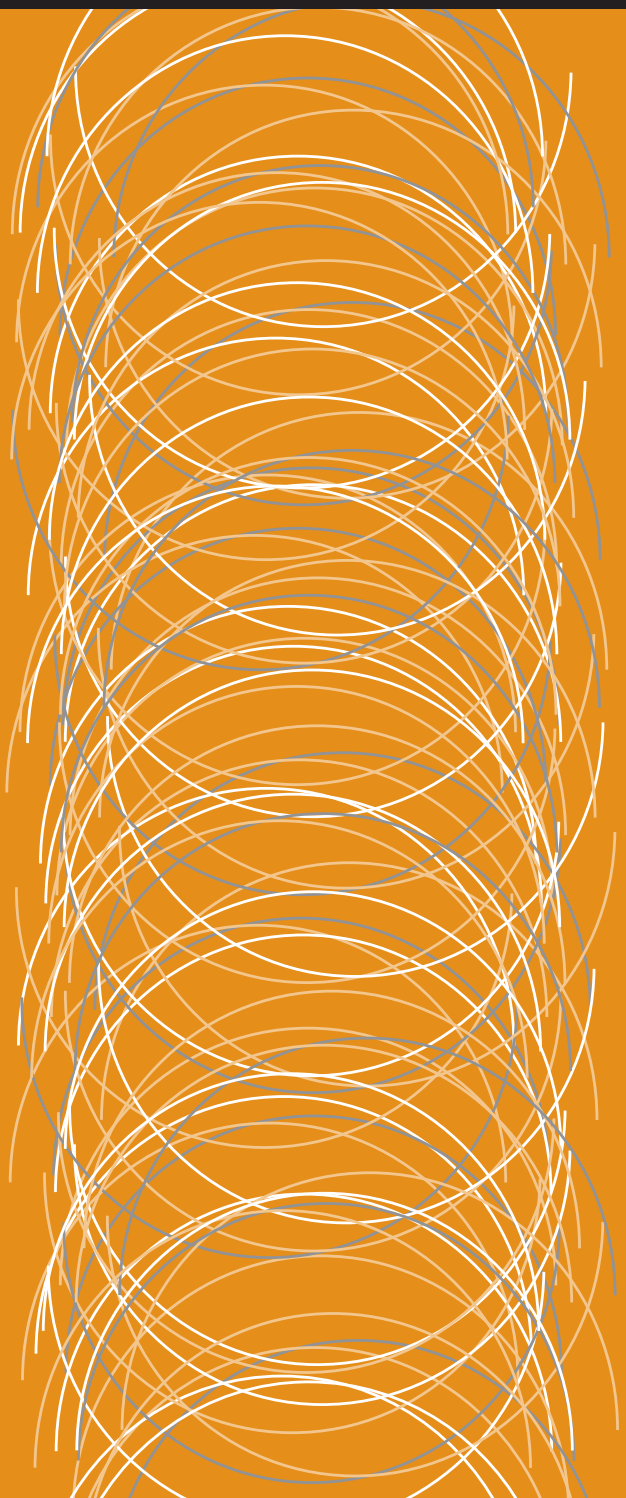
Australian Medical Council Limited

Accreditation of the Deakin University, Faculty of Health, School of Medicine, medical program

AMC



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Accreditation process

According to the Australian Medical Council's (AMC) *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2018,* accredited medical education providers may seek reaccreditation when their period of accreditation expires. Accreditation is based on the medical program demonstrating that it satisfies the accreditation standards for primary medical education. The provider prepares a submission for reaccreditation. An AMC team assesses the submission, and visits the provider and its clinical teaching sites.

The accreditation of the Deakin University medical program expires on 31 March 2019.

An AMC team completed the reaccreditation assessment. It reviewed the School's submission and the student-run Deakin Medical Students Association (MeDUSA) report, and visited Geelong, Waurn Ponds campus and associated clinical teaching sites in the week of 26 February – 2 March 2018.

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 2018*, section 5.1, the accreditation options are:

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

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

- a full accreditation assessment, with a view to granting accreditation for a further period of six years; or
- a more limited review, concentrating on the areas where deficiencies were identified, with a view to extending the current accreditation to the maximum period (six years

since the original accreditation assessment). Should the accreditation be extended to six years, in the year before the accreditation ends, the education provider will be required to submit a comprehensive report for extension of the accreditation. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to the maximum possible period, before a new accreditation assessment.

(iii) Accreditation may be withdrawn 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.

The AMC is satisfied that the medical programs of Deakin University meets the approved accreditation standards.

The 20 September 2018 meeting of AMC Directors agreed:

(i) That accreditation of the Doctor of Medicine (MD) medical program of the Deakin University, Faculty of Health, School of Medicine be granted for a period of six years, that is until **31 March 2025;**

(ii) That accreditation of the Bachelor of Medicine / Bachelor of Surgery (BMBS) medical program of the Deakin University, Faculty of Health, School of Medicine be granted for a period of four years, that is until **31 March 2021** (the BMBS program will conclude in 2019 and be replaced entirely by the MD);

(iii) That accreditation of the programs is subject to meeting the monitoring requirements of the AMC, including satisfactory progress reports; and to the following conditions:

2019 Conditions

- Develop the governance structures for the school to enhance communication and to support transition and integration of the curriculum between the preclinical and clinical years of the program. (Standard 1.3, 3.3)
- Implement actions to improve the student experience at the Eastern Health Clinical School, particularly at Box Hill Hospital. (Standard 2.2, 8.3)
- Implement strategies to facilitate continuity between the clinical and pre-clinical years of the program. (Standard 3.3)
- Develop a framework to guide the delivery and assessment of inter-professional learning throughout the program. (Standard 4.7)
- Define the School's model for assessment blueprinting and standardise the approach across themes and years. (Standard 5.2, 5.4)
- Develop and implement a comprehensive program evaluation framework that is linked to the governance structure of the medical program. (Standard 6.1).
- Provide the updated policies and procedures for identification and support of students whose professional behaviour is of concern, particularly with regard to the role of the Professional Standards Subcommittee. (Standard 7.4)

Key findings

Under the *Health Practitioner Regulation National Law* (the National Law), the AMC may 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 (meet/substantially meet) in making decisions about accreditation programs and providers.

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

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

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

Standard 1.3 is substantially met

Condition

Develop the governance structures for the school to enhance communication and to support transition and integration of the curriculum between the preclinical and clinical years of the program. (Standard 1.3, 3.3)

Recommendations

Continue to develop the Professional Education Scholarship Unit to enhance the opportunities for the development of educational expertise within the program. (Standard 1.4)

Report on any additional resourcing that is required for the implementation of the MD program and the School's plans to address these requirements. (Standards 1.5, 1.7, 1.8)

Further develop and formalise relationships with Aboriginal health services in the region to increase the School's capacity to deliver its Indigenous Health curriculum and research aspirations. (Standard 1.6)

Evaluate and report on the effectiveness of the structures applied to support less experienced staff in the Knowledge, Health and Illness theme, particularly in anatomy teaching, in Years 1 and 2. (Standard 1.8, 6.2)

Implement structures to support the workload of the Indigenous health staff. (Standard 1.8)

Commendations

The outstanding leadership demonstrated within the School, at both Waurn Ponds and the various clinical sites. (Standard 1.2)

The strong Indigenous health expertise and leadership. (Standard 1.4, 3.5)

2. The outcomes of the medical program	Met

Standard 2.2 is substantially met

Condition

Implement actions to improve the student experience at the Eastern Health Clinical School, particularly at Box Hill Hospital. (Standard 2.2, 8.3)

Recommendation

Integrate the Indigenous Health curriculum into the program as a longitudinal theme. (Standard 2.1)

Commendation

The Rural Community Clinical School model, allowing students to undertake a longitudinal integrated clerkship in rural Victoria. (Standard 2.2)

3. The medical curriculum	Met

Condition

Implement strategies to facilitate continuity between the clinical and pre-clinical years of the program. (Standard 3.3)

Recommendations

Formalise a structure and develop effective contingencies to support the sustainability of anatomy teaching in the Knowledge of Health and Illness theme. (Standard 3.2)

Develop and implement a program-wide map, or similar, to describe the expected learning across the whole program. (Standard 3.3, 3.4)

Develop and implement a strategy to enhance sustainability and reduce key-person risk associated with the current processes that link students to Aboriginal communities for clinical placements. (Standard 3.5)

Ensure that cultural safety training is provided to all staff that have a role in teaching and assessing students to facilitate a greater understanding of culturally safe ways of working with students. (Standard 3.5)

Develop alternative opportunities for students to experience Aboriginal health contexts in the MD program. (Standard 3.6)

4. Teaching and learning	Met

Standard 4.7 is substantially met

Condition

Develop a framework to guide the delivery and assessment of inter-professional learning throughout the program. (Standard 4.7)

Recommendations

Review the supplemental material provided to students and standardise core resources across all sites of the program. (Standard 4.1)

Update the online learning resources. (Standard 4.1)

Evaluate the tertiary hospital experiences that have been instituted in order to provide students in the Rural Community Clinical School with exposure to specific clinical specialties. (Standard 4.1)

Provide a Transition to Clinical Practice program in Year 2 in order to align student and School expectations prior to commencing Year 3. (Standard 4.3)

Develop, implement and evaluate the proposed longitudinal placement within the General Practice rotation in Year 3. (Standard 4.6)

Commendation

The strength and value of the clinical and communication skills program. (Standard 4.3)

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

Standards 5.2 and 5.4 are substantially met

Condition

Define the School's model for assessment blueprinting and standardise the approach across themes and years. (Standard 5.2, 5.4)

Recommendations

Develop an overarching School or program assessment philosophy and framework that embodies principles of the University, and the concept of the Deakin Doctor. (Standard 5.1)

Share good practice in assessment design and delivery with students. (Standard 5.1)

Rationalise standard setting practices to ensure transparency, consistency and sustainability of the approach. (Standard 5.2)

Consider the inclusion of formative and summative practical anatomy assessment to help guide student learning. (Standard 5.2)

Ensure consistency of the reflective assessments in Years 3 and 4 across the course and teaching locations. (Standard 5.3)

Review the utility of the numerical value provided as feedback in the reflective assessments in Years 3 and 4, as this may detract from the purpose of the assessment. (Standard 5.3)

Implement and evaluate the "Practique" exam management system. (Standard 5.4)

6. The curriculum – monitoring	Met

Standard 6.1 is substantially met

Condition

Develop and implement a comprehensive program evaluation framework that is linked to the governance structure of the medical program. (Standard 6.1).

Recommendations

Clarify the role of the evolving Health Professional Education Scholarship Unit in the context of its evaluation functions. (Standard 6.1)

Develop a framework to facilitate reliable two-way feedback for teaching clinicians, tutors and supervisors. (Standard 6.3)

7. Implementing the curriculum – students	Met

Standard 7.4 is substantially met

Condition

Provide the updated policies and procedures for identification and support of students whose professional behaviour is of concern, particularly with regard to the role of the Professional Standards Subcommittee. (Standard 7.4)

Recommendation

Consider extending student representation to the Year Committees and Theme Advisory Committee of the School. (Standard 7.5)

Commendations

The School's review of its social accountability mission and the consequent, positive changes to admission and selection processes. (Standard 7.1)

The prioritisation and work to support student wellbeing and resilience. (Standard 7.3)

8. Implementing the curriculum - learning environment	Met

Recommendation

Explore ways that the clinical sites can engage more strongly with Aboriginal health services to enhance students' understanding of Aboriginal health and health services in the local context. (Standard 1.6, 8.3)

Commendation

The high standard of direct clinical supervision. (Standard 8.4)

Introduction

The AMC accreditation process

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

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

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

The AMC's Medical School Accreditation Committee oversees the AMC process of assessment and accreditation of primary medical education programs and their providers, and reports to AMC Directors. The Committee includes members nominated by the Australian Medical Students' Association, the Confederation of Postgraduate Medical Education Councils, the Council 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 2018*. The granting of accreditation may be subject to conditions, such as a requirement for follow-up assessments.

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

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

The University, the Faculty and the School

Deakin University was formally established in 1974 and was the first regional campus in Victoria.

Deakin University campuses in Victoria include the Melbourne Burwood campus, the Geelong Waurn Ponds campus, the Geelong Waterfront campus, the Warrnambool campus and the Cloud campus (online).

As at the end of 2016, Deakin University had 54,360 course enrolments with a full-time student load of 37,587 students. In this year, the Geelong Waurn Ponds campus, at which the School of Medicine is based, hosted 7,312 students.

Deakin University offers courses from 14 schools across the faculties of:

- Arts and Education
- Business and Law
- Health
- Science, Engineering and Built Environment.

Schools in the Faculty of Health include:

- School of Exercise and Nutrition Sciences
- School of Health and Social Development
- School of Medicine
- School of Nursing and Midwifery
- School of Psychology.

The Deakin University, School of Medicine offers a four-year Bachelor of Medicine/Bachelor of Surgery (BMBS) medical program that commenced in 2008. The School intends to transition the current BMBS program into a four-year Doctor of Medicine (MD) program from 2019, with new enrolments commencing exclusively in the MD program from Semester 1, 2019 and all current Year 1 and Year 2 students transitioning into the MD program from this time. Current Year 3 students will graduate in 2019 with a BMBS. This change was approved by the AMC in 2017 and was not seen to be a major change to the program. The details of this evolution will be part of the 2018 assessment.

The School's student profile for 2017 includes 127 Commonwealth Supported Places (CSP) (comprising 89 standard CSP and 38 Bonded Medical Places) and 13 fee-paying international students.

The School's major site is Deakin's Geelong Waurn Ponds Campus. This site provides the facilities for all students, as well as housing staff offices, research groups, and the School's administration. Students in the medical program complete their first two years at Waurn Ponds before moving to a clinical school for their final two years.

While Years 1 and 2 include some clinical placement, Years 3 and 4 of the program see students in full-time clinical placement. The School has five clinical schools that are aligned with hospitals, health services and clinics, including several rural and regional training locations (see Table 1).

Table 1: Clinical Schools and associated sites

Clinical School	Clinical Sites
Geelong Clinical School (GCS)	University Hospital Geelong McKellar Centre Epworth Geelong St John of God Hospital, Geelong Barwon Health Community Mental Health Services (Corio, Bellarine and Surf Coast, as well as JIGSAW clinics)
Greater Green Triangle Clinical School (GGTCS)	South West Healthcare, Warrnambool St John of God Hospital, Warrnambool
Grampians Clinical School	Ballarat Base Hospital Queen Elizabeth Centre Residential Aged Care Facilities Grampians Psychiatry Service St John of God Hospital, Ballarat
Eastern Health Clinical School (EHCS)	Box Hill Hospital Maroondah Hospital William Angliss Hospital Peter James Centre Wantirna Health
Rural Community Clinical School (RCCS)	Ararat Medical Centre The Camperdown Clinic Robinson Street Medical Clinic, Camperdown Coleraine Casterton Medical Clinic Corangamite Clinic Otway Medical Clinic Springs Medical Centre, Daylesford Hamilton Medical Group Mynara Medical Centre, Horsham Roberts Avenue Medical Centre, Horsham Lister House Clinic, Horsham Stawell Medical Centre Active Health, Portland Bacchus Marsh Medical Centre

Accreditation Background

In April 2006, the Commonwealth Government provided funding to Deakin University to develop a new medical school. The proposed program was a four-year graduate-entry Bachelor of

Medicine/Bachelor of Surgery (BMBS) degree. The course was based on the Flinders' curriculum, with a focus on rural and regional medicine, inter-professional learning and the management of patients with chronic illness.

Following a successful Stage 1 submission, Deakin University provided a Stage 2 submission to the AMC in March 2007. The AMC assessed the Deakin School of Medicine and its program and visited the Waurn Ponds campus, and the proposed clinical placement sites in Geelong, Ballarat and Warrnambool from 9 to 13 July 2007 to assess the plans and facilities for delivery of the new program. Following this assessment the School was granted accreditation until December 2013 subject to conditions including a follow-up assessment in 2009.

In 2009, an AMC assessment team visited the School to review the implementation of the early years of the course and detailed plans for the later years. At this time, the School was continuing to strengthen its teaching resources and the first cohort of students was in Year 2. Students were enthusiastic about the program. Detailed planning for clinical placements for Years 3 and 4 was well in hand.

In 2010, 2011 and 2012, the School of Medicine submitted satisfactory progress reports.

In 2013, the School submitted a comprehensive report to extend the period of accreditation. The AMC found that the School continued to meet the accreditation standards, and extended accreditation until 31 December 2017, subject to satisfactory progress reports.

An AMC team was to conduct a reaccreditation assessment of the School in the second half of 2017. Due to the heavy accreditation workload in 2017, and given that the School of Medicine had submitted satisfactory progress reports and had continued to meet the accreditation standards, in September 2016 the AMC approved a short-term extension of accreditation of the School and program to March 2019.

In June 2017, the AMC received a submission from the School (concerning plans to transition its BMBS program to a Doctor of Medicine (MD) program. This program would be a Level 9E Extended Masters, in accordance with the requirements of the Australian Qualifications Framework, with commencement in 2019.

The Medical School Accreditation Committee considered the proposal at its 17 July 2017 meeting and requested more information to be provided. At its 18 September 2017 meeting, it determined that the changes proposed did not constitute a major change.

This report

This report details the findings of the 2018 accreditation assessment.

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

The members of the 2018 AMC team are at **Appendix One**.

The groups met by the AMC team in 2018 are at **Appendix Two**.

Appreciation

The AMC thanks the University and the School of Medicine 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.

Deakin University admitted its first cohort of medical students in 2008, and this year it is celebrating its tenth anniversary. From its inception, the School has been part of the Faculty of Health, and in 2018, the School delivers the medical program, as well as degrees in optometry and medical imaging. In 2014, Professor Jon Watson was appointed Head of School. The title was subsequently changed to Dean, and Professor Watson is now supported by Professor Karen Dwyer as Deputy Head of School, Executive Dean Professor Brendan Crotty, who was the inaugural Head of the School of Medicine, leads the Faculty of Health.

The School of Medicine occupies a prominent position on the Executive of Faculty of Health, and is well represented on faculty structures, including the Faculty Board and other key committees.

The School Executive Group achieves operational administration of the school. This group meets quarterly on a formal basis, although ad hoc interactions among its members ensure that functional management of school affairs occurs. The membership includes the Dean and Deputy Head, the Associate Heads for Research, Teaching and Learning, and International, and the School Executive Officer. Each member has specific responsibilities within their portfolio, though, ultimately, the Dean is responsible for the functioning of the School.

The Executive Group regularly communicates with the staff of the School via a number of mechanisms, including briefings, School Board meetings and general announcements.

In addition to the Executive Group, governance of the School is via a Teaching and Learning, and a Research and Research Training Committee. These committees bring together the various programs of the School (BMBS, Optometry and Medical Imaging), and transmit decisions to Faculty Committees, and thence central University structures.

The BMBS program is led by a Course Director and Deputy Course Director, and they have responsibility for the administration of academic matters within the medical degree. There are two major committees that advise the Course Director. These are the Year 1/2 and the Year 3/4 Committees. The composition of these committees differs slightly. While unit chairs are represented on both committees, the themes have a more prominent position in the Year 1/2 Committee than the 3/4 Committee. Rotation chairs are evident in the Year 3/4 Committee. It is notable that students are not members of these committees, nor is there substantive representation from others who hold an interest in the program outside those directly involved in delivery of the curriculum.

Staff of the School, both at the Waurn Ponds campus, and at the clinical sites have a good understanding of the roles of the committees, how decisions are made and how changes are approved prior to implementation.

The School has a variety of mechanisms to ensure that relevant stakeholders are consulted regarding the direction of the School and the BMBS degree. Principal among these is the School Advisory Committee, which has an external chair, healthcare and service representatives, and student representatives.

Committee structures for the proposed MD program are similar to those currently in place, with the addition of a course leadership team. This will comprise the Course Director and Deputy Director, Year 1/2 and Year 3/4 Coordinators, the four Theme Leaders and an Academic Indigenous Education leader.

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 team was impressed with the strong leadership that was apparent within the School, at both Waurn Ponds and the various clinical sites and this was acknowledged by many of the groups with whom the team met during the assessment.

The School enjoys substantial support from both the Faculty and the University. The Executive Dean and the Vice Chancellor are both strong advocates for the School and see it as an important vehicle to enable the Faculty and University to achieve its strategic goals.

The responsibilities of the Dean of the School are clear and well defined. As stated above, the responsibilities of the Executive Group are clearly demarcated, enabling the Dean to exercise authority over the program, working with autonomy.

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.

A feature of the management of the Deakin BMBS program is the prominence of the Year 1/2 and Year 3/4 Committees. It appears that the deliberations of these committees are integrated via the functions of the Course Director and Deputy Director, respectively. The School Learning and Teaching Committee may also play a role in integrating aspects of the curriculum. At this stage, there do not appear to be committees that carry responsibility for specific curriculum functions, such as Assessment, Evaluation and Admissions. A consequence of these structural arrangements may be that there is a degree of siloed delivery of various aspects of the curriculum, with challenges to both vertical and horizontal integration of curriculum elements.

Changes to curriculum committee structure are planned for the MD course, though these changes are not major, with the basic structure of separate campus and clinical committees persisting.

The introduction of the MD program presents an opportunity for the School to introduce a committee that will be able to perform the integrative functions required to achieve the objectives

of the medical program. This committee could have clear and explicit responsibility, authority and accountability for the planning, implementation and review of the curriculum. It could be served by subcommittees that provide important curriculum functions, including Admission, Assessment and Evaluation.

The Deakin BMBS program and the future MD program have been appropriately approved by the University as meeting the current Level 7 and future Level 9 (extended) Australian Qualifications Framework criteria.

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.

Deakin University has substantial educational expertise, which also resides within the School and a number of recent and planned appointments have enhanced this expertise. These have occurred in the areas of Indigenous health education and assessment, and there are planned appointments of Senior Lecturers in medical education to oversee aspects of delivery of the clinical curriculum. The Indigenous Health Education Lecturer is well placed to lend expertise to relevant aspects of the curriculum. The School also actively promotes scholarship and research in medical education via the School of Medicine Education Research Group.

The formation of a specialist group in health professional education is planned, though details of its name and functions are emerging. Whether this is a Medical Education Unit, with specific reference to the medical course, or a Health Professional Education Scholarship Unit, with broader responsibility across the School, may determine how the amassed expertise is able to provide assistance to the medical course.

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 School of Medicine budget is managed by the Dean of the School, in concert with the School Executive Officer and Senior Finance Officer. The budget process involves the School, along with other schools of the Faculty, negotiating their operating situation for the forthcoming year at a faculty level. This budget is then negotiated centrally with the University.

At the School level, considerable autonomy is granted to the organisation units within the School. They are actively involved in the preparation of the School budget and are given the responsibility to manage their own budgets, with assistance and oversight from the School Office.

The Faculty and the University are supportive of the School of Medicine budget, and this is explicitly recognised by both the Executive Dean and Vice-Chancellor. In their views the medical program is a necessarily expensive part of the University's operations, which brings with it much prestige. Their commitment and support are evident.

The School has responsibility to the Faculty for the management of the Rural Health Multidisciplinary Training (RHMT) program funds, which requires cooperation and negotiation

with other schools (e.g. Nursing and Midwifery). This control ensures that the School is able to deliver on the RHMT parameters that apply to the Rural Clinical Schools, while delivering the placement requirements across the Faculty.

The School was able to provide recent examples of sound financial management (control of casual spends and deployment of research staff to assist with teaching) which point to the ongoing maintenance of the current financial situation. The effects of recent changes in Federal Government funding arrangements for the University are difficult to predict, but there was no evidence that these would have significant negative impact on the School.

The School budget has sufficient structure, but flexibility, to ensure that capital and discretionary spending are accounted for each year. Examples of Faculty and central University support for specific capital works initiatives were given.

The financial effects of the introduction of the MD program are unknown. While the School generally expressed the view that there would be little effect, it was not clear whether there would be increased financial demands on the School associated with the enhanced research project of the MD program. The implementation of the MD program has implications for resourcing and the team is interested to hear how the School will manage this.

The School clearly has the responsibility, authority and autonomy to ensure the financial arrangements for the successful delivery of the medical program.

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 School enjoys strong relationships with its health partners, whether they be in hospital or community environments. For many of the health services in the south west of Victoria, the medical program is seen as an important conduit for the delivery of medical practitioners into the region, and therefore the relationship with the School is sometimes seen as an investment into future workforce capacity.

In the case of Barwon Health, where the largest contingent of students are placed, the service sees its relationship with the School as representing an opportunity to develop its profile via combined collaboration in education and research. It is significant that Barwon Health has recently renamed its major site “University Hospital Geelong” and it recognises that its medical workforce has increasingly experienced part of its training at Deakin University. The Executive Dean of Health has recently joined the Board of Barwon Health.

The establishment of the Epworth Geelong Hospital at a site adjacent to the Waurn Ponds campus is a recent significant advance. Epworth Geelong has made significant investment in education, both for its workforce and Deakin students, and provides a valuable learning opportunity in the private sector. Students appear to be well accepted into the environment and modern and high technology learning facilities are available to them. Epworth Geelong has joined with the School

to ensure appropriate high-level clinical appointments can be made to support education and research.

In the broad variety of clinical sites, from primary to tertiary care, Deakin is well regarded and prominent. There is general acknowledgement of the concept of the "Deakin Doctor", with a well-developed understanding of the mission of the University in developing the workforce and engaging with the health needs of the region.

Formal agreements are in place with all the partners. That being said, these agreements do not always cover the broad range of activities that occur between the health partner and the School. In the case of Barwon Health, an ambitious portfolio of agreements covering a range of activities, including appointment, research and education (among others), is planned. It will be good to see its development, along with more sophisticated agreements with other partners, as appropriate to the size and nature of the endeavour.

While there are many positives, recognition of Deakin University is not always prominent within the Health Services. Greater overt recognition and signage will enhance and consolidate the relationships, and enable a deeper engagement in these areas.

Deakin has developing relationships with the local Aboriginal health service, Wathaurong Health Service, though size and capacity limit the nature of the exposure that can occur. Relationships with other Aboriginal health services in the region are also developing. Further development of these relationships will increase the School's capacity to deliver its Aboriginal Health curriculum and research aspirations. Staff at the health services are keen to engage with medical students and the University to advance Aboriginal health. Through the agency of the Institute for Koorie Education (IKE), involvement of the local Aboriginal community in appropriate cultural training is achieved.

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.

In the ten years since its inception, the School of Medicine at Deakin University has developed an enviable record of achievement in research, as evidenced by income, publications and graduations. Recently, the School has been able to attract a number of prominent researchers in the medical field, who will enhance the potential for output. As the range of research activities in the School broadens, including basic and applied clinical research, there may be opportunities to extend the range of research experiences that contribute to the MD program.

The research endeavours inform learning and teaching within the medical program, and students appear well trained in aspects of evidence-based practice and critical appraisal. The introduction of the MD program will provide an opportunity for further development of the research activities of the School and the students. It is recognised that student research education within the MD program will be led by the Public Health Medicine and the Ethics, Law and Professionalism themes of the curriculum. This will include the Extended Studies program in the clinical years.

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 School has an appropriate complement of staff to deliver the program. In recent years, a number of significant appointments in a range of areas including Clinical Communication, General Practice and Surgery have further bolstered the School's capacity to deliver high-quality medical training. The team noted that some critical areas of the curriculum, particularly within the Knowledge, Health and Illness theme in Years 1 and 2, are led by relatively junior staff. These staff have achieved high quality outcomes, most especially the improvements in the area of anatomy. The team notes that support structures are being developed around these staff, via the involvement of senior staff with clinical backgrounds. To support the sustainability and the effectiveness of these approaches, additional staffing, including a more senior profile, may be necessary.

Elsewhere, the effects of the introduction of the MD program will require careful analysis and attention. It is noted that there are plans for additional recruitment into public health medicine to support the Extended Studies program in the clinical years, though the supervisory and assessment load of this initiative is yet to be fully identified. In parallel, the introduction of the clerkship in Community Placement in Year 3 may also have significant resource and curricular implications, which are still in the process of being planned. The appointment of Senior Lecturers in Medical Education is acknowledged, and the holders of these posts may be well positioned to assist with, and advise on, some of the implications of the changes.

The School has a range of technical staff, who appear to support the program in an appropriate and efficient manner. These staff have a very student-centred approach to their activities, and seem willing to broaden their responsibilities to achieve the best outcomes. The introduction of a University-wide Shared Services Network (SSN) is noted, and the effects of this initiative on the medical program is yet to be realised. This may result in reduction in the staff available to provide student support. The effects of the SSN will require monitoring.

The School has made significant progress in attracting Aboriginal staff to assist with the delivery of the Aboriginal health curriculum. A more senior staff member has recently been joined by a new staff member to ensure coverage across the spread of educational activities of the whole School. The resources of the IKE are available and can assist with aspects of pastoral care and educational support for students. However, the burden on the Aboriginal staff members is significant, especially if appropriate academic development of these individuals is to be achieved. The School may benefit from careful attention to the workload of Indigenous health staff given the amount of teaching, cultural immersion, supervision, pastoral support, collegial support and other expectations such as administrative load that is placed on these staff members.

Thought should be given to separating curriculum development and pastoral care responsibilities of the current roles, to enhance the sustainability of the efforts.

The School has an extensive database of patients and community members who contribute to the learning of students, via training sessions and formal examinations. In addition, Clinical Teaching Associates are used, when appropriate. These contributors are appropriately trained for the activities they are engaged with and feedback about their contribution is positive.

There is appropriate indemnification and insurance for those involved in delivering the medical program.

1.9 Staff appointment, promotion & development

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

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

The University's Academic Performance Framework outlines the criteria for promotion, and examples of successful applications for promotion using the full range of criteria were provided. There is an effective process of performance planning and appraisal that guides staff members in developing their academic profile in preparation for promotion.

The demands on staff in different environments, such as campus-based or clinical roles are recognised by the School and University, allowing nuanced approaches to promotion and recognition.

New staff are required to complete the Deakin Graduate Certificate in Higher Education Learning and Teaching, which appears to provide a good framework for the development of staff. This program allows staff to develop interests in education and when combined with other professional development provided by the School enables the establishment of critical pedagogical practices.

Professional development, of up to four hours per year, is offered for all casual teachers. Mentoring and leadership programs are starting this year for early and mid-career researchers through the School of Medicine Research and Research Training Committee.

2 The outcomes of the medical program

Graduate outcomes are overarching statements reflecting the desired abilities of graduates in a specific discipline upon completion of 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 School does not have a mission statement nor overall aim relating to the medical program, but shares the mission of Deakin University in producing graduates who are work ready and practise with professionalism and social accountability. The essence of this is the concept of the "Deakin Doctor" who has attributes related to professionalism and ethical behaviours, strong communication skills, and a focus on public health, generalist and rural practice. This concept is supported by the strong thematic curriculum structure which ensures students have to achieve outcomes in the Public Health Medicine, and Ethics, Law, Professionalism themes, as well as the themes of Knowledge of Health and Illness; and Doctor and Patient.

The concept of the Deakin Doctor is broadly familiar and echoed by all Faculty members, the student body, the University Vice Chancellor, as well as some individuals in Victoria Health, although it is less well known to some frontline teaching staff.

Indigenous health is a core theme of the medical program and steps are being taken to improve the governance and delivery of the program following the employment of an Indigenous health educator. Student feedback suggests that there have been some difficulties in the delivery of the curriculum, particularly taking into account the distribution of students across sites in the clinical years.

The Indigenous health curriculum uses the Medical Deans Australia and New Zealand curriculum together with a cultural competency continuum map (derived from the Universities Australia

2011 Framework) and specific outcomes are horizontally integrated into the four other themes, with some attempts at vertical integration across the four years of the program. There is a mooted change in the governance structure to add Indigenous health as a separate longitudinal theme across the four years of the course.

There is a strong relationship with the Institute of Koorie Education (IKE), its Director being part of the School Advisory Board. An Australian Indigenous Doctors' Association (AIDA) member is also part of the School Advisory Board and part of the Indigenous Health Curriculum Team.

An additional educator has been recently employed, predominantly to teach in the programs of Medical Imaging and Optometry, but consideration is currently being given to harmonising the functions and workload of the two Indigenous educators in the School. There appears to be widespread enthusiasm and engagement to deliver the Indigenous health curriculum within the medical program, increase selection and support of Indigenous students, and provide culturally secure environments for Indigenous and non-Indigenous students and staff.

The team will be interested to see the implementation of the revisions to the governance and thematic structures of the medical program to formally recognise Indigenous health as an integrated longitudinal theme.

The School of Medicine Advisory Board has members from the Department of Human Services, the AIDA, the IKE, medical students, and the affiliated healthcare provider organisations. This provides an accessible path for stakeholders to the governance structure of the School. The individual members and the organisations they represent seem to shape the purpose of the School in its activities and, in particular, to the preferred attributes of the Deakin medical graduate.

The School and University are strongly embedded in the local community of Geelong and rural western Victoria. There is an explicit philosophy and academic structures to enable meeting local needs. In particular, there is an emphasis on rural health, integration of clinical training into rural communities, and a recent history of having graduates return to the local communities as health professionals to help meet the healthcare needs.

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.

The medical program has curriculum outcomes structured by vertical themes, which map to the AMC Graduate Outcome Statements, as well as the generic graduate outcomes of the University. Different emphases within the outcomes and the thematic structure suit the purpose of the medical program. This allows rural health care, work-readiness, practical training, and communication skills and ethical behaviours to be promoted as capabilities of the medical graduates, thus reinforcing the aims of the medical program in improving health care in the rural communities.

The medical program educational activities and outcomes are appropriate for developing graduates who are work-ready to practise safely and effectively as junior doctors. The problem-based learning methodology in the first two years, and the self-directed and supported clinical training have assisted in the development of life-long learning skills. Feedback from healthcare professionals and organisations is that Deakin medical graduates are sought after by employers, are ready to commence professional practice, and are described as resourceful and practical with good clinical skills and workplace knowledge. Deakin graduates have progressed to general practice and other specialty training programs, including returning to the local area in junior doctor and specialty training positions, which helps confirm success of the program in terms of its purpose, and its development of generic and further training capabilities, including life-long learning skills.

The first two years of the Deakin medical program show consistency of teaching for all students in terms of lectures, tutorials, laboratories and other online and face-to-face learning opportunities. Students in each year cohort also have the same assessment tasks and feedback provided.

Distribution of students across different sites during the clinical attachments in Years 3 and 4 presents some challenges, in terms of both delivery and assessment. In particular, students and staff have identified substantial differences in the student experience in the Rural Community Clinical School in terms of patient case mix. Although not unexpected, and balanced by many positives of this model, this has been a source of student anxiety regarding adequacy of preparedness for future clinical practice. This is particularly noteworthy in the clinical disciplines of Paediatrics and Obstetrics & Gynaecology since the students do not have any significant further attachments in these areas. Recognition of these difficulties and putting into place some remedies via more intense attachments in Paediatrics in particular, seem to have improved student perceptions for the most recent cohort.

The Eastern Health Clinical School, which also hosts a large number of Monash University students, has different challenges, predominantly related to a negative student experience. This is in marked contrast to other sites where students seem to have a positive and engaged experience. Although the Eastern Health Clinical School students were complimentary regarding formal and informal bedside teaching by clinicians, numerous other challenges in the learning environment were identified. These include challenges associated with being a member of a smaller cohort of Deakin students compared to a larger cohort of Monash students, with clinicians being unaware of Deakin requirements or imposing Monash requirements. In addition, students reported clinical attachment allocation complexities, travel to other sites for formal assessments, and significant difficulty in obtaining information and support as further issues.

The team notes that assessment results have not shown any difference in the Objective Structured Clinical Examinations or written examination results across the sites, thus it appears the medical program provides comparable assessment outcomes despite the differences in student experience outlined above. However, the team is interested in the analysis of the student experience in the Eastern Health Clinical School and implementation of remedial actions to address difficulties.

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 Deakin Medical School BMBS is a four-year, graduate-entry, semester-based program. Students are required to successfully complete eight, 4-credit point core units delivered on a semester basis, to achieve a total of 32 credit points. The duration of the years vary from 36 weeks to 42 weeks, which will not change with the introduction of the MD program.

In 2019, enrolments in Year 1, and progression to Years 2 and 3 will be into the new MD program. The first graduates of the Deakin MD program will be in 2020. Those students going into Year 4 in 2019 will stay in the BMBS program and those who have failed to progress or need to repeat years will also be able to continue in the BMBS program.

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 content of the curriculum is structured into the four vertically-integrated major themes.

The Ethics, Law, Professionalism theme clearly distinguishes knowledge about professionalism from student professional development and behaviour. The introduction of a Clinical Communication program into Aged Care, Rehabilitation and Palliative Care is also noted and well regarded.

The Doctor and Patient (DP) theme has increased opportunities for real-time assessment through in-training assessments and direct observation of procedural skills.

The Knowledge of Health and Illness theme consists of the biological and behavioural sciences and is predominantly taught in a formal fashion in Years 1 and 2. Anatomy teaching and learning is still being consolidated locally and a new system of swipe cards and monitored attendance is being rolled out. As anatomy teaching relies on a small number of people to conduct the full course, important and strategic relationships are being developed to support the sustainability of the program. The team notes the goodwill that is present but is interested in seeing how sustainability and contingency will be built into the structure.

Public Health Medicine consists of preventative and public health, health systems and cultural aspects of health including Indigenous health. Preliminary research and evidence-based practice is also a part of this theme, and the expected research extended studies program in the MD program will occur within this theme. The embedded research opportunities for students on placement in General Practice appear to be valuable.

3.3 Curriculum design

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

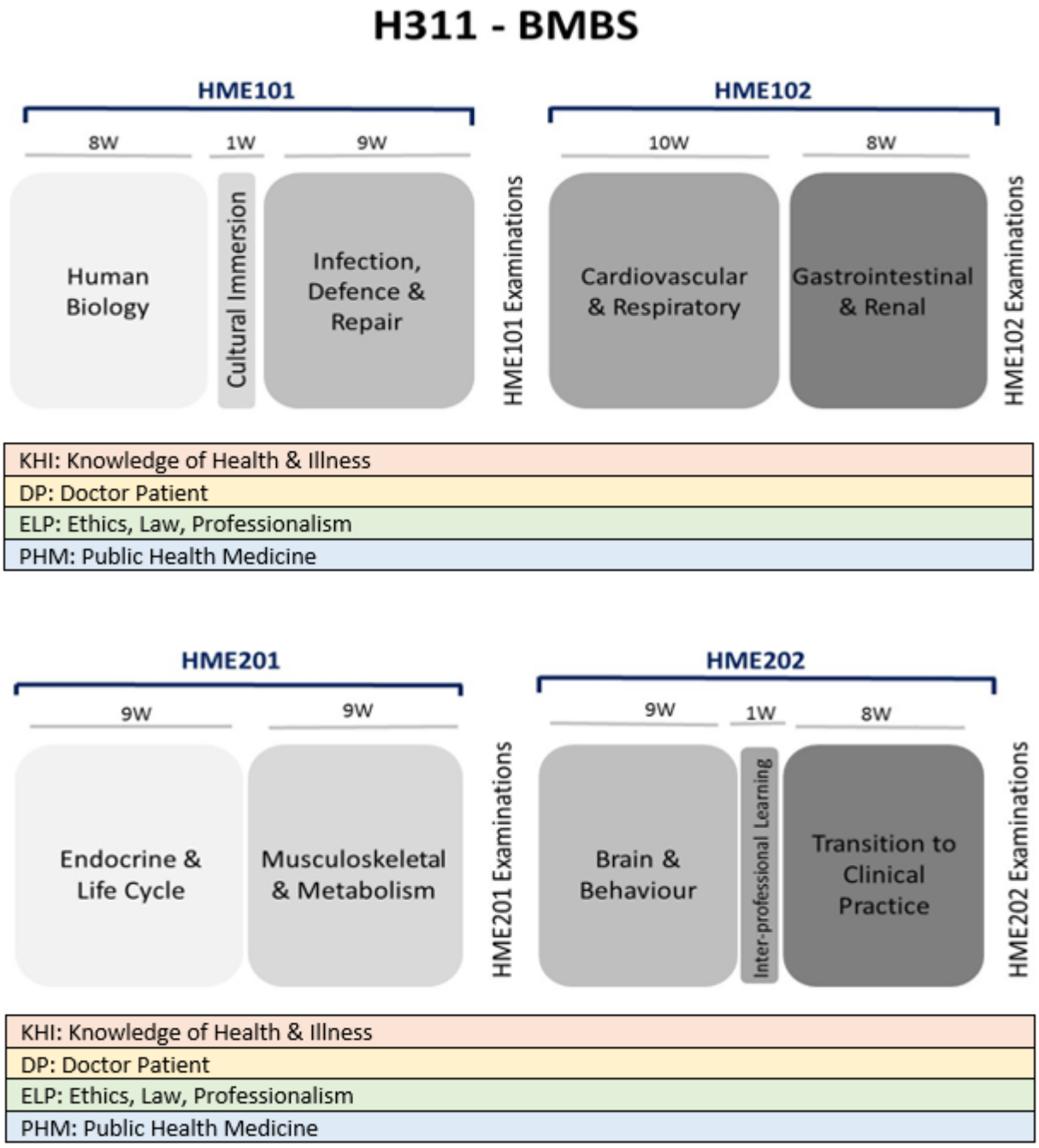
Themes and curriculum development is governed by the Teaching and Learning Committee convened by the Associate Head of School (Teaching and Learning). The Theme Leaders attend the Year (1-4) meetings enhancing cross representation. Further, all the Unit Chairs and Theme Leaders are co-located in the same working space, thus enhancing day-to-day communication about the curriculum. Curriculum maps are available to guide development, although access to and the use of these maps is unclear. The development and use of one primary map that is utilised by all relevant people in developing the program may be beneficial.

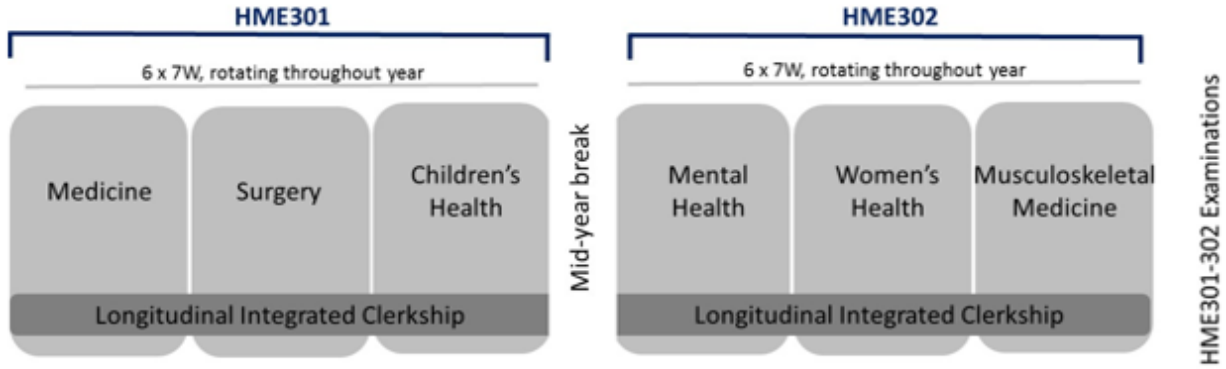
The predominant structure of the curriculum is through four major themes described earlier, which are integrated as a spiral learning matrix through the four years of the program. Vertical integration appears well constructed in the first two years within the theme structure, but is less evident in the final two years. Horizontal integration within each theme is also strong, but less so across themes.

The pre-clinical years, taught at the Deakin Geelong Waurn Ponds campus, contains sufficient patient contact through exposure to simulated patients. Supporting the early exposure to patients is an eight-week Transition to Clinical Practice block at the end of Year 2.

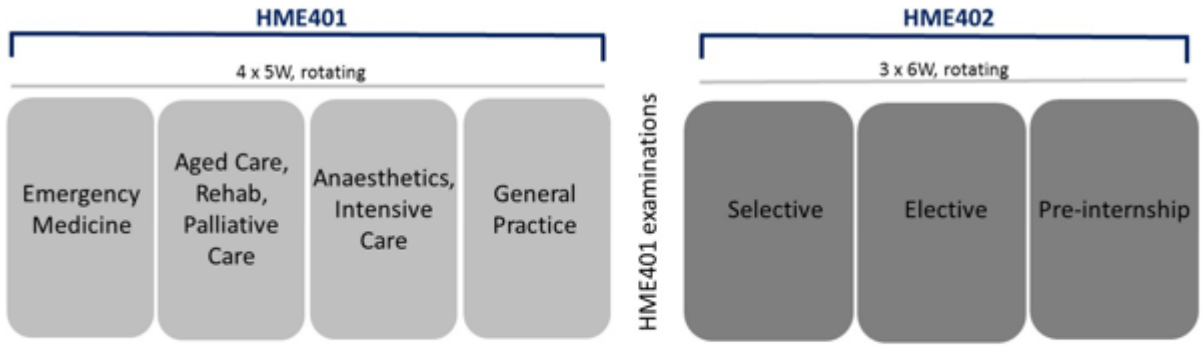
Years 3 and 4 are clinical years based on a work-integrated learning model where students are located wholly within health care settings in Geelong, Western Victoria and East Melbourne. In these, students work through ten key discipline rotations, a selective rotation, a preparation for internship rotation and have the opportunity to identify an elective rotation in a field or specialty of interest. Year 3 is delivered on a year-long model whilst the Year 4 delivery mirrors the pre-clinical structure of a semester basis.

Figure 1: BMBS Program Structure





KHI: Knowledge of Health & Illness
DP: Doctor Patient
ELP: Ethics, Law, Professionalism
PHM: Public Health Medicine

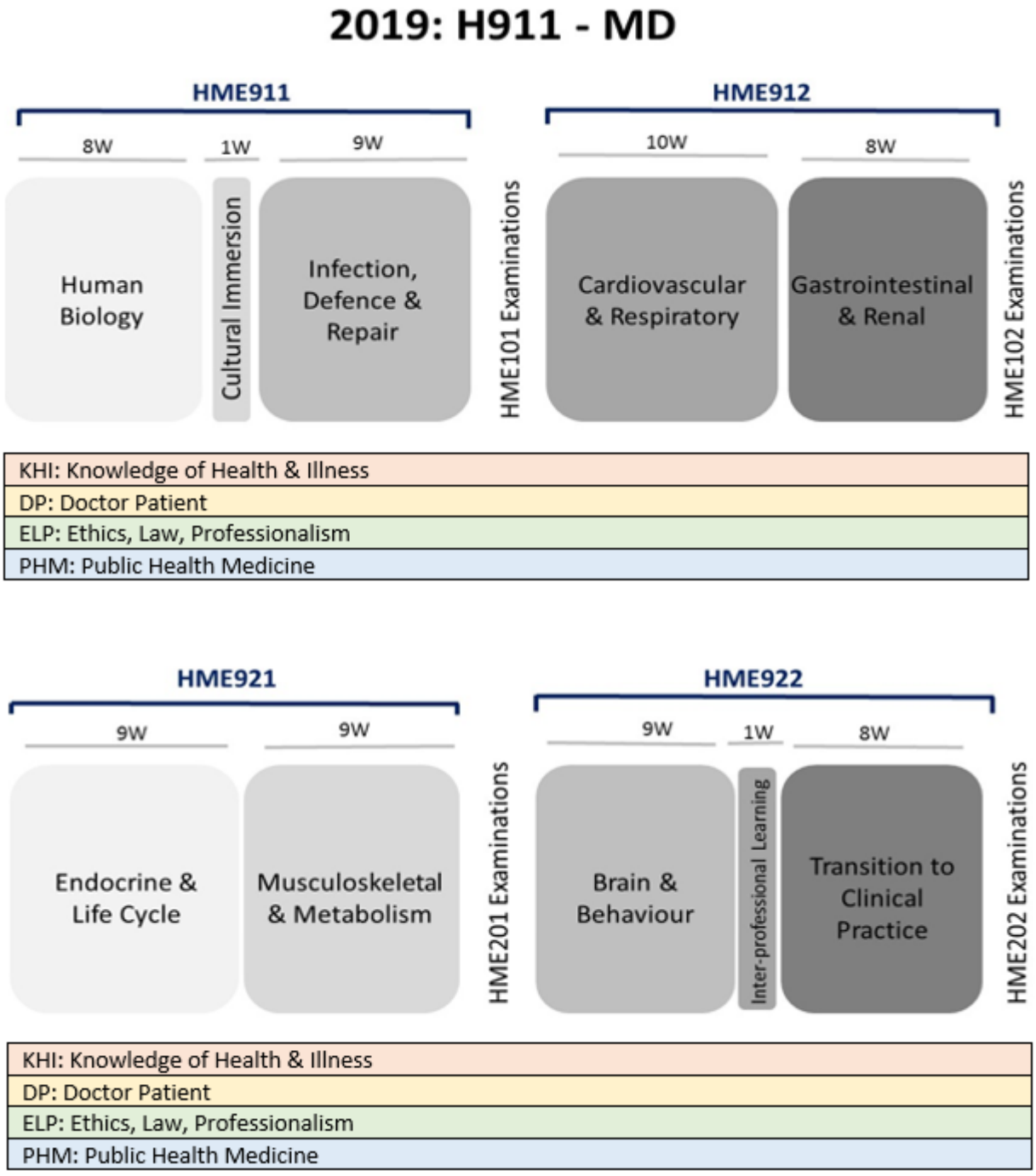


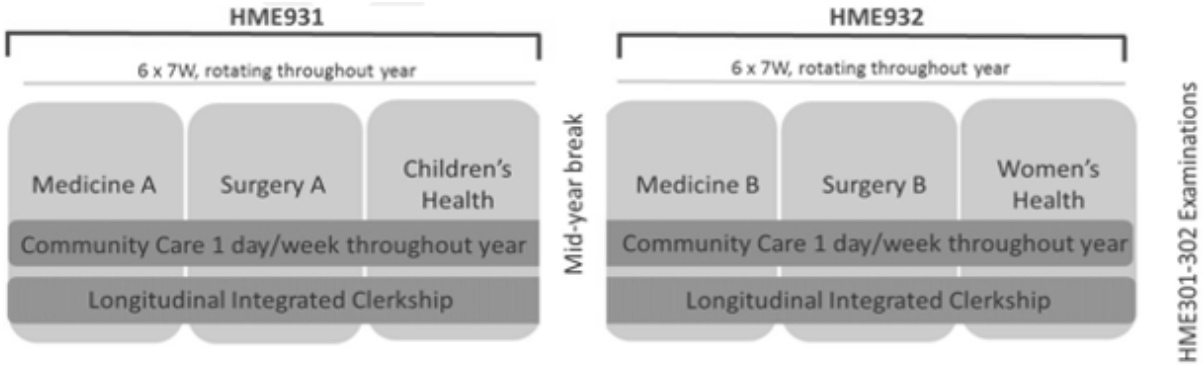
KHI: Knowledge of Health & Illness
DP: Doctor Patient
ELP: Ethics, Law, Professionalism
PHM: Public Health Medicine

The boundaries between the pre-clinical and clinical years are not fixed, as the thematic structure is integrated across the four years. However, Years 1 and 2 do not appear to be easily connected to Years 3 and 4 in a way which enhances governance of the curriculum and supports transition and integration between the preclinical and clinical years. The team is interested in hearing about the strategies that the school implements to facilitate continuity between the clinical and pre-clinical years.

The proposed MD program will have the same structure as the current BMBS program, i.e. four themes and eight units running across the four-year degree. However, a revised delivery structure will be introduced as shown below.

Figure 2: MD Program Structure





KHI: Knowledge of Health & Illness
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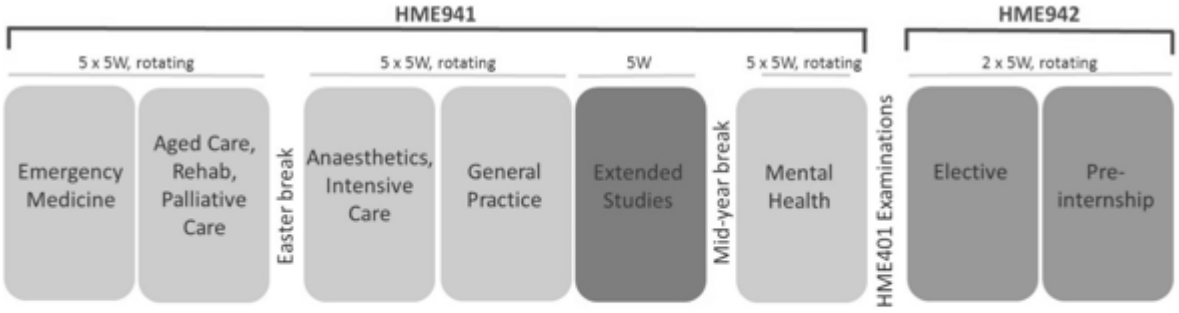


KHI: Knowledge of Health & Illness
DP: Doctor Patient
ELP: Ethics, Law, Professionalism
PHM: Public Health Medicine

The MD program will feature several changes to the BMBS program, including:

- an increase in medicine and surgery components to 28 weeks
- an integrated longitudinal community care curriculum in Year 3, which allows students to follow patients or groups over time
- moving of mental health from Year 3 to Year 4
- an Extended Studies Program to be introduced in Year 3
- building on the research principles, currently taught in the preclinical years of the BMBS program, in Year 4 of the MD program to satisfy the requirements of a program at Australian Qualifications Framework Level 9 Extended. The research component of the MD program will be centred on the themes of public health medicine and ethics, law, professionalism and communication.
- the addition of a five-week Extended Studies block in Year 4 in which students apply knowledge gained over the program to interrogate a local health issue and produce a research proposal
- appointment of additional academic staff, particularly surrounding the research component in the relevant themes

- maintaining the elective rotation, but replacing the selective rotation of the BMBS to accommodate the Extended Studies component and an additional medical/surgical rotation
- minor changes to the sequence of rotations in the clinical years.

3.4 Curriculum description

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

The School has specific learning outcomes and the students and staff work to those outcomes. Students reported that the stated learning objectives provide a good framework on which to base their work.

Students access program information through the learning management system, although the team notes that a course blueprint or roadmap that shows the expected learning across the course would be advantageous for students and staff. An accessible roadmap would enhance engagement with the curriculum and allow students better control over their learning strategies.

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).

A competency framework is being introduced to guide student learning of Indigenous health within the curriculum. Aboriginal staff members are recognised as central to course development and delivery. All face-to-face teaching and other staff are supported in a cultural continuum of learning. Aboriginal and Torres Strait Islander Health is the responsibility of all, with strong support given by the two Aboriginal staff in the School. Further, an Aboriginal doctor is now a member of the Advisory Board. There is no direct Aboriginal representation in the School Executive. The Dean currently represents this perspective himself.

Over the last two years, the School has developed a series of well-established local processes to link the students into the communities in which they are placed. While the team notes that these are currently effective, it is not clear how these are mapped or whether they are sustainable if key people leave. The reliance on individual relationships will be stretched further in the new MD program as research interests in Indigenous health across the final two years of the degree become a more popular choice for students

There are a number of highly motivated Aboriginal students in the program who are interested in contributing to enhancement of the experience for Aboriginal students in the program. Having students who are seriously engaged can make a significant contribution to the program. The team notes that amongst these, are a number of Aboriginal students who have gained entry following completion of other health degrees, who bring a level of expertise into the student cohort that is excellent. These students in particular may sometimes be inappropriately relied on by non-Aboriginal staff teaching the program. To support a greater understanding of culturally safe ways of working with students, the team encourages the School to ensure that cultural safety training is provided to all staff who have a role in teaching and assessing students.

The School is to be commended on its work in Indigenous health. There are opportunities to extend the Aboriginal and Torres Strait Islander Health curriculum further into wellbeing, resilience, and holistic health, and focus on urban and regional Aboriginal populations. The team will be interested to hear more about the development and delivery of the Aboriginal health and cultural capability curriculum.

3.6 Opportunities for choice to promote breadth and diversity

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

The current BMBS program includes choices for students enabling them to participate in selectives and electives, as well as an intercalated honours research year. The team also notes the initiative of structured international medical electives for students.

Current planning for the MD program involves removal of the selective, which is currently where most clinical placements in Aboriginal health contexts occur. This will reduce student choice, particularly the opportunity to experience placements in this context, and the School is encouraged to consider how alternatives might be incorporated into curriculum design. Although the elective and the option for an Honours or similar research year will remain in the MD program, the loss of the selective may impact on choice and clinical placements.

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 medical course enjoys input from a group of academic staff committed to the students and delivery of a high quality course.

The course utilises a broad range of learning and teaching methods across the four years. In Years 1 and 2 (the pre-clinical years), teaching is structured around problem-based learning (PBL) in which students explore a different clinical scenario each week. These PBL sessions are supported by a PBL facilitator and are used to introduce the weekly content and provide a wrap-up/synthesis session for students. Each of the four themes of the curriculum utilises appropriate learning and teaching methods to support student learning of content relevant to the PBL scenario. Dependent on the theme and topic, these methods include lectures, practicals, role-plays, clinical skills sessions, simulations and workshops. Collectively these provide a rich learning environment for students who report that they are busy but supported through this learning.

Cultural awareness is introduced early in the curriculum via the Cultural Immersion in semester 1, Year 1. This immersion exposes students to Aboriginal culture and requires their participation in an interview with an Aboriginal health worker and an Aboriginal patient. The immersion experience has been extended from two to two and a half days in 2018.

In the clinical years of the curriculum (Years 3 and 4), students are immersed in clinical experiences at one of the School's five clinical sites. Students' clinical experiences are supplemented with lectures, clinical skills sessions, tutorials and online resources to ensure coverage of the curriculum at all sites. Students report that this coverage is uneven across sites and that the quality of the online resources is poor with much of the content being outdated. The overall low quality of the resources has resulted in many students reporting that they do not use any of the resources. The School is aware of the need for development in this area and has appointed a new Senior Lecturer in Medical Education who has commenced work to improve the quality of these resources. The team supports this initiative and looks forward to seeing greater student use of the revised and new resources.

A parallel initiative to improve student access to the materials via use of the Deakin Cloud is in progress and will be appreciated by the students. The School is supported in this work by the team of educational developers located within the Deakin Faculty of Health Digital Futures team (the Health Pod). Staff based at Geelong were consistently positive about interactions with this team and continued collaboration is encouraged.

Each clinical site is responsible for its own program of curriculum delivery, coordinated through regular meetings of the Site Coordinators. All sites include ward rounds, bedside teaching, parallel consulting, lectures, tutorials, clinical skills sessions, simulations, case presentations and/or case discussions. The Rural Community Clinical School (RCCS) involves students' immersion in rural general practice clinics and small local hospitals. Students at the RCCS also have face-to-face blocks at various sites in which they are exposed to theoretical learning and clinical skills training. Students have reported concern that their experiential learning at the RCCS did not provide adequate coverage of some specialties, although assessment outcomes are equivalent, and the School has instituted blocks of time in tertiary hospitals to provide immersive experiences in

these specialties. The assessment team looks forward to hearing about the outcome of these initiatives.

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 School reports that a major element of preparing students for lifelong learning is the PBL approach in which students are explicitly introduced to the process of learning. A recent addition to the curriculum in this area has been the introduction of a session early in Year 1, discussing learning styles, which was received favourably by the students. The Doctor and Patient (DP) theme also provides students with many opportunities to receive feedback, and reflect and act upon it to improve identified areas. These opportunities reinforce the benefits of reflective learning that can be applied throughout their career.

4.3 Clinical skill development

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

The School has a well-developed DP theme that benefits from strong leadership and a broad team of tutors and facilitators. Although students report some variability between tutors, they acknowledge the efforts the School has taken to address this and overall report satisfaction with the quality of teaching they receive in this aspect of the curriculum.

Within the DP theme there is a well-developed clinical and communication skills curriculum that provides students with multiple opportunities to develop skills in safe environments prior to applying them in a clinical setting. Clinical skills tutorials are supported by online resources, collaborative peer learning and work with the clinical tutor.

Clinical tutorials are supplemented by simulation-based education and training that is utilised throughout the course. These activities provide important skill development opportunities for the students. Self-reflection is embedded and feedback is provided to students through debrief sessions.

The clinical and communication skills program, inclusive of simulation, received consistent positive feedback across the course. The staff running this program received universal endorsement from students and clinical staff, and are an important touch-point for students at all sites; the School is commended for the strength of this program.

Student competence in clinical skills is assessed prior to contact with patients via in-training assessment during the clinical skills program, Direct Observation of Procedural Skills, Objective Structured Clinical Examinations (OSCE) or assessment within the simulation program. Collectively these measures aim to ensure that students are safe and confident prior to applying their skills in a clinical setting.

An important element of preparation for clinical immersion in Years 3 and 4 is the Transition to Clinical Practice (TCP) program in the last eight weeks of Year 2. This preparatory component of the program incorporates lectures, tutorials, clinical skills sessions, PBL, small-group sessions and simulation, providing a rich environment for student learning. The major focus of the program is to provide exposure to advanced clinical skills, however students report that inclusion of sessions addressing expectations in the clinical immersions of Year 3 would also be helpful and appreciated.

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.

As noted previously, clinical skills development is a strength of the course and is appreciated by students and clinicians at all sites. The TCP program at the end of Year 2 provides students with opportunities to refine their clinical skills prior to the clinical experiences in Years 3 and 4. Within the clinical years, students at all sites report that supervising clinicians are supportive, and their level of participation is appropriate for their skill level and that opportunities to extend clinical skills safely are provided.

Student progress in attaining core skills is monitored through formative assessments, end-of-year OSCEs in Years 2, 3 and 4 and in-training assessments that combine to provide a balance of feedback and assessment of competence.

4.5 Role modelling

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

Role modelling occurs through all years of the course and is seen through the professionalism and dedication of staff. Students report favourably on their interactions with staff. Exposure to a broad range of clinicians in Years 3 and 4 provides students with multiple opportunities to observe behaviours and they report that the majority of teaching clinicians are high quality and engaged role models.

Staff involved in teaching research are active researchers who provide positive reinforcement of the importance of research to evidence-based medical practice and expansion of knowledge. It is expected that the MD course will provide further opportunities for students to engage with research and researchers and enhance exposure to role models in this sphere.

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.

Patient centred care and collaborative engagement is consistently promoted through the concept of the Deakin Doctor. This promotes a holistic, engaged approach to practice that the students embrace. Although not all supervising clinicians were aware of the "Deakin Doctor" concept they did consistently report that if there are differences between Deakin students and those of neighbouring medical programs they are that Deakin students are strong communicators who adopt an inclusive approach to their practice.

The proposed longitudinal placement within the General Practice rotation in Year 3 is intended to further promote concepts of patient centred care and collaborative engagement. Planning for this component of the program is in the early stages. Further reporting of its final format and success is welcomed.

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 major structured exposure to interprofessional learning (IPL) occurs in the Year 2, Collaborative Practice in Healthcare unit. In this unit, students learn with, from and about other health professional students in the Faculty through simulating the design of health care plans in collaborative multiprofessional teams.

In addition, Eastern Health Clinical School has initiated an Inter-professional Practice Placement (Student-Led Ward) that received favourable comment from staff and students.

Although there are rich opportunities for IPL in the clinical years, these are mainly unstructured and sporadic and the team recommends that the School develop an overarching framework for IPL to guide scaffolding of this important element throughout the program.

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.

Deakin University has clear documentation around assessment as articulated in the Assessment (Higher Education Courses) Procedures and Deakin Curriculum Framework, available to all staff and students. The latter contains a set of assessment principles that guide assessment in the BMBS program. The BMBS Course Rules contain a short paragraph on assessment principles and the rationale for using formative and summative assessments. Unit and Theme Handbooks have information on learning outcomes, formative and summative assessment requirements and level of achievement required to pass. Students reported that at unit level, information provided was appropriate and clear.

Assessment and progression rules are contained within the BMBS Course Rules and Deakin University Academic Progress Procedure, although students reported variable knowledge of the rules. Students must pass all themes in each unit or rotation in order to progress to the subsequent semester year through attainment of hurdle requirements. There is no compensation across units, rotations or themes. Students who fail a semester are required to intermit and retake the semester the following academic year. There is clear information on weighting of theme assessments across the BMBS program in the Course Rules. Grades in Years 1 and 2 of the BMBS are given as an ungraded Pass or Fail. Students are supportive of this approach as they feel it promotes collaboration within the cohort. In Years 3 and 4, numerical marks are provided, aligned to grades from High Distinction to Fail.

The team was of the opinion that in the transition to the MD, the program could be enhanced through the addition of an overarching School or BMBS program assessment philosophy and framework that embodies principles of the University, the AMC and the concept of the Deakin Doctor. This framework would be available to teachers and students and contain information on the School's approach to formative and summative assessment.

Assessment is currently managed through the Year Committees, driven mainly by Theme Leaders with some input from Unit Chairs. Some themes have clear documentation for their teams on assessment design and delivery, but it is unclear how this good practice in assessment is communicated to students. The theme-based approach however appears to lack continuity between the preclinical and clinical years. The team was therefore pleased to see the formation and operationalisation of a School Assessment Committee (with a nominated academic lead for assessment) that will review assessment across the School to ensure an appropriate and evidence-based program is developed, sharing best practice in assessment design, delivery, quality assurance and enhancement.

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 School assesses students regularly throughout the BMBS program with a range of summative and formative written and clinical assessments that are fit for purpose and comparable to those seen at other medical schools. As the School is relatively small, short answer questions (SAQs) can be used to assess higher levels of knowledge application. The use of the progress test is appropriate, moving from formative to summative between Years 2 and 4 of the course. At the theme level, in Public Health Medicine (PHM), learning outcomes are mapped to AMC domains, the Junior Doctor Framework and other appropriate professional body standards on an excel spreadsheet and in more granular detail in Unit/Theme Guides. It is not clear how much of this course-wide mapping is available to teachers and students and how other themes ensure constructive alignment in teaching, learning and assessment.

The approach to blueprinting is variable and it is not clear if the blueprint defines the selection of assessment questions or the questions selected define the blueprint. Despite this variability, the School does appear to ensure appropriate representation of discipline-specific content that matches to the curriculum.

As students progress through the course, the complexity and clinical focus of the assessment increases. The School uses multiple choice questions (MCQs), short answer questions (SAQs), reflective writing, workplace (intra-rotational) assessment and Objective Structured Clinical Examinations (OSCEs) to assess student achievement of learning outcomes. The School is to be commended on including assessment of professionalism during the course, and the team would be interested to hear the outcomes of the current review of assessment of professionalism by the Ethics, Law, Professionalism and Communication Theme Lead.

The School uses its own version of the Modified Angoff process for standard setting in the progress test, where 50% of the final standard setting score is derived from the theme or rotation convenor, and the remaining 50% from the other assessors. Student marks are then scaled to a pass mark of 50%. It is not clear from documentation whether this same or another version of the method is used for Knowledge of Health and Illness theme assessment. In the PHM theme, SAQs are written to a 50% threshold of difficulty. PHM assessments contain a small number of MCQs, and the decision has been made not to use the Modified Angoff method due to the poor psychometric reliability with a small number of questions. OSCEs are standard set using the borderline regression method, scaled to a pass mark of 50%. Information on standard setting is given to students during presentations, but it is unclear if there is formal documentation available to students.

The team was concerned about the sustainability of resource-intensive methods such as the Angoff, and would be interested to hear if the School has considered alternatives such as the Cohen method and use of the standard error of the measurement. The team would recommend that the School look at its standard setting practices to ensure consistency and transparency of approach and appropriate dissemination to students and teachers.

It appears to the team that anatomy is assessed summatively through MCQ or SAQ assessments. The team would encourage the School to consider formative and summative practical anatomy assessment to help guide student learning.

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.

Assessment feedback to poorly performing students in Years 1 and 2 is clear, with provision of guidance, remediation and support to those falling below the acceptable standard or in the lowest 10% of the passing cohort. This process seems to be less effective in Years 3 and 4 as students move to dispersed clinical rotations, and the team would recommend that this be reviewed to ensure equitable access to support at all clinical sites.

The School gives feedback to students on assessment, including cohort analysis so that students know how they performed compared to their peers. Students have expressed some concern around the timeliness of feedback in some areas, and the team would recommend the School look at this. An example of feedback on MCQ and SAQs in the Brain and Behaviour Unit linking performance to the unit learning outcome is good practice and well received by the students. School teaching leads also provide large group face-to-face feedback sessions that help exemplify areas where students did well or need further development. Currently, written OSCE station-specific examiner feedback only goes to failing and borderline students as comments are transcribed manually by professional staff. This qualitative data is rich and the team would encourage the School to give this to all students.

Students report variability in the utility of the intra-rotational clinical assessments at clinical schools, with the most negative feedback coming from staff and students where student numbers are larger, where they feel it is a tick-box exercise and there is inconsistency in marking and feedback. Conversely, where students are well known by the clinicians, students report that this is a very helpful activity. The reduction in the number of intra-rotational assessments in 2018 has been welcomed by all the team spoke to. Students also report that there is inconsistency in the marking and utility of the feedback in the reflective assessments in Years 3 and 4, which are currently scored numerically and may detract from the purpose of the assessment. The team recommends that the School review the utility of these assessments across the course and teaching locations.

The Year Committees review assessment and progression data to identify areas of strength and areas for development. In Years 3 and 4, this can be broken down to performance at each clinical site. Generally, there do not seem to be significant discrepancies in student performance at each clinical site, and the team recommends this be reviewed on an ongoing basis. It is not clear, beyond the teaching leads and rotation coordinators, how assessment and progression data is disseminated through to the broader teaching teams at Waurn Ponds or clinical schools.

5.4 Assessment quality

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

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

The assessment program appears to be implemented through the Year 1/2 and Year 3/4 Committees, together with theme and rotation leads. The team welcomes the formation of the School Assessment Committee as a central mechanism for reviewing assessment data across the BMBS program.

The system for writing and reviewing MCQs, SAQs and OSCEs seems appropriate, and the piloting of new OSCE stations before use in a main examination is good practice in quality assurance. Examination security seems adequate, with use of secure servers and password-protected documents. Each theme appears to have its own question database. The team is interested in the progress of the implementation of the "Practique" Exam Management System, which is likely to enhance question banking, blueprinting, assessment delivery, feedback to all students and quality assurance with regard to assessment.

Poorly performing MCQs identified through psychometric data or feedback from teachers and students are reviewed, and removed if agreed by the assessment leads. The reliability of the progress test and OSCE are satisfactory. OSCEs take place simultaneously in multiple cycles. Care is taken to ensure examiners are trained and calibrated appropriately, and scores are reviewed for any significant variability across OSCE sites.

The team recommends that these theme and rotation-led approaches to quality assurance and enhancement are integrated to ensure continuity and consistency across clinical and pre-clinical phases of the course.

The team notes the School's leadership in the Australian Collaboration for Clinical Assessment in Medicine quality assurance in OSCEs, and its engagement with the Australian Medical Schools Assessment Collaboration and Medical Deans Australia and New Zealand benchmarking initiatives.

The School takes seriously its responsibilities for students requiring reasonable adjustments for examinations. The School works closely with the student and University Disability Resource Centre in agreement of Learning Access Plans.

As mentioned previously, students report variability in examiner engagement in the intra-rotational assessments at clinical sites. The team would be interested to hear initiatives to help improve consistency of assessment and the enhancement of the student experience in this area.

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.

The evaluation of the Deakin medical program primarily utilises online surveys of student perception, the Deakin University Student Experience Survey, and the eVALUate student satisfaction survey. As University-wide managed systems, these have limited flexibility to accommodate specific needs, although medical program staff have been able to negotiate some changes to better suit the needs of the program. The student survey occurs regularly, with the evaluation cycle planned to occur mid-year to enable implementation of changes in a timely fashion for the following year. The most beneficial part of this evaluation activity seems to be the free-text comments provided by students.

Additional evaluation activities occur through occasional Deakin Medical Students Association (MeDUSA) administered student surveys. In consultation with the School, items are sometimes added to these surveys to target aspects of the program that are of particular interest to the School.

Although teacher feedback occurs informally through curriculum committee meetings, the current evaluation approach appears to be largely unidimensional around student perception surveys. The School may benefit from exploring other methods of collecting evaluation data for important issues such as students sampled for focus group interviews. There are some areas where student assessment results are used to inform the functioning or quality improvement of the medical program, but these also appear to be sporadic and not part of an overall strategy.

Evaluation in the clinical schools also takes place in an uncoordinated fashion, with resultant difficulties in interpreting the results between sites. Although curriculum changes related to the introduction of the MD program are imminent, there is no prospective blueprint or strategy for evaluating the positive or negative effects of the proposed changes.

These difficulties may result from the absence of an explicit framework for the systematic evaluation of the various educational and structural aspects of the medical program (curriculum structure, teaching and learning, assessment and feedback, learning environment, student engagement and governance, student support, teacher experience, student selection). Although lower level evaluation is conducted, there does not appear to be formal and systematic higher level evaluation for phenomena such as student learning, changes to student behaviour, changes to staff behaviour, changes to educational structures, or professional or health outcomes for example.

The School would benefit from the development of a systematic and program-wide philosophy and framework for evaluation. An effective framework could describe:

- the purpose and aims of evaluation

- the governance of the programmatic evaluation process including limitation of potential or perceived conflicts of interest
- the role of the Health Professions Education Scholarship Unit
- diversity of modes of evaluation to provide triangulation of results
- differing levels of evaluation including the potential for higher-level outcomes
- mitigation of evaluation overload and fatigue for students and staff
- integration with University and MeDUSA evaluation activities
- processes and procedures to deal with evaluation results in a timely and nimble fashion
- communication pathways with students and staff regarding the evaluation process including results and associated changes.

Targeted prospective evaluation of the expected changes to the program from introduction of the MD degree should also be considered. The team looks forward to hearing more about developments in this area.

Changes are planned from 2018, as the Health Profession Education Scholarship Unit develops its functions and structures, to promote better coordination across clinical sites. The team looks forward to hearing more about the evolving role of this unit.

The team acknowledges the recent history of difficulties in anatomy teaching and learning experiences for students. Many changes have been implemented including:

- staff changes
- improved engagement of anatomy staff in the governance of the program
- anatomy staff suggesting structural changes to the program
- benchmarking to the Anatomy Society and British anatomy curricula
- involvement in Australian Medical Schools Assessment Collaboration benchmarking
- improved communication between staff.

Anecdotal comments from staff and students have suggested improvements have occurred over 2017 and early 2018 but no objective evidence is currently available. The team is interested in hearing the outcomes of the evaluation of the recent changes.

6.2 Outcome evaluation

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

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

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

The School undertakes analysis of the performance of student year cohorts in assessment results with the OSCE and written assessments. The analysis relates predominantly to the Knowledge of Health and Illness and Doctor and Patient themes and occurs via the assessment panels of each year. As the School is relatively young, the longer-term outcomes of the medical program are not yet available but projects are currently being undertaken to follow students after graduation.

Certain student groups such as rural background students have been monitored in terms of assessment performance and Indigenous entry students are currently being monitored to better identify educational needs, but it is unclear how these analyses are managed. Likewise, the process by which the results of analysis affect changes to the medical program is equally unclear.

In terms of student selection, background and performance analyses have been reviewed, resulting in justifiable changes to selection criteria for entry to the program in 2018.

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.

Evaluation results are provided via the committee structures to academic staff. Results are also distributed to senior coordinators and stakeholders at clinical sites, individual discipline and topic leads where appropriate, and to the Medical Advisory Board on a biannual basis. Changes that are made to units based on the evaluation results, predominantly related to teaching and assessment, are described in the subsequent year's unit guides. The feedback loop for students occurs via this process.

The mechanism for feedback to and from clinical teachers, supervisors and tutors seems to occur in an ad hoc fashion and, in some cases, relies on pre-existing professional relationships. Greater clarity and structure concerning the two-way feedback for teaching clinicians and supervisors would be beneficial.

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.

Deakin University has had a relatively stable student intake and number of students since 2013, with a Commonwealth Supported Places target of 130 places. There were 4,326 applications for entry to Deakin in 2018 through GEMSAS, with first preferences steady or increasing over time. The opening of the Epworth Geelong Hospital and increased capacity has allowed it to increase its intake of international students from 2016. There were five or less per year until 2016, then 9 in 2016, 13 in 2017, and 12 in 2018. The current physical and clinical resources are adequate to support the number of students across all years of the program.

The school is to be commended on its priority to revisit its social accountability mission. As part of this, it has reviewed its admission and selection processes to continue to attract students from a diverse range of backgrounds, with a focus on rural or regional background, work experience and financial disadvantage. It has done this by expanding the bonus points system and changing the weighting of the GPA/GAMSAT and the MMI to 50% each. The MMI Subcommittee has also modified the MMI to focus on "Deakin Doctor" attributes.

The current bonuses include:

- Rural/regional residency bonus – Geelong and ASGC-RA 2 = 4%, RA 3-5 = 8%
- Prior clinical experience in a heath discipline = 4 %
- Work experience bonus – two years full-time work = 2%
- Demonstration of financial disadvantage = 2%
- Deakin graduate bonus = 4%.

The School has met its target of rural origin students, with 28.22% of the 2017 cohort from a rural background. The 2018 intake was the first under these criteria, and the School is pleased with the maturity and diversity of the cohort. There are no planned changes to numbers or the entry process for the MD program.

The School has a separate Indigenous Entry Stream (IES) and up to 5% of domestic places per year are held for Indigenous applicants. Indigenous applicants may submit a direct application to the School through the IES, or apply via the GEMSAS system. Assessment of applicants entering via the IES pathway considers confirmation of Aboriginal or Torres Strait Islander status, GPA and a successful interview with a panel comprising of staff from the Medical School and Deakin's Institute of Koorie Education (IKE) and the Australian Indigenous Doctors Association. In 2018, most applied through the GEMSAS system.

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 School has clear and transparent selection policies that can be implemented and sustained in practice. As noted above, the school has specific affirmative action policies for specific groups of students. The policies and procedures are set by the School of Medicine Admission and Selection Committee (SOMAC), and these are consistent with relevant University and Faculty policies and procedures. The policies and procedures, including those for the IES, are clearly articulated and readily accessible on the University's website.

Entry to the School (other than through the IES) is a combination of GAMSAT, a result within two years of application with a score of >50 in each domain, a GPA average >5.0 and the Deakin MMI.

Deakin University bonuses (see above) are applied to the combined aggregate GPA and GAMSAT score, and this aggregate is worth 50% of the total score, with the MMI also worth 50%.

There are no anticipated changes to this for the MD program. The Year 1 2017 and 2018 cohort will transition to the MD program in 2019, and successful applicants were made aware of this in their letter of offer. There are appropriate arrangements for students from previous cohorts who intermit or repeat.

The School has clear policies and guidelines on the admission of students with disabilities and students with infectious diseases, including blood borne viruses. It also has guidelines regarding the inherent requirements of the medical program. The School works closely with Deakin Equity and Diversity divisions, and staff at the Disability Resource Centre assists students in various ways. All the infectious diseases and immunisation policies are on the website and students are advised of their requirements prior to course commencement

Indigenous student recruitment is mainly through IKE, and the team understands that consideration is being given to longer-term recruitment strategies including high school outreach. There are retention and support strategies for Aboriginal and Torres Strait Islander students that include financial support through bursaries that provide free on-campus accommodation for semester 1, which is also provided to international students.

The team is satisfied that all the above policies and procedures, including those for the IES, and for appeal, are clearly articulated and readily accessible on the University's website. Selection processes are also available on the GEMSAS website.

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 is to be commended on its prioritisation and work to support student wellbeing and resilience. The employment of a counsellor within the School has been very well received by students. As well as telephone counselling, which is available to all students off campus, including those in rural placements, it is anticipated that Skype counselling, which will be in place by mid-year, will enhance support to students at clinical sites. The service has been well utilised, and at this stage seems sustainable. The counsellor also works with staff to up-skill them in the recognition and appropriate referral of students with problems and this is highly valued.

Each clinical site has unique characteristics and clear identity. At each, students are known and are seen as a small tight cohort. Student wellbeing is paramount, with a full-time equivalent wellbeing officer appointed within the Deakin University Division of Student Life and the School of Medicine. The School has introduced the CaRE (Coping and Resilience Education) program, aimed at Year 1 students, to foster wellbeing and resilience. The innovative program has significant involvement and commitment from the wider student body, and students the team spoke to were appreciative of this initiative. In addition, a CaRE dog comes in and makes regular visits.

There is additional support for students through a number of University-provided services, including study support, disability services, counselling, medical centres, multifaith chaplaincy, student housing, financial assistance and international student support. Reasonable adjustments are made, including to assessment processes for students with disabilities

Students overall feel very well supported by the School. However, there appears to be a lack of clarity about the process of identification, and 'next steps' after identification, of students who need support. The Unit Chair, in Years 1 and 2, and the Clinical School Director in Years 3 and 4 seem to be the 'go to' people for staff who have concerns about a student. The team heard that particularly in the clinical years, concerns about a student's health and wellbeing, as well as academic progress are often raised first with the Clinical School Director, and the team was unclear about consistent policies and actions across these sites.

Students at academic risk are identified through assessment progress and feedback. In Years 1 and 2 the mid semester assessments uses a quartile ranking system, which is included in feedback

to students, and those in the bottom 10% are encouraged to arrange a meeting with the topic coordinator of the relevant theme in which they performed poorly.

In the clinical years, the process is not as clear, and formative progress is assessed mainly though logbooks and portfolios, and tutors and clinical staff may speak to the Clinical School Director about their concerns. Student results in the assessment at the end of Year 3 are communicated to the relevant Clinical School Director. Students however indicated that appropriate remediation was not instituted at all sites, and the team was concerned about the feedback and monitoring of these processes in the clinical years.

The team notes the significant role that the Academic Coordinator for Indigenous Education plays in supporting the students, and the tension that may arise between her educational leadership role for the School and pastoral care for the students. The team has some concern that with a growing number of Aboriginal students the workload of support and educational leadership may be unsustainable.

The team was impressed by the establishment of a culturally safe room in collaboration with students at the Waurn Ponds campus. The team also notes efforts towards providing culturally safe and appropriate spaces at the various school sites. Considerable support is provided to students through IKE, but it appears that not all students are aware of all the supports that are available. The team notes that the School is working towards ongoing improvement of the process for retention and support of Aboriginal and Torres Strait Islander students.

The student counsellor is clearly separate from decision making involved in academic progression. However, given the complex interrelationship between academic performance and mental health and wellbeing, the roles of Unit Chairs and Clinical School Directors may at times blur this clear distinction of student support and academic progress decision making.

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 has demonstrated a deep and holistic approach to student professional behaviour across a number of domains. These are: attendance and time management; motivation to learn; respect for patients; respect for colleagues; ability to work in a team; recognition of own limitations; and balancing external commitments. Professionalism is a hurdle assessment of these domains each semester and requires completion of the Professionalism Competency Form A, which encourages self-reflection, and the Professionalism Competency Form B, which is completed with a supervisor.

The School has a Professional Standards Subcommittee (PSS) which is tasked with managing students whose professional behaviour is of concern. The processes and outcomes of the PSS appear to be essentially remedial/supportive for students.

Although the team was provided with a flow chart outlining the processes of referral, it understands that with the introduction of assessment of professionalism into all units, the policies and procedures for identification and support of students whose professional behaviour is of concern, are in the process of review and finalisation. The team anticipates receiving updates on this review particularly with regard to the processes of referral to, and the role of, the PSS.

Students whose behaviour raises concerns about their fitness to practise are referred from the PSS to the Faculty of Health Student Misconduct Committee. The School has reported two students to AHPRA in the past six years.

7.5 Student representation

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

The students consider that their voices are heard, and are represented on a number of high-level committees, including the Advisory Board and the Teaching and Learning Committee, but not on the Year 1 and 2, and Year 3 and 4, or Theme Advisory Committees. The School could consider further extending student representation to these committees to enhance access to student perspectives.

7.6 Student indemnification and insurance

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

The information provided to the team indicates that the School has adequate insurance and indemnity coverage for students engaged in the formal requirements of the program.

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.

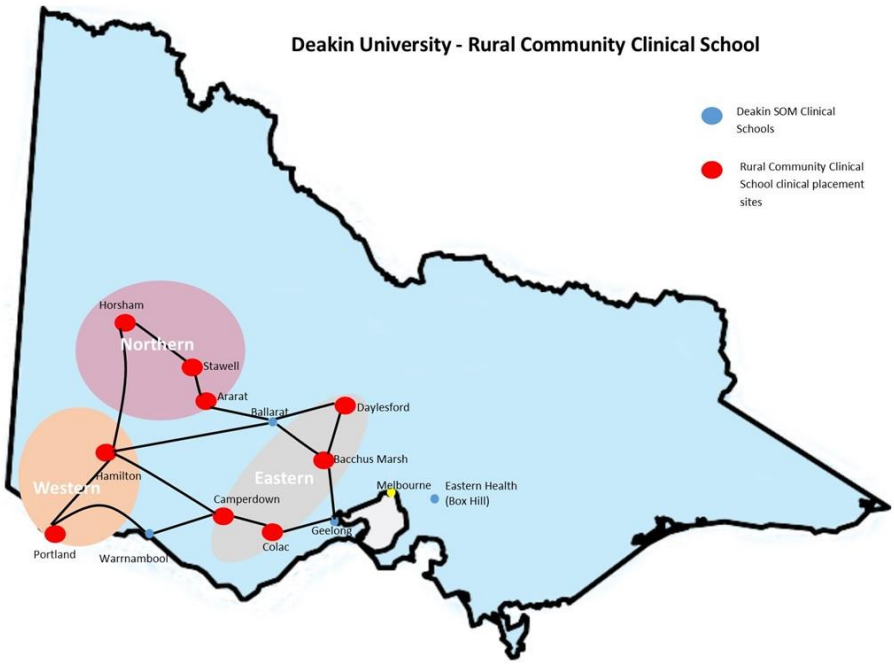
Years 1 and 2 of the program are taught at the Geelong Waurn Ponds campus. Facilities at this campus are largely centred in a building that was refurbished specifically for the BMBS program and has sufficient, high-quality physical facilities for all activities and outcomes associated with the program.

Years 3 and 4 of the program are delivered at five clinical schools (see **Table 2** below) each of which has multiple sites. Figure 3 indicates the locations of sites within the Rural Community Clinical School (RCCS).

Table 2: Clinical Schools

Geelong Clinical School (GCS)
Greater Green Triangle Clinical School (GGTCS)
Grampians Clinical School (Ballarat)
Eastern Health Clinical School (EHCS)
Rural Community Clinical School (RCCS)

Figure 3: RCCS sites



Facilities at each clinical school include administration offices, teaching and lecture spaces, clinical education spaces and access to hospital infrastructure including wards and consulting rooms. The clinical education spaces at all schools include physical facilities to support the clinical skills simulation program that is a feature of the course and valued by students. All schools have adequate space for current numbers although Grampians Clinical School reported that it would require significant restructuring at Ballarat Base Hospital if numbers increase.

8.2 Information resources and library services

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

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

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

The School is working towards embedding the University's *LIVE the future 2020* plan including "harnessing new and emerging technologies to provide highly visual, media-rich, interactive learning experiences wherever our students are located" in the medical program.

The School utilises information communication technologies across the spectrum of its activities. This includes delivery of learning and teaching materials to Years 1 and 2 at the Waurn Ponds campus and in Years 3 and 4 at the clinical schools and communication between staff at the various sites.

The infrastructure to facilitate delivery of resources is adequate across all major sites. Access at remote sites continues to present challenges and the School is addressing these where possible. Students and staff at all sites access the University network through Eduroam and also have access to health sector IT systems as appropriate to their needs.

The major library site is the Deakin Library at Waurn Ponds campus. This library hosts the medical collection and provides extensive work areas for students individually or in groups. Access to appropriate electronic books, journals and resources is managed by the Medical Librarian who works closely with staff of the School to ensure currency of the collection and database access. The Medical Librarian also provides staff development and support for students in skills necessary to identify and evaluate resources. Staff and students at the clinical schools can access the electronic resources of the Deakin Library and have access to the hospital libraries and librarians.

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.

The School has established relationships with a range of health services across the state which enables student exposure to a wide range of clinical contexts and sufficient patient contact across the course. The majority of clinical learning falls within Years 3 and 4. For clinical schools other than the RCCS, students are placed at one clinical school for both years and undertake a series of seven-week rotations through the major clinical disciplines. Students placed at RCCS undertake a longitudinal integrated clerkship in Year 3 followed by attachment to another clinical school in Year 4.

In general, the sites provide sufficient teaching facilities to support the breadth of experience across disciplines, models of care and contexts necessary. However, there is a need for all sites to engage more strongly with Aboriginal health to ensure that students gain sufficient understanding of Aboriginal health and health services in the local context.

The recent initiatives to promote cultural safety through the display of welcome plaques and artwork are acknowledged as positive steps towards culturally appropriate practice, as is the establishment of safe spaces for Aboriginal students at each site.

The School shares clinical sites with multiple other medical programs, notably the University of Melbourne, Monash University and the University of Notre Dame Australia, Sydney. There are positive and collaborative working relationships with all providers particularly amongst the high-level leadership at the University of Melbourne and Monash University with whom there is most sharing of clinical facilities. These relationships extend from high-level consultations between Deans to largely effective strategies to provide adequate supervision for students from all schools across sites.

At Eastern Health Clinical School however, students consistently report dissatisfaction with their experience, particularly in relation to interactions with and support from staff of the Medical School Program at Box Hill Hospital and their connection to staff at Waurn Ponds. The team was reassured that the School is aware of these issues and is working to improve the student experience at this site. Updates on the implementation of initiatives to improve student experience at Eastern Health Clinical School and an evaluation of their effectiveness will be welcomed. The team notes the challenges at the Eastern Health Clinical School and is confident that a collaborative approach to resolving the issues will ensue.

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.

Governance of clinical supervision is structured to facilitate effective, quality supervision of students at all sites and provides conduits for communication between sites and the central site at Waurn Ponds. Students observed that direct clinical supervision is generally a strength of the School, reporting high levels of satisfaction with most supervisors.

At each clinical school there is a Clinical School Director who oversees the topic leads (or, regional coordinators at the RCCS), administrative staff and clinical skills lecturers for each clinical school. In turn, the topic leads are responsible for the clinical teachers within their topic. The topic leads reported they have an established network for communication across sites in some disciplines but that this was not facilitated by the School and nor is it inclusive of all sites or disciplines.

Ongoing professional development in education and clinical teaching is available to all clinicians through curriculum days, OSCE training sessions and briefings. The School communicates these professional development opportunities directly to the clinicians. As part of this communication, the School has informed clinicians at all sites of the proposed MD program and the changes for Years 3 and 4. However, consideration could be given to strengthening communication about the planned changes as there is considerable uncertainty amongst supervising clinicians about the model, and in particular the model for research within the MD program.

Staff at the clinical schools are employed through a variety of models including conjoint appointments, fractional appointments and casual/sessional arrangements. These adequately compensate clinicians for the time and effort they devote to the medical course and appropriate time is allocated to student supervision.

Position descriptions defining the roles are available for all senior positions within the clinical schools including topic leads and simulation or clinical skills senior lecturers. The School provides staff at clinical schools with access to Deakin systems including the medical program learning management system. Expectations of staff and obligations of the School are clear and are documented within Student Placement Agreements.

Appendix One Membership of the 2018 assessment team

Professor Amanda Barnard (Chair), BA (Hons), BMed (Hons), FRACGP, SFHEA
Associate Dean, Rural and Indigenous Health, and Head, Rural Clinical School, ANU Medical School

Professor Tony Celenza (**Deputy Chair**), MBBS, MClinEd, FACEM, FRCEM
Director, MD Program, University of Western Australia

Associate Professor Linda Crane BSc (Hons), PhD, GCertEd
Deputy Dean, Faculty of Health Sciences and Medicine, Bond University

Professor Inam Haq BSc Biochemistry (Hons), MBBS, MD, FRCP, FRACP
Professor and Co-Director - Sydney Medical School, University of Sydney

Professor Ben Canny BMedSc (Hons), MBBS, PhD
Head, School of Medicine, University of Tasmania

Professor Lisa Jackson-Pulver PhD, GDipEpi, MASS
Pro Vice-Chancellor Engagement and Aboriginal and Torres Strait Islander Leadership, Western Sydney University

Mr Alan Merritt
Manager, Medical School Assessments

Australian Medical Council

Ms Chrissy Arnaoutis
Program Administrator, Australian Medical Council

Ms Brooke Pearson
Accreditation Officer, Australian Medical Council

Appendix Two Groups met by the 2018 assessment team

Heads of School

Dean of School, Medicine

Deputy Head of School, Medicine

School Executive Committee

Dean

Deputy Head of School

School Executive Officers

Associate Head of School Teaching and Learning

Associate Head of School Research

Associate Head of School International

Course Team

Course Director

Deputy Course Director

ELP Theme Leader

KHI Theme Leader

PHM Theme Leader

DP Theme Leader

Academic Coordinator of Indigenous Medical Education

Years 1 & 2 Committee

Deputy Course Director

KHI Theme Leader

DP Theme Leader

DP Year 1 and 2 Co-ordinator

HME101 Unit Chair

HME102 Unit Chair

HME102 Unit Chair

HME201/HME 202 (2017) Unit Chair

Aboriginal and Torres Strait Islander Health Curriculum Team

Academic Coordinator of Indigenous Medical Education

Director, Institute of Koorie Education

Associate Head of School International

Director, Deakin Rural Health

AIDA Representative, Emergency Physician, Epworth Healthcare, Advisory Board

Vice Chancellor, Deakin University

Executive Dean, Faculty of Health

Years 3 & 4 Committee

Unit Chair HME301-302; HME401-402

Course Director

Doctor and Patient Theme Leader

Ethics, Law, Professionalism Theme Leader

Public Health Medicine Theme Leader

Knowledge of Health and Illness Theme Leader

Indigenous Theme Leader

Grampians Clinical School Director

Rotation Convenor: Children's Health

Rotation Convenor: Aged Care/Rehabilitation Medicine/Palliative Care

Rotation Convenor: Surgery

Rotation Convenor: Medicine

Medical Librarian

Medical Education Unit

Course Director

Senior Lecturer in Medical Education (Assessment)

Associate Head of School Teaching and Learning

Deputy Course Director

Finance

Finance Team Leader

Faculty General Manager

Faculty Finance Manager

School Assessment

Course Director/Academic Progress Committee Chair

KHI Theme Leader

Deputy Course Director

Senior Lecturer in Medical Education (Assessment)

Associate Head of School Teaching and Learning

Clinical Curriculum and Assessment Coordinator

Doctor and Patient Theme Leader

Doctor and Patient Year 3 and 4 Coordinator

Curriculum Support Leader

Administrative Officer (Assessment)

Acting Director, Rural Community Clinical School

Professionalism and Student Welfare

Professionalism Standards Subcommittee Chair

Student Welfare Counsellor

Lecturer in Ethics, Law and Professionalism

Professor of Communication and End of Life Care

Ethics, Law and Professionalism Theme Leader

Academic Coordinator of Indigenous Medical Education

MD Working Group

Deputy Head of School, Medicine

Associate. Head of School Teaching and Learning

Course Director

Senior Lecturer in Medical Education (Assessment)

Chair in Academic General Practice

Ethics, Law and Professionalism Theme Leader

School Operating Group

School Executive Officer

Human and Physical Resources Team Leader

Executive Assistant to Dean

Student Experience Team Leader

Laboratory Team Leader

Rural Clinical School Operations Coordinator Team Leader

Administrative Officer Research

Administration and Grants Officer

Student Selection and Admission

Dean of School, Medicine

School Executive Officers

Admission and Selection Coordinator

Student Experience Team Leader

MeDUSA Student Society/ Student Representatives

President, MeDUSA

Vice-President, MeDUSA

Preclinical President, MeDUSA

Preclinical Vice President, MeDUSA

3rd Year Rep, MeDUSA

4th Year Rep, MeDUSA

Preclinical Academic, MeDUSA

NOMAD President

1st Year International Medical Student

2nd Year International Medical Student

4th Year International Medical Student

Year 2 Indigenous Medical Student

Eastern Health Clinical School

Clinical School Director Eastern Health

Eastern Health Chief Executive Officer

Eastern Health Chief Medical Officer

Ballarat Health Services Chief Executive Officer

Year 3 & 4 Students

EHCS Academic, Teaching & Administrative Staff

Clinical Senior Lecturer, MBBS Curriculum and Innovation

Clinical Skills Instructor

Clinical Site Team Leader

Adjunct Senior Lecturer, Medicine Alfred Hospital

Teaching Clinicians

Surgery Rotation Coordinator

Women's Health Rotation Coordinator

Grampians Clinical School

Clinical School Director for Grampians Clinical School

Year 3 Student Representative

Community Advisory Board Student Representatives

Year 3 Student

Year 4 students

Academic, Teaching and Administrative Staff

Clinical Skills Senior Lecturer

Senior Clinical Lecturer

Clinical Skills and Simulation Instructor

Administrative Co-ordinator

Clinical School Administrative Assistant

Teaching Clinicians – Topic Leads

GP Topic Lead

Surgery Topic Lead

Women's Health Topic Lead

Medicine Topic Lead

Geelong Clinical School

Clinical School Director for Geelong Clinical School

Simulation and Communication Skills

Senior Clinical Lecturer

Deputy Director of Clinical Studies

Professor of Communication and End of Life Care

Barwon Health Chief Executive Officer

Teaching Clinicians

Clinical Associate Professor

Clinical Lecturer

Associate Professor of Surgery

Deputy Director of Simulation

Chair in Academic General Practice

Academic and Clinical School Staff

Clinical Skills Instructor

Clinical Skills Instructor, OSCE & CSI Coordinator

Clinical School Administrative Coordinator

Institute of Koorie Education

Indigenous Students

Year 1 Indigenous Medical Student

Year 2 Indigenous Medical Student

Year 2 Indigenous Medical Student

Year 3 Indigenous Medical Student

Year 3 Indigenous Medical Student

Year 4 Indigenous Medical Student

Wathaurong

Deputy Chairperson

Supervising GP

Aboriginal and Torres Strait Islander Health

Associate Professor, Indigenous Teaching and Learning, Faculty of Arts and Education, Institute of Koorie Education.

Lecturer, Nursing, Institute of Koorie Education

Dhauwurd Wurrung Elderly and Community Health Service (DWECH)

CEO DWECH (Portland)

Director, Deakin Rural Health

Academic Coordinator of Indigenous Medical Education

RCS Funded Clinical Schools

Greater Green Triangle Clinical Sites

Director of Greater Green Triangle Clinical School

Teaching Clinicians

Senior Lecturers

Academic Staff

Medical Director of Simulation and Clinical Skills

Senior Lecturer in Medical Education

Deputy Director of Clinical Studies

Senior Lecturer in Medical Education

Clinical Skills Lecturers

Clinical School Administrative Coordinator

Clinical School Administrative Assistants

Students

Year 3 Medical Students

Year 4 Medical Students

South West Healthcare

Chief Executive Officer

Director of Medical Services

RCCS – Clinical School Director

Students

Camperdown Students

Colac Students

RCCS Students

Supervising General Practitioners

Robinson St Medical Clinic Supervising GP

Camperdown Clinic Supervising GP

Corangamite Clinic RCCS Site Supervising GP

Clinic RCCS Site Supervising GP

Community Advisory Board members

Members of the Community Advisory Board

Kardinia Health General Practitioners

Chief Executive Medical Director

Practice Manager

General Practitioners

General Practitioner Registrar

Evaluation

KHI Theme Leader

Senior Lecturer in Medical Education (Assessment)

Acting Director, Rural Community Clinical School

Clinical Skills Senior Lecturer

Research

Associate Head of School Research

Strategic Research Centres Director

Honours Course Director

Medical Education Unit representative

CRADLE Fellowship representative

SOMERG representative

Academic Higher Degree Research Student

Ethics, Law and Professionalism Theme Leader

MD Extended Studies representative

Director, Deakin Rural Health

RCS Funded Clinical Schools' representative

Academic Coordinator of Indigenous Medical Education

Simulation Lab Teaching

Lecturer in Simulation and Clinical Skills

Senior Lecturer

Pathology and Anatomy Teaching

Senior Lecturer

Associate Lecturer in Anatomy and Physiology

Lecturer in Pathology

Laboratory Team Leader

Library

Student Welfare Counsellor

Medical Librarian