance Life Support in the MD Learning Hub and the pilot UQ Healthy Communities program.

There are fewer examples at metropolitan sites, and the School is encouraged to pursue opportunities to strengthen IPL and teaching throughout the current MD program at metropolitan sites and to embed IPL in MD Design across all teaching and learning sites.

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.

Assessment in the current MD program is guided by the MD Program Assessment Strategy 2018. Each course in Year 1 and 2 is assessed individually and includes a mid-semester and end of semester examination. Across the program, some courses (e.g. Clinical Sciences; Health Society and Research; Medicine; Surgery; Mental Health; Obstetrics & Gynaecology; Paediatrics) are awarded a numeric grade while others (e.g. Clinical Practice; Ethics and Professional Practice; General Practice; Rural and Remote Medicine; Medicine in Society) are assessed as pass/fail. eAssessment was introduced into the program in 2016 with the School using the commercial software ExamSoft to deliver examinations, analyse questions post-examination and provide feedback to students. Objective structured clinical examinations (OSCE's) are a key component of the assessment strategy as is the recently introduced Workplace Learning Portfolio to provide a longitudinal assessment of workplace learning.

The Team noted the effective and active engagement between the Academy for Medical Education and the Academic Board of the University and its sub-committees to support the development of assessment methods and practices in MD Design development.

The MD Program Assessment Strategy 2018 clearly outlines the links between the AMC assessment standards and the intended level of skills being assessed. The School's assessment strategy draws on Miller's Pyramid of Clinical Competence including the Cruess modification, with each course in the current MD program assessed individually using a mix of formative and summative assessment.

The strategy includes outlines for review, quality assurance, fairness and links to the curriculum via individual course rules. Course coordinators have responsibility to manage the assessment process in each course and report to the Board of Examiners after each examination period.

The School uses formative assessments and hurdle assessments throughout the program with the balance between formative and summative assessment managed at the course level. The School has identified that this approach has led to the potential over assessment of students in the current program (i.e. 144 separate assessment tasks across the 29 courses of the MD program).

Oversight of assessments will remain the responsibility of the Academic Lead - Assessment in the Academy for Medical Education. For MD Design, a whole of program assessment system is being developed in line with the MD Design Assessment Strategy. MD Design presents an opportunity to streamline processes and blueprinting across the program. The Academic Lead -Assessment is a standout development that will serve the MD Design project well.

The Team noted that changes in clinical teaching curriculum material delivered at the clinical sites were not necessarily linked with assessment processes with some lack of clarity noted by some clinician teachers, particularly at the regional sites.

Progression requirements for individual courses are clear to students and staff, but some students expressed uncertainty about how results in individual courses were aggregated to determine progress across the MD program.

The progress of students from the new articulated university partner pathways needs to be monitored, with appropriate feedback regarding the quality of preparedness for medical program in future cycles.

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 medical program currently employs a range of established assessment methods in line with the MD Program Assessment Strategy 2018. Assessment blueprints are generally completed at the course level. A current recognised limitation of this approach to blueprinting is the lack of a whole-of-year and whole-of-program blueprint mapped to program level learning outcomes.

The assessment strategy includes outlines for review, quality assurance, fairness and links to the curriculum via individual course blueprints.

The Team noted that assessment methods are blueprinted to the graduate outcomes, but clear articulation to the learning outcomes within each course are needed and should be developed. This will be actioned as part of MD Design implementation. It will be important for the School to demonstrate a clear blueprint for assessment across the new program. This will be critical for the success of the progressive assessment model planned.

The medical program employs a range of established assessments methods including theory examinations, oral examinations, written assignments, practical and clinical assessments, supervisor assessment, and a learning portfolio. Formative and summative OSCE assessments have been reintroduced in Year 2, with a small number of cases and some self-review which has been welcomed by the students and clinician supervisors.

Current standard setting processes are well understood by staff and students.

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.

Feedback on individual performance is complex in a medical program with a large number of students. The introduction of ExamSoft has provided increased feedback to students for assessments delivered via this platform and has been well received by the cohort. At sites where there are smaller cohorts and closer relationships (e.g. Ochsner and Rural Clinical School Regional Clinical Units), opportunities for individual feedback were greater as outlined by students in those cohorts.

The reinstitution of the Year 2 formative and summative OSCEs were welcomed by students as was the move of the OSCE from Year 4 to Year 3 to allow for sufficient time for remediation and demonstration of meeting the passing criteria.

Student feedback satisfaction rating improvements were noted by the Team, but ongoing work in this area is encouraged.

Students report that the feedback from (and concerns raised to) course coordinators in the first two years of the program is unclear. The roles of phase, year and course coordinators need to be clearly articulated, particularly for the MD teach out students. Some of these issues may be resolved by the integration of courses in MD Design. The new feedback cycle outlined with the progressive assessment planned for MD Design is also likely to be beneficial for student feedback. The plans for these need to be clearly shared with the remote sites, particularly the rural sites.

Feedback is reliant on systems already in place such as Examsoft. That online resource should continue to be supported. Future technology solutions need to allow for collated student feedback from the multiple assessment sources, including from clinical placements.

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.

Overall, the review of assessment policies and practices meets the AMC standard. The MD Assessment Advisory Group is responsible for assessment quality oversight.

The progression data for Aboriginal and Torres Strait Islander students was provided on request to the Team. This data needs to be tracked annually to allow responsive action relevant to student performance, if needed.

A course level assessment review is completed as part of the Course Examiners Reporting process for the Board of Examiners. In addition, assessment quality is reviewed via appraisal of a sample of deferred/supplementary exams, clinical participation assessment and assessment moderation practice. Whilst the quality oversight of assessment is clearly articulated, the quality control aspects of assessment were not always clear to the Team and appeared to be somewhat informal at times (clinical skills training).

While the range of assessment activities and the processes of fairness and transparency were clear, there are some examples of current assessment that will not necessarily match the aspiration of progressive assessment in MD Design courses. This is addressed in the whole of program assessment strategy in MD Design.

Regarding calibration across sites, there are good grade descriptors; clinical training sites contribute to the design and station writing for the clinical assessments. This approach is commended.

While there was a strength in specialist and discipline networks as they pertain to curricular design, the links to assessment design and feedback could be strengthened and made clear to clinical teachers.

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.

Formal course and program monitoring is led by the Dean of the Medical School through the Director of Teaching and Learning and the Program Convenor, working with the Academic Leads and Course Coordinators. A commitment was made to develop and implement a quality framework specifically for the MD program (Quality Improvement and Evaluation Project, 2019), noting there had been a reliance on external regulatory quality assurance rather than a locally owned cycle of quality improvement. The framework is designed to provide a '*fit for purpose framework to enable meaningful feedback from a range of key stakeholders to foster a culture of continual quality improvement*'. Its focus is on enhancing the development and success of the education offered to students.

The plan sets out a goal for evaluation across all stages of the MD program, from admission to graduation and beyond, that occurs as part of an annual plan alongside an evaluation strategy for any new initiatives. There is a Faculty of Medicine appointment of a Coordinator – Accreditation and Quality, to support evaluation and quality assurance activities. It will be important for this coordinator and their work to link with the MD Program Committee.

Formal course and program monitoring occurs through routine university structures and processes, internal and external surveys and reviews. Survey findings such as those from the Student Evaluation of Course and Teaching (SECaT) are discussed at key committee meetings, including at the MD Program Committee. Some current plans for course improvement are in response to evaluation feedback. The standard student surveys have a low response rate (less than 20%). It will be important to increase student feedback across the whole cohort. The AMC intern preparedness survey data has also been used to help prioritise program improvements. Additional evaluation occurs in the Rural Clinical School setting, including the use of student entry and exit surveys, and at the Ochsner Clinical School.

The School is generally responsive to student feedback and concerns, with students reporting feeling respected and heard in their feedback around the program. Students felt empowered to provide feedback on the curriculum and there were examples of responsiveness to concerns.

The School has many avenues to collect data and there are several examples of the School responding to the need for change. Some students provided examples of issues being raised where there has been no clear communication of the resolutions. It is not clear where mechanisms will be implemented to provide whole of program evaluation data, outcome evaluation data and how the recommendations from the Quality Improvement and Evaluation Project will be acted upon. Given the extensive changes planned, with MD Design and end to end pathways in regional centres, it will be important for the School to prioritise and resource a whole of program evaluation that has some independence from current structures and provides feedback to the range of key stakeholders. Increases in student placements will necessitate further attention to ensure effective evaluation and timely responses.

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.

There is an annual Academic Quality Assurance process through the University which involves analysing the courses including indicators relating to student retention, performance, satisfaction and graduate outcomes.

The MD Program Annual Report 2020 provides information on employment destinations for all MD graduates. The report provides a comprehensive picture relating to course performance, with data being drawn from a range of sources.

As part of the evaluation strategy, it will be important for the School to measure and report on the outcomes of the medical program, including those such as alignment of workforce need, given the new developments of Medical Pathways in the regions and the partnerships with other organisations.

The challenge of evaluating assessment and performance outcomes across the multiple courses and dispersed data sets that currently make up the medical program is noted in the submission. Despite these challenges, it is clear that efforts are made to review the data and respond accordingly.

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.

The results of evaluation are reported under the current governance structures and assessment outcomes are specifically reviewed by the Board of Examiners. The Mayne Academies provide a discipline-specific focus for engaging and communicating with teachers and other academic staff. There are ad hoc events, such as where the Academy for Medical Education has presented to the General Practitioners to update them on the development of MD Design.

Formal reporting on changes as a result of evaluation appeared to be limited and the School could enhance its processes for communicating its responsiveness to issues raised through various stakeholder channels.

The Team heard of an excellent example of content renewal generated by a regional teaching site. However, it was not clear to these staff whether the updated content was then reflected in the linked assessments.

Noting that the MD Program Committee will oversee evaluation, it will be important to include outcome evaluation in their Terms of Reference. The School will be required to report on how the Quality Framework can be extended beyond program evaluation to provide outcome evaluation data, to inform stakeholders including local health service providers and partner universities.

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 School has an annual student intake of 450-480 students drawn from multiple pathways and broadly defined in three main categories: domestic Commonwealth Supported Places (CSP) students, international onshore full fee paying students, and international UQ-Ochsner full fee paying students.

The Medical School has a current allocation of approximately 275 commencing CSP allocated as Bonded Medical Program (28.5%) and non-Bonded (71.5%) places. A proportion of the commencing cohort (28%) must be students from regional, rural and remote backgrounds based on Australian Government definition.

Domestic student intake has decreased since 2017, when the School relinquished 35 CSPs to the Griffith University medical program based at the Sunshine Coast University Hospital. In addition, three CSPs per year for four years (2021-2024) are being redistributed to the Murray Darling initiative. Between 2017 and 2022, on average 271 domestic students commenced the program each year with a balance sought between those who had gained provisional entry and graduate entry.

The original UQ-Ochsner agreement allowed for a total cohort of 480 UQ-Ochsner students across the four years of the program. The recent agreement plans for 80-100 UQ-Ochsner students per year from 2021, with a maximum cohort number of 400 across the program. Onshore international student numbers have varied in recent years, affected by changes to admission processes and COVID-19 related border restrictions.

The School has demonstrated their ability to resource the program, provide clinical placements and required physical infrastructure for the current student intake.

The School sought to admit 24 Aboriginal and/or Torres Strait Islander students in the years 2019-2021 with an achieved total intake of 23 students. It has the same target for the period 2022-2024 and is on track to exceed this number. Subsequent to the review visit the School advised it has nine enrolments in 2022. The School is proud of this achievement as it is the equal highest yearly enrolment of Aboriginal and/or Torres Strait Islander medical students, and the current cohort size of 29 Aboriginal and/or Torres Strait Islander medical students is the largest to date. This growth in Aboriginal and/or Torres Strait Islander student enrolments is commendable and signals a range of pathways into the MD program are operating successfully. The School is encouraged to continue and build on these successful strategies and to be ambitious beyond the Rural Health Multidisciplinary Training (RHMT) Program Aboriginal and/or Torres Strait Islander enrolment targets, and define a vision to achieve strong and ambitious participation targets for Aboriginal and/or Torres Strait Islander students within the MD program.

Similarly, intake targets for students from rural backgrounds are defined through the RHMT Program at a minimum of 28% of domestic places. It is commendable that the School has worked to achieve and currently exceeds this target with 30.4% of students from a rural background

enrolled in 2021. The developing partnerships with CQUni and UniSQ for the Medical Pathways in the regions seek to further encourage and support students from regional and rural backgrounds and Aboriginal and Torres Strait Islander students through the Central Queensland and Wide Bay Regional Medical Pathway and the Darling Downs and South West Medical Pathway.

Whilst no specific targets are set for admitting students from low socioeconomic backgrounds, it is commendable that the School recognises these students as an under-represented group. The School has identified barriers to students with low socioeconomic backgrounds accessing the program and implemented initiatives to mitigate some of these barriers. Subsequently there has been some improvement in enrolment from 6.5% (2019) to ~9% (2021). Further work in this area is encouraged.

The Ochsner Clinical School has identified the need to attract a more diverse student intake and is working towards establishing a widening participation strategy. It would be useful for updates about the development and implementation of this strategy.

The development of the Medical Pathways in the regions will provide end-to-end medical training in Central Queensland (CQ) and Wide Bay (WB) as well as Darling Downs (DD) and South West (SW). In 2021, UQ and CQUni established processes for a CQUni Bachelor of Medical Sciences (Pathway to Medicine) degree that supports students with provisional entry into the UQ medical program in CQ and WB. In 2023 and 2024, the CQ-WB Regional Medical Pathway (RMP) will admit 60 graduate entry students and from 2025 will admit 20 graduate entry students. From 2025, the first graduates from the CQUni articulated degree will commence MD Design with an expected cohort mix of 20 graduate entry students and 40 from those holding provisional entry status through the partnership with CQUni. A similar partnership with UniSQ will support end to end medical training in the DD and SW, beginning in 2024.

The establishment of the Medical Pathways in the regions will require a revision of domestic student numbers. In 2021, UQ applied to the Commonwealth Government for 30 additional CSP from the redistribution pool from 2023 onwards for the CQ-WB RMP. It was proposed that these 30 new places would be supplemented with 30 CSPs from the existing UQ allocation, making a cohort size of 60 students per year for the CQ-WB RMP. Subsequent to the review visit the School advised the proposal was unable to be considered by the Commonwealth as there were no open rounds for medical places. UQ intends to apply for a share of the 80 additional CSPs that were announced as part the 2022-2023 Federal budget.

The table below outlines planned enrolments for the next five years and does not include any additional CSPs.

Table 1 Planned enrolments (commencing students) for the next five years

	2022	2023	2024	2025	2026
Domestic					
CSP – Provisional and Graduate Entry	275	245	230	230	230
CSP – CQ/WB Regional Medical Pathway – Graduate Entry	0	60	60	20	20
CSP – CQ/WB Regional Medical Pathway – CQUni pathway to medicine	0	0	0	40	40
CSP – DD/SW Medical Pathway ^ – Graduate Entry	0	0	30	30	30
International					
Full fee-paying international – Onshore	90	90	90	90	90
Full fee-paying international – Ochsner	90	90	90	90	90
TOTAL	**455**	**485**	**500**	**500**	**500**

^ The USQ pathway to medicine to commence in the MD program in 2027.

While the School has indicated that it is confident that it has the capacity to provide comprehensive academic, clinical and pastoral support for current student numbers, and these changes will bring on board additional regional resources, there is still an overall increase in projected student numbers alongside the transition to and refinement of MD Design. This presents tangible capacity and resource challenges to maintain teaching quality and strong student support. At the same time, students in the existing program will need to be fully supported during the teach out. The School will need to integrate strong monitoring and reporting functions as these changes evolve.

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 MD program has clear and well documented selection policies and processes that are implemented and sustainable. Policies and procedures governing admission, selection and appeals are detailed online and available publicly in the UQ Policy and Procedures Library. The application of these admission and selection policies are appropriately governed by the MD Admissions Board.

The School implemented a new MD Admissions Framework from 2020. Key changes within the new Admissions Framework included:

- Introduction of Multiple-Mini Interviews (MMI)
- Introduction of subject pre-requisites
- Using the unweighted average Graduate Medical School Admission Test (GAMSAT) score
- Offer of a place based on merit order ranking derived from Grade Point Average (GPA)/Australian Tertiary Admissions Rank (ATAR) (25%), admissions test e.g., UCAT, GAMSAT (25%) and MMI score (50%).

Considerable work has gone into the introduction of Multiple Mini Interviews (MMI) as an important tool for admission into the program. Given the MMI contributes substantially to the admission score, the School recognised the need for the process to be robust. The School has invested significant effort in the design of MMI scenarios that test a number of applicant qualities. In 2019, the Team administering these scenarios won a service award within the Faculty of Medicine. MMI interviewers are convened from academics, clinicians, professional staff, community members and others. Interviewers are given significant training in preparation for their role.

As a consequence of the introduction of the MMIs, the previous gender imbalance favouring male candidates is being addressed. At least 50% of the 2021 and 2022 commencing cohorts have been female, beginning to resolve the imbalance.

The introduction of cell biology and physiology subject pre-requisites was in response to academic challenges experienced by students without these subjects in their undergraduate

degree and will continue to be a basis for entry into MD Design. Continued close monitoring and reporting of student demographics of each cohort, especially students from low socioeconomic positions (SEP), rural and regional and Aboriginal and Torres Strait Islander backgrounds, will be important to ensure that any unintended consequences of these changes are addressed in a timely manner.

There have also been changes in recruitment of UQ-Ochsner medical students. Previously, an independent student recruitment company was contracted to provide this service. From 2019 student recruitment has been undertaken by UQ in partnership with Ochsner Health, with the aim of achieving greater student diversity and increased enrolments from the Gulf region of the United States of America (USA).US .

For students living with disabilities, applicants are able to request support and discuss reasonable adjustments with student advisors from UQ Student Services. The Medical School plans to further refine processes for supporting applicants living with disabilities aligned with the MDANZ Inclusive Medical Education: guidance on medical student applicants and students with a disability publication.

The School provides a specific and direct Alternative Entry Pathway for Aboriginal and Torres Strait Islander students seeking admission to the MD program. This pathway is supported through the Aboriginal and Torres Strait Islander Studies Unit within the University. They receive applicants in both the provisional and graduate entry categories. Alternatively, Aboriginal and Torres Strait Islander applicants can also apply through mainstream processes via QTAC for provisional entry and GEMSAS for graduate entry. The Aboriginal and Torres Strait Islander Studies Unit convenes a panel, shortlists applicants and follows with a semi-structured interview that focuses on academic preparedness and connection to community. Following success in this interview, shortlisted applicants then participate in the MMI where they need to achieve a minimum score to receive an offer.

Staff at the Aboriginal and Torres Strait Islander Studies Unit seek to provide a culturally safe space for Aboriginal and Torres Strait Islander students and use every engagement with students to offer advice to improve student's capacity to be successful in their academic pathways.

With the development of the CQ-WB RMP, UQ worked with CQUni in 2021 to assist with the development of aligned processes for admissions, especially provisional admission into the CQUni undergraduate degree that articulates into the MD program. This included CQUni academics being members of the UQ Admissions Board and being trained in MMIs. The MMI scenarios used for the RMP are the same as the UQ program but have an additional station that seeks to gauge interest to pursue a medical career in regional, rural or remote Queensland. This process of including partner universities into the admissions process aims to assist the smooth transition of expertise about high stakes processes.

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 School seeks to promote excellence in student support through a mix of services, opportunities and resources whereby students develop critical reflective strategies to optimise and manage their own wellbeing.

UQ's support strategy for students in the MD program is primarily derived from the Medical Student Aspirations and Support Strategy 2021-2023. This strategy is dedicated to the systematic improvement of student support. A central pillar of student support is operationalised through the Medical Student Support Team (MSST) which functions out of the student support services centrally at UQ, although funded by the School. The MSST includes 2 full time Principal Student Advisors who provide direct student support through both fielding email and phone concerns from students, and active outreach to students at clinical sites (including at rural or regional sites), either in-person or online. The MSST staff were enthusiastic and caring and noted the large volume of student support requests, with ~900 individual support requests addressed last semester, demonstrating considerable need and strong engagement by students.

Students noted both positive and negative reactions about the nature of the support provided by the MSST. Some students felt that the staff/student ratio was too low to be productive and chose not to engage with the service. They suggested this issue would become more acute as more students spend longer periods in campuses outside Brisbane. Other students reported being able to engage with the service and being supported to navigate university services to obtain timely and suitable support. In particular, students were grateful for the work of the MSST in rolling out the Mental Health First Aid (MHFA) certificate funded by the Commonwealth Government from 2020-2022, and in arranging additional personal development events, e.g., Assertiveness Training, to support cohort level professional skills development.

The MSST has a strong communication strategy and ensures that content is available and accessible through monthly MD Community News emails, orientation week, BlackBoard and the dedicated Medical Student Support and Aspirations website. Further, the MSST structures communication around identified key stress points throughout the academic year or curriculum in order to best support students.

The MSST has other functions beyond student support including supporting Clinical School staff to facilitate the early intervention and management of student concerns, especially in relation to students requiring reasonable adjustments or additional support which may involve complex sensitive multi-stakeholder issues.

Other concerns raised by students in relation to the MSST related primarily to complex pastoral and academic issues that could not be solved by a simple email reply and those issues that critique the university staff or program systems. Students reported that when they raised issues that were systemic in nature, they were advised to manage these as if they were interpersonal problems. Because students felt these issues were not adequately dealt with by MSST, they felt compelled to raise the issue separately in other forums.

In addition to support from the MSST, medical students are able to access additional site-specific supports, whether it be through events, mentoring or other interventions. Many of these supports are informal and speak to the culture and network of support cultivated among staff and students in the program. Further there are Academic Guidance Leads responsible for Years 1 and 2, and Years 3 and 4.

The School provides medical student specific services, including outreach services, which are actively engaged with by many students. There is clear separation between student support and academic progression decision making at onshore sites. This could be improved at the offshore site.

A number of students identified having experienced bullying and harassment in both clinical and non-clinical environments, noting a low understanding about pathways for complaints and formal escalation. While some students believed that the Clinical Schools and MSST were a natural port of call, they were not able to tangibly influence situations. These students were also uncomfortable and unwilling to report instances of bullying because of the potential impact on their grades and future career. While formal complaints about bullying and harassment may be low, it remains a significant challenge to ensure that there are safe processes for students reporting these issues, within the University and clinical contexts.

UQ-Ochsner students, in addition to the above supports, are allocated on admission into one of five medical societies which provide further tailored academic, pastoral and wellbeing support. UQ-Ochsner students reflected positively on these medical communities, which provide support during both pre-clinical and clinical years of the degree. This support is especially important during periods of high stress, such as preparing for the USMLE and residency match. Beyond the structured medical societies, UQ-Ochsner students have generally found clinical, administrative and teaching staff at Ochsner Health to be very supportive and concerns easily escalated. UQ-Ochsner students said they utilised their medical society supports more readily than the MSST or other university support services, as it provides more 'USA-centric' and tailored support for students.

Aboriginal and Torres Strait Islander medical students noted that the Associate Dean (Indigenous Engagement), the Coordinator, Indigenous Health Education and the staff of the Aboriginal and Torres Strait Islander Studies Unit provide comprehensive and timely academic and pastoral support. This support was highly valued among Aboriginal and Torres Strait Islander students and they associated this support with improved student engagement and success. Students reported that these staff are the immediate contact person for most student issues and they were less inclined to engage with other university or medical school supports. This raises a 'key person' challenge that is familiar to many Aboriginal and Torres Strait Islander academics and exposes a vulnerability of the organisation. An ambitious plan to recruit and develop Aboriginal and Torres Strait Islander staff will be important to mitigate this risk in the future.

Aboriginal and Torres Strait Islander medical students noted that the strong community and peer relationships developed during pre-clinical years are often lost when students move into their clinical years. Prioritisation of Aboriginal and Torres Strait Islander students accessing on-country placements where peer support is available should be considered.

Key clinical staff are acutely aware of the vulnerability of student isolation in rural and regional locations; however greater consistency and policy level changes are encouraged to minimise this risk and to provide a consistent student experience, especially in light of the development of end-to-end Medical Pathways in the regions with more students undertaking rural and regional placements.

There is clear separation of academic progression decisions from student support at the main UQ campuses. However, staff from smaller sites noted that it remains a challenge to entirely separate these responsibilities at all times. This was not discussed in the MD Design proposal, particularly for the Medical Pathways in the regions where this issue will become increasingly important.

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.

The School utilises central university policies and procedures for managing medical students whose impairment raises concerns about their fitness to practise medicine. These policies apply to the current MD and are intended to be used for MD Design.

The recent appointment of an Associate Professor in Ethics, Law and Professionalism, positioned within AME, provides a focus that reflects the need for culture change within medicine with an increased prominence of professionalism and integrity. This academic will take over the role of MD Integrity Officer as part of their portfolio.

The School has investigated a number of fitness to practice and academic integrity or misconduct matters between 2019 to 2021. The majority of the academic misconduct issues relate to plagiarism, while there is a broader range of issues that are investigated as fitness to practice concerns. The School is seeking to focus on education about expected standards of professionalism in medicine, thus preventing issues arising. If they do arise, informal discussions are often appropriate for early intervention and rehabilitation. There is an escalation pathway for serious concerns.

For UQ-Ochsner students who undertake the majority, or all, of their clinical training in the Ochsner Health System, there are clear communication pathways between the Deputy Head (Students) at the Ochsner Clinical School and the MD Integrity Officer in the Academy for Medical Education. This liaison will become more important with MD Design as they will have early exposure to clinical teaching in the Australian health system.

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.

Student representation is a strength of the MD program.

The University of Queensland Medical Student Society (UQMS) is the student representative body. UQMS senior leadership and appropriate members are actively involved in the governance of the medical program at appropriate levels and were extensively engaged in the development of MD Design. Furthermore, local level representation and advocacy at clinical sites is also strong, with Student Staff Liaison Groups (SSLG) being raised by both staff and students as key avenues to discuss key student related matters.

Students have had representation at most interviews for key academic positions. Most recently, this was for the Associate Professor of Ethics, Law and Professionalism. This was well received by UQMS and sends a strong signal about supporting student voice and realities.

The School should continue an active process of consultation with students, both in the existing program as it is being taught out, as well as in each phase of MD Design and each of the Medical Pathways in the regions as they continue to develop. Real-time feedback from students will be important to refining all elements.

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.

UQ provides adequate indemnity and insurance arrangements for relevant and sanctioned activities, both onshore and offshore. These include Public Liability, Professional Indemnity,

Medical Malpractice, Student Personal Accident Insurance, WorkCover, Clinical Trial and Travel Insurance. Placement providers also hold a number of indemnity and insurance arrangements for students. These policies are readily accessible through central university links. International students are also required to have adequate health insurance. UQ-Ochsner students are also covered through appropriate arrangements when undergoing placement and travel to the Ochsner Health System.

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 physical facilities of the Medical School locations at Greater Brisbane Clinical School, the Rural Clinical School with sites at Toowoomba, Rockhampton, Bundaberg and Hervey Bay, and the Ochsner Clinical School all meet the needs of the program and are of an appropriate standard both for delivery of the current MD program and for MD design. The UQ-Ochsner MD program in Louisiana, USA was not visited by the Team but feedback from staff and students was supportive.

Students in Year 1 would value increased access to the Gross Anatomy Facility which is currently unavailable outside of formal teaching sessions.

There was a lack of clarity about the physical spaces and staffing resources needed for the effective delivery of team-based learning activities to support the implementation of MD Design in regional locations.

There may be a need for some upgrading of specific physical spaces at Hervey Bay (such as Videoconferencing and lecture facilities, toilets). Rockhampton and Toowoomba facilities are well resourced and work collaboratively with the health services. UQ are developing strong partnership relationships with CQUni including arrangements for sharing of facilities.

The Team noted plans to increase social accountability opportunities through greater access to a range of social and health service environments including up to 200-250 general practices in Greater Brisbane area. There are also opportunities for further development and reinvigoration of relationships with Aboriginal Community Controlled Health Organisations (ACCHO) for student placement.

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.

Students and staff considered the current ICT infrastructure is adequate for the School's needs and commensurate with the School's size and complexity. Students and staff were generally positive about ICT infrastructure across all learning sites although there are some local concerns regarding variable access to internet at Hervey Bay.

The Team was advised of the strong need to ensure ICT systems continue to develop to support the growing complexity of the MD program going forward in the context of dispersed delivery across numerous sites. A need has been identified for the review of ICT governance, structure and services. This should be supported by the development and implementation of an ICT Strategic Plan to support improvements and efficacy of the School. This would also support the

development and implementation of MD Design. ICT support for curriculum mapping, eOSCE and support for ExamSoft is seen as a priority.

Library resources appear otherwise appropriate across all sites.

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.

There are good processes in place for regular review and student feedback regarding clinical learning environments.

Overall, the Team considers that there will be adequate clinical placement capacity for the delivery of MD Design. The School has identified potential placement pressures in paediatrics and women's health during transition and are working to address this at both metropolitan and rural sites. The School is working collaboratively with the other education providers and health services particularly in the regional areas. Particular attention will need to be given to clear collaboration with all Queensland medical schools to ensure they are aware and supportive of MD Design and Medical Pathway developments.

It is noted there may be pressure on capacity with the introduction of providing all four years of MD Design in the regions and maintenance of a rural experience for metropolitan students. Currently there are an adequate number of places for the Medical Pathways in the regions with consideration of strategies for securing additional clinical placements to be managed actively in rural sites.

Some concern was noted that a number of clinical learning environments may not provide the students with adequate experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander people. A number of students felt that they had not acquired the appropriate skills to provide that care in the clinical context. This has been identified as a focus for improvement in MD Design. This is also related to the need to foster further clinical environment settings within ACCHO settings.

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.

The MD program engages many enthusiastic and committed clinical teachers. The Team commends the support for Education Registrar positions at the Greater Brisbane Clinical School. The Team also commends the access to clinical supervision in all rural sites participating in the MD program. The quality of clinical supervision is a strength of the program and one that is valued by the students.

There are perceived barriers to the acquisition of academic titles (Academic Title Holder) amongst some clinical supervisors. These barriers could be explored and where appropriate professional development strategies implemented to ensure the continued high quality of clinical teaching. The School undertakes a proactive performance management program for academics and supervisors which is to be commended.

Appendix One Membership of the 2022 AMC Assessment Team

Professor Wayne Hodgson (Chair) BSc, GradCertHighEd, PhD (Monash)
Deputy Dean (Education), Medicine, Nursing and Health Sciences, Monash University

Professor Annemarie Hennessy (Deputy Chair) MBA, PhD, MBBS, FRACP
PVC, Health and Medicine, Dean of Medicine, Western Sydney University

Professor Alison Jones PhD, BA (Hons)
Dean (Education), College of Medicine and Public Health, Flinders University

Professor Cheryl Jones MBBS (Hons), PhD, FRACP, FAHMS
Head of School and Dean, University of Sydney Medical School

Professor Michael Kidd AM MBBS Melb, MD Monash, DCCH Flin, Dip RACOG, FRACGP, FACHI, FAFPM, Hon FHKCFP, Hon FRNZCGP, Hon FCGPSL, Hon MAICD
Principle Medical Advisor and Deputy Chief Medical Officer, Australian Government Department of Health

Professor John Prins MBBS, PhD, FRACP, FAHMS
Head of Medical School, University of Melbourne

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

Dr Mary White MB, BCh, BAO, FFARSCI
Senior Consultant, Intensive Care, Royal Adelaide Hospital
Associate Professor, Discipline of Acute Care Medicine, University of Adelaide

Mr Daniel Zou
Current Medical Student, University of Melbourne

Mr Glenn McMahon
Manager, Medical School Assessments, Australian Medical Council

Ms Georgie Cornelius
Program Coordinator, Accreditation Assessments, Australian Medical Council

Ms Rebecca McKee
Program Support Officer, Australian Medical Council

Appendix Two Groups met by the 2022 Assessment Team

Meeting	Attendees
Monday, 9 May 2022	
Herston Campus, The University of Queensland	
Acknowledgement of Country and Welcome	Executive Dean, Faculty of Medicine Associate Dean (Academic), Faculty of Medicine Dean, Medical School Associate Dean (Indigenous Engagement), Faculty of Medicine Associate Dean (Strategic Development) and Head of Mayne Academy, Medicine Faculty Executive Manager, Faculty of Medicine Director, Academy for Medical Education (AME) and Academic Lead, MD Design School Manager, Medical School Senior Manager, Business Improvement and Analytics, Faculty of Medicine Director, Greater Brisbane Clinical School (GBCS) Director, Rural Clinical School (RCS)
Governance	Dean, Medical School Director, AME and Academic Lead, MD Design MD Program Convenor School Manager, Medical School Associate Dean (Academic), Faculty of Medicine MD Program Committee members MD Design Project Board members
Academy for Medical Education	Director, AME and Academic Lead, MD Design MD Program Convenor AME Management Group members MD Design Team members
Indigenous Strategy – Faculty	Associate Dean (Indigenous Engagement), Faculty of Medicine MD Design Theme Lead - Kind and Compassionate Professional and MD Design Year 3 Course Design & Implementation Group Lead
Curriculum	Director, AME and Academic Lead, MD Design MD Program Convenor Academic Lead, Assessment and MD Design Theme Lead – Assessment Academic Lead, Staff Development and MD Design Theme Lead – Dynamic Learner and Educator Academic Lead Year 1 & 2 and MD Design Year 1 Course Design & Implementation Group Lead Academic Lead Year 3 & 4

Meeting	Attendees
	MD Design Theme Lead - Critical Thinker Scientist and Scholar (Clinical and Biomedical Sciences) and MD Design Year 1 Course Design & Implementation Group Deputy Chair and Deputy Head of School, School of Biomedical Sciences Director, MD Student Research and MD Design Theme Lead - Critical Thinker Scientist and Scholar (Research) MD Design Theme Lead - Advocate for Health Improvement and MD Design Year 2 Course Design & Implementation Group Member, School of Public Health MD Design Theme Lead - Kind and Compassionate Professional and MD Design Year 3 Course Design & Implementation Group Lead MD Design Theme Lead - Safe and Effective Clinician and MD Design Year 2 & Year 4B Course Design & Implementation Group Lead MD Design Theme Lead - Partner and Team Player and MD Design Year 4A Course Design & Implementation Group Lead Project Manager, MD Design Manager, MD Design Director, GBCS Director, RCS Director, Ochsner Clinical School (OCS)
Griffith University	Griffith University Dean of Medicine
Bond University	Bond University Dean of Medicine
Student Support	Director, Student Services, UQ Student Services Senior Manager - Student Wellbeing and Support, UQ Student Services Principal Student Adviser, UQ Student Services Academic Guidance Lead Year 3 & 4
Student Experience	University of Queensland Medical Society (UQMS) Executive Committee members Student representatives from Student Staff Liaison Group Former UQMS Presidents
Information Technology	Faculty Executive Manager, Faculty of Medicine Relationship Manager, UQ Information Technology Services Director, AME and Academic Lead, MD Design Academic Lead, Assessment and MD Design Theme Lead – Assessment Manager, MD Design

Meeting	Attendees
Tuesday, 10 May 2022	
St Lucia Campus, The University of Queensland	
UQ Vice Chancellor and President	UQ Vice Chancellor and President
UQ President of Academic Board	UQ President of Academic Board
Indigenous Strategy – UQ perspective	UQ Pro-Vice-Chancellor (Indigenous Engagement) Director, Aboriginal and Torres Strait Islander Studies Unit Academic Director, Aboriginal and Torres Strait Islander Studies Unit
MD Learning Hub	Director, GBCS Senior Manager, GBCS Team Leader Academic Lead Year 1 & 2 and MD Design Year 1 Course Design & Implementation Group Lead Clinical Teaching & Professional Practice Lead, Year 1 & 2 Clinical Science Lead
Admissions and Selection	Dean, Medical School School Manager, Medical School Senior Manager, Student & Academic Administration, Faculty of Medicine Academic Lead, Medical Program Student Selection Director, RCS Associate Dean (Academic), Faculty of Medicine Chair, MD Admission Board and Masonic Chair of Geriatric Medicine, Centre for Health Services Research Senior Principal, Marketing and International Recruitment, Faculty of Medicine Deputy Head (Admission & Enrolment), OCS Deputy Director, UQ Planning and Business Intelligence Associate Director, UQ Academic Services
Indigenous Student meeting	Aboriginal and Torres Strait Islander students
James Cook University	James Cook University Dean of Medicine
IPE Curriculum, current MD and planned MD Design	Director, AME and Academic Lead, MD Design MD Program Convenor MD Design Theme Lead - Partner and Team Player and MD Design Year 4A Course Design & Implementation Group Lead Course Coordinator Personalised Learning Course (PLC) & Observerships and Interprofessional Education Committee representative

Meeting	Attendees
IPE Curriculum, inter-Faculty relationships	Director Interprofessional Education, Faculty of Health and Behavioural Sciences
Mater Clinical Unit	
Clinical Placement Supervision & Placement Strategy	Acting Head, Mater Clinical Unit Senior Lecturer, Year 3 Academic Lead Team Leader Simulated Patient Program Coordinator Course Administrator, Surgery Acting Course Administrator, Obstetrics & Gynaecology Student Coordinators Clinical Supervisors
Student Experience	Mater Clinical Unit students Mater Hospital interns
Children's Health Queensland Clinical Unit	
Clinical Placement Supervision & Placement Strategy	Head, Children's Health Queensland Clinical Unit Team Leader Student Coordinators Course Administrator, Paediatrics & Child Health Medical Education Fellow Head, Mayne Academy of Paediatrics & Child Health Clinical Supervisors
General Practice Clinical Unit	
Research	Director, MD Student Research and MD Design Theme Lead – Critical Thinker, Scientist and Scholar (Research) Director, GBCS and Chair, Medical School Research Committee Deputy Associate Dean (Research), Faculty of Medicine Manager, Research and Research Training, Faculty of Medicine MD Design Theme Lead - Advocate for Health Improvement and MD Design Year 2 Course Design & Implementation Group Member, School of Public Health
Clinical Placement Supervision & Placement strategy Indigenous Health Service	Head, Mayne Academy of General Practice and Head, General Practice Clinical Unit Senior Lecturer and GP at Inala Indigenous Health MD Design Theme Lead – Partner and Team Player, MD Design Year 4A Course Design & Implementation Group Lead, and Course Coordinator, Medicine in Society Course Coordinators, General Practice Course Coordinator, Urban LInCC Senior Lecturer
Wednesday, 11 May 2022	

Meeting	Attendees
Rockhampton Regional Clinical Unit	
Rockhampton Hospital Leadership	Executive Director Medical Services, Central Queensland Hospital & Health Service Director Medical Services – Rockhampton Business Unit, Central Queensland Hospital & Health Service
CQ-WB Regional Medical Pathway	Director, Rural Clinical School (RCS) Senior Manager (Projects CQ-WB) Director of Medical Academic Development, Central Queensland & Wide Bay Hospital and Health Services
CQUni Pathway to Medicine - curriculum & entry pathway planning	Dean, School of Health, Medical, and Applied Sciences, CQUni
Program delivery	Director, RCS Head, Rockhampton Regional Clinical Unit Academic Lead, GP Senior Clinical Lecturer Clinical Skills Educator Head, Regional Training Hub Research Team Leader Student Coordinator
Student Experience	Rockhampton Regional Clinical Unit students Rockhampton Hospital interns
Library and Resources - Tour of facilities and Simulation labs	Director, RCS Head, Rockhampton Regional Clinical Unit Library/Research Officer
Laidley Hospital	
Rural Clinical Placements & Supervision **Placement Strategy** **Student support**	Course Coordinator, Rural and Regional Medicine Head, Mayne Academy of Rural and Remote Medicine and Head, Rural and Remote Medicine Clinical Unit
Student experience	Laidley students
Rural GP Visit	Course Coordinator, Rural and Regional Medicine Head, Mayne Academy of Rural and Remote Medicine and Head, Rural and Remote Medicine Clinical Unit GP Preceptor, Laidley Family Doctors
Toowoomba Regional Clinical Unit	
Program delivery – Welcome	Head, Toowoomba Regional Clinical Unit Academic Lead
Program delivery – Academic & Professional Staff	Operations Manager, RCS Head of Research, RCS Librarian

Meeting	Attendees
	Team Leader
Program delivery – Discipline Leads & Consultants	Academic Lead, GP Discipline Lead, Orthopaedics Discipline Lead, Paediatrics Discipline Lead, Emergency
Toowoomba Hospital Leadership	Deputy Director of Medical Services, Toowoomba Hospital
Student experience	Toowoomba Regional Clinical Unit students Toowoomba Hospital interns
Indigenous Curriculum & Aboriginal Medical Service Partnerships	Co-ordinator, Indigenous Health Education and Director, Carbal Medical Services MD Design Theme Lead - Kind and Compassionate Professional and MD Design Year 3 Course Design & Implementation Group Lead
PA Southside Clinical Unit	
Clinical Placement Supervision & Placement Strategy	Head, PA-Southside Clinical Unit Team Leader Course Coordinator, Mental Health Mayne Professor Academy of Surgery and Course Coordinator, Surgical Specialities Director, Department of Internal Medicine, Princess Alexandra Hospital Course Coordinator, PLC/Observership Academic Lead, Year 3 Medicine Academic Lead, Year 4 Medical Specialties Academic Lead, Redland Hospital Course Coordinator, Critical Care Academic Lead, Surgery
Student experience	PA-Southside Clinical Unit students Princess Alexandra Hospital interns
Princess Alexandra Hospital Leadership	Executive Director of Medical Service, Princess Alexandra Hospital Acting Director of Clinical Training, Princess Alexandra Hospital
Bundaberg Regional Clinical Unit	
Clinical Placement Supervision, Placement Strategy, Facilities & Resources, Student Support	Head, Bundaberg Regional Clinical Unit Clinical Skills and Simulation Lead Academic Lead, General Practice General Practice Principal and Chair, Community Advisory Group Team Leader Student Co-ordinator

Meeting	Attendees
	Librarian Clinical Skills Lead Educators Senior Manager, RCS
Hervey Bay Regional Clinical Unit	
Clinical Placement Supervision, Placement Strategy, Facilities & Resources, Student Support	Head, Hervey Bay Regional Clinical Unit Director, RCS Academic Lead, General Practice Lead Clinical Educator Clinical Skills Educator Team Leader
Wide Bay Hospital and Health Service Leadership (Bundaberg & Hervey Bay)	Executive Director of Medical Services, Wide Bay Hospital and Health Service
Royal Brisbane Clinical Unit & Northside Clinical Unit	
Clinical Placement Supervision & Placement Strategy	Head, Royal Brisbane Clinical Unit Team Leader, Royal Brisbane Clinical Unit Student Coordinators Academic Staff Clinical Supervisors Head, Northside Clinical Unit Team Leader, Northside Clinical Unit
Student experience	Royal Brisbane Clinical Unit students Royal Brisbane and Women's Hospital interns
Royal Brisbane and Women's Hospital Leadership	Deputy Executive Director, Royal Brisbane and Women's Hospital Deputy Executive Director of Medical Services, Royal Brisbane and Women's Hospital
Queensland Health Partnership	Acting Deputy Director-General & Chief Medical Officer, and Queensland Health Medical Advisory and Prevocational Accreditation Unit
Thursday, 12 May 2022	
Herston Campus, University of Queensland	
Ochsner Health and Ochsner Clinical School - Senior Leadership	Senior Vice President & Chief Academic Officer, Ochsner Health Head, Ochsner Clinical School (OCS) System Vice President, Academic Affairs Assistant Vice President, Education Operations
Ochsner Clinical School, Governance, Admissions, Curriculum, Research, Physical facilities	Director, OCS Deputy Head (Students) Deputy Head (Curriculum) Deputy Head (Admissions & Enrolment) Medical Director Student Research

Meeting	Attendees
	Director, Medical Education Director, Enrolment Management
Ochsner Clinical School, Program delivery, Learning environment & Clinical Placement Supervision	Deputy Head (Curriculum) Manager, Clinical Education Clerkship Director, Surgery Clerkship Director, Obstetrics and Gynaecology Clerkship Director, Mental Health Clerkship Director, Paediatrics and Child Health Clerkship Director, Surgical Specialties Clerkship Director, Medicine Clerkship Director, Critical Care Clerkship Director, Medical Specialties Clerkship Director, General Practice Clerkship Director, Medicine in Society Director, Medical Education
Ochsner Clinical School, Student Support & Medical Societies	Deputy Head (Students) Alton Ochsner Medical Society Head Tyrone Medical Society Head Burns Medical Society Heads LeJeune Medical Society Head Caldwell Medical Society Head Director, Medical Education
Ochsner Clinical School – Students	Ochsner Medical Student Association (OMSA) Student Representatives President, OMSA Year 3 and 4 OCS student representatives Ochsner Health First Year Residents
Inter Faculty Relationships	Executive Dean, Faculty of Health and Behavioural Sciences