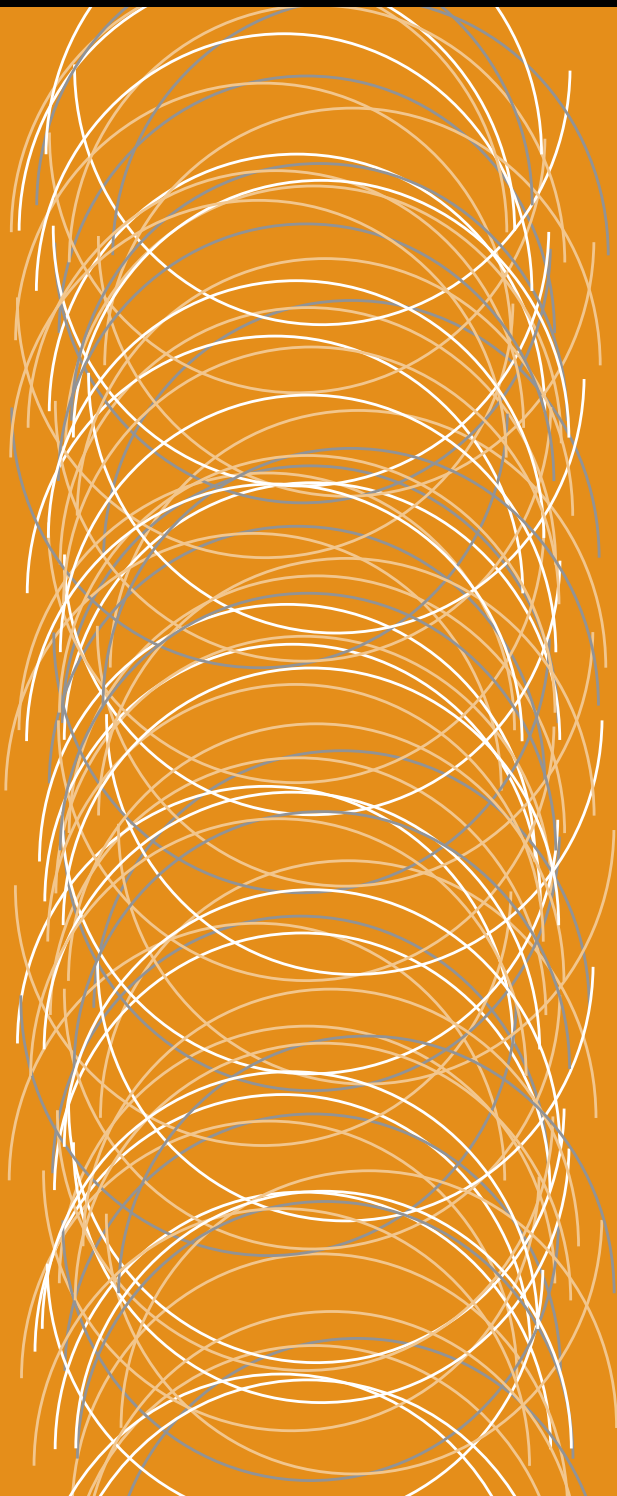


Australian Medical Council Limited

Accreditation of the
Monash University, Faculty of Medicine,
Nursing & Health Sciences medical programs

AMC



Medical School Accreditation Committee
November 2017

August 2018
Digital edition

ABN 97 131 796 980
ISBN 978-1-925829-14-3

Copyright for this publication rests with the
Australian Medical Council Limited

Australian Medical Council Limited
PO Box 4810
KINGSTON ACT 2604

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

Contents

Executive summary 2017	1
Key findings	4
Introduction	9
1 The context of the medical program	13
1.1 Governance	13
1.2 Leadership and autonomy.....	13
1.3 Medical program management	14
1.4 Educational expertise	14
1.5 Educational budget and resource allocation	15
1.6 Interaction with health sector and society.....	15
1.7 Research and scholarship	16
1.8 Staff resources.....	16
1.9 Staff appointment, promotion and development	17
2 The outcomes of the medical program.....	18
2.1 Purpose	18
2.2 Medical program outcomes	19
3 The medical curriculum.....	21
3.1 Duration of the medical program	21
3.2 The content of the curriculum	21
3.3 Curriculum design	22
3.4 Curriculum description	23
3.5 Indigenous health	24
3.6 Opportunities for choice to promote breadth and diversity.....	24
4 Learning and teaching	25
4.1 Learning and teaching methods.....	25
4.2 Self-directed and lifelong learning.....	26
4.3 Clinical skill development.....	27
4.4 Increasing degree of independence.....	27
4.5 Role modelling.....	28
4.6 Patient-centred care and collaborative engagement	28
4.7 Interprofessional learning.....	29
5 The curriculum – assessment of student learning	31
5.1 Assessment approach.....	31
5.2 Assessment methods	32
5.3 Assessment feedback.....	33
5.4 Assessment quality.....	34
6 The curriculum – monitoring.....	37
6.1 Monitoring	37
6.2 Outcome evaluation	38
6.3 Feedback and reporting	38

7	Implementing the curriculum - students.....	40
7.1	Student intake.....	40
7.2	Admission policy and selection.....	40
7.3	Student support.....	41
7.4	Professionalism and fitness to practise	42
7.5	Student representation.....	43
7.6	Student indemnification and insurance.....	43
8	Implementing the curriculum – learning environment.....	44
8.1	Physical facilities.....	44
8.2	Information resources and library services.....	44
8.3	Clinical learning environment	45
8.4	Clinical supervision	45
Appendix One	Membership of the 2017 assessment team	47
Appendix Two	Groups met by the 2017 assessment team- Malaysia	48
Appendix Three	Groups met by the 2017 assessment team - Melbourne	51

List of Figures

Figure 1: Relationship between Campuses, Clinical Schools and Affiliated Sites	11
--	----

List of Tables

Table 1: Student numbers for 2017	11
---	----

Executive summary 2017

Monash University, Faculty of Medicine, Nursing and Health Science is seeking reaccreditation of its medical program.

The Monash University medical program is a 4-year graduate entry (Years A, B, C, D) and a 5-year direct entry MBBS program (Years 1, 2, 3, 4, 5) with separate entry pathways that are merged and integrated for the clinical years. The pre-clinical years are taught at three sites. Years 1 and 2 of the Undergraduate Entry Program are taught at the Clayton campus and the Malaysian campus, and the Graduate Entry Program is taught in Gippsland.

In keeping with the submission documentation provided by Monash University, this report makes reference to the “School” of medicine for convenience and clarity, even though it is not described as such in the Monash University Academic structure.

The School intends to transition to a Bachelor of Medical Science / Doctor of Medicine (BMedSci/MD) program with new enrolments commencing exclusively in the BMedSci/MD program from 2017. The Australian Medical Council (AMC) does not consider this change to be a major change. In the BMedSci/MD program students in both entry pathways will graduate with a Bachelor of Medical Science (AQF 7) and MD degree (AQF 9).

Accreditation process

According to the AMC’s *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2017*, 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 Monash University medical program expires on 31 March 2018.

An AMC team completed the reaccreditation assessment. It reviewed the School’s submission and the student-run Monash University Medical Society (MUMUS) report, and visited the Malaysian campus and associated clinical teaching sites in the week of 31 July – 2 August 2017 and the Clayton and Gippsland campuses, and associated teaching sites in the week of 21 – 25 August 2017.

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 2017*, section 5.1, the accreditation options are:

- (i) Accreditation for a period of six years subject to satisfactory progress reports. 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 six years subject to certain conditions being addressed within a specified period and to satisfactory progress reports. 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.
- (iii) Accreditation for shorter periods of time. If significant deficiencies are identified or there is insufficient information to determine the program satisfies the accreditation standards, the AMC may award accreditation with conditions and for a period of less than six years.
- (iv) 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 is satisfied that the medical programs of Monash University meet the approved accreditation standards.

The 18 December 2017 meeting of the AMC Directors agreed:

- (i) That accreditation of the Bachelor of Medical Science / Doctor of Medicine (BMedSci/MD) medical program of the Monash University, Faculty of Nursing, Medicine and Health Sciences be granted for a period of six years, that is until 31 March 2024;
- (ii) That accreditation of the Bachelor of Medicine / Bachelor of Surgery (MBBS) (Hons) medical program of the Monash University, Faculty of Nursing, Medicine and Health Sciences be granted for a period of four years, that is until 31 March 2022; (the MBBS (Hons) program will conclude in 2020 and be replaced entirely by the BMedSci/MD)

That accreditation of the programs is subject to meeting the monitoring requirements:

- a) By the 2018, evidence that the medical program has addressed the following conditions from the accreditation report:

AMC condition	Accreditation condition
1	Demonstrate that the medical programs' revised governance structures and functions are operating in a timely and effective manner and are understood by staff and stakeholders. (Standards 1.1, 1.3)
2	Implement Faculty development initiatives across teaching sites to enhance academic expertise to meet the needs of the program. (Standard 1.4)
3	Report on any additional resourcing required to meet program requirements for the implementation of the BMedSci/MD program (including but not limited to managing the Scholarly Intensive Projects) and the School's plans to address these requirements. (Standards 1.5, 1.7)

AMC condition	Accreditation condition
4	Develop and implement the Indigenous Health curriculum across all years of the program. (Standard 3.5)
5	Increase and embed interprofessional teaching and learning, linked to assessment, throughout the program and ensure ongoing and increased resourcing is available for interprofessional teaching and learning. (Standard 4.7)
6	Ensure that assessment of the Monash Case Record (MCR) is fit for purpose and consistent across clinical sites. (Standards 5.2, 5.4)
7	Establish a process that includes ongoing monitoring of the MCR and faculty development to support consistent delivery. (Standards 5.2, 5.4)
8	Implement the process currently employed for providing feedback for the mid-semester assessments in Years 1 and 2 to other written assessments in the program. (Standard 5.3)
9	Clarify the overall governance, leadership and oversight of the evaluation strategy. (Standard 6.1)
10	Provide a clear plan and purpose for the School evaluation strategy that will offer clear direction for the School, the Faculty and other stakeholders. (Standard 6.2)

Key findings

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

The AMC uses the terminology of the National Law (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
--	------------

Standards 1.1 and 1.4 are substantially met.

Conditions

- 1 Demonstrate that the medical programs' revised governance structures and functions are operating in a timely and effective manner and are understood by staff and stakeholders. (Standards 1.1, 1.3)
- 2 Implement Faculty development initiatives across teaching sites to enhance academic expertise to meet the needs of the program. (Standard 1.4)
- 3 Report on any additional resourcing required to meet program requirements for the implementation of the BMedSci/MD program (including but not limited to managing the Scholarly Intensive Projects) and the School's plans to address these requirements. (Standards 1.5, 1.7)

Recommendations

- A Describe any further changes to the governance and management structure and the expected outcomes from these changes. (Standard 1.1)
- B Investigate opportunities to enhance research in Malaysia and at the rural sites. (Standard 1.7)

Commendation

The exemplary leadership provided by the Deputy Dean and the Faculty Dean. (Standard 1.2)

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

Recommendations

- C Improve students' ability to interrogate the curriculum and identify course outcomes and assessment, through the provision of access to documentation for students, noting that the current mapping of course outcomes is useful for academic staff for the purpose of planning and blueprinting. (Standard 2.2)

- D Refine the common suite of online resources available to students via the Learning Management System (LMS) to ameliorate the current variations in content across sites. (Standards 2.2, 8.2)

3. The medical curriculum	Met
----------------------------------	------------

Standard 3.5 is substantially met.

Condition

- 4 Develop and implement the Indigenous health curriculum across all years of the program. (Standard 3.5)

Recommendations

- E Address the perceived difference in access to resources between Year A and Years 1 and 2 students by ensuring that students have access to all resources that are relevant to their current learning. (Standards 3.2, 4.2)
- F Further develop the Medicine of the Mind curriculum description, assessment tasks, and enhance the readiness of the students for the psychiatry rotation. (Standard 3.2)
- G Report on the ongoing development and implementation of the Interprofessional Education Framework. (Standard 3.2)
- H Provide faculty development for Case-Based Learning (CBL) teachers to support the delivery of the Indigenous health curriculum. (Standard 3.5)
- I Provide faculty development for teaching clinicians to reinforce learning from the Indigenous health curriculum in clinical years. (Standard 3.5)
- J Describe the range and scope of the Scholarly Intensive Projects (SIP) under development for the BMedSci/MD program. (Standard 3.6)

Commendations

The Indigenous health curriculum, and the Collaborative Care Framework which have strengthened the program. (Standard 3.1)

The revision of pathology resulting in an improvement in student outcomes and supportive student evaluations. (Standard 3.2)

The preparation for internship aspects of Year 5D which enable suitable preparation towards 'work-readiness'. (Standard 3.3)

4. Teaching and learning	Met
---------------------------------	------------

Standard 4.7 is substantially met.

Condition

- 5 Increase and embed interprofessional teaching and learning, linked to assessment, throughout the program and ensure ongoing and increased resourcing is available for interprofessional teaching and learning. (Standard 4.7)

Recommendations

- K Review the differences between the Year 2 and Year A learning outcomes and adopt a closer alignment of outcomes and delivery where possible. (Standards 4.1)

- L Review and articulate the curriculum for Year 4C to ensure consistency in the delivery of individual components of the curriculum across sites. (Standard 4.1)
- M Report on changes to the program in response to the graduate-entry students being primarily drawn from the Monash Biomedicine program. As exposure to anatomy is likely to be more homogenous for these students, refinements to the program may be made to reflect this. (Standard 4.1)
- N To complement the recently revised Year 3B curriculum map and booklet which link clinical skills with body systems and conditions, and outline the level of competency expected for clinical and procedural skills; develop similar curriculum documentation for Year 4C and Year 5D. (Standard 4.3)
- O Clarify the expectations for scheduled learning for both students and staff so that students can ensure adequate exposure to opportunities that arise in the clinical environment. (Standard 4.4)

Commendations

The pedagogical principles that underpin teaching and learning methods and the innovative way in which technology enhances the student experience and scaffolds learning. (Standard 4.1)

The extensive, high-quality anatomy teaching for Years 1 and 2 students. (Standard 4.1)

The interactive, immersive, large group DigiLab session. (Standard 4.1)

Innovations in teaching and learning, such as the development and introduction of the MEyeNET online resource to enhance teaching in ENT and ophthalmology. (Standard 4.1)

The many clinical and academic role-modelling opportunities provided to students. (Standard 4.5)

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

Standards 5.3 and 5.4 are substantially met.

Conditions

- 6 Ensure that assessment of the Monash Case Record (MCR) is fit for purpose and consistent across clinical sites. (Standards 5.2, 5.4)
- 7 Establish a process that includes ongoing monitoring of the MCR and faculty development to support consistent delivery. (Standards 5.2, 5.4)
- 8 Implement the process currently employed for providing feedback for the mid-semester assessments in Years 1 and 2 to other written assessments in the program. (Standard 5.3)

Recommendations

- P Make the core elements of the assessment policy available to students via the LMS. (Standard 5.1)
- Q Monitor and appropriately adjust assessment load, with particular regard to the timing of assessment items. (Standard 5.2)

Commendation

The collaborative process used to develop and provide quality assurance of assessments. (Standard 5.2)

6. The curriculum – monitoring	Met
---------------------------------------	------------

Standard 6.2 is substantially met.

Conditions

- 9 Clarify the overall governance, leadership and oversight of the evaluation strategy. (Standard 6.1)
- 10 Provide a clear plan and purpose for the School evaluation strategy that will offer clear direction for the School, the Faculty and other stakeholders. (Standard 6.2)

Recommendations

- R Develop approaches to decrease student survey fatigue as part of the new evaluation strategy. (Standard 6.1)
- S Provide a systematic approach to identifying teaching excellence that aligns to recognition and promotion pathways within medical education. (Standard 6.1)
- T Ensure that feedback loops are embedded in evaluation processes. (Standard 6.3)

7. Implementing the curriculum – students	Met
--	------------

Recommendations

- U Evaluate the impact of the specified entry requirements from Monash biomedical and other degrees to the graduate-entry program on applicants of rural background. Describe how this informs selection criteria and processes. (Standard 7.1)
- V Provide an update on the development and sustainability of the Associate Dean Professionalism and the Senior Administrative Officer roles. (Standard 7.3)

Commendations

The work by the Faculty's Gukwonderuk Unit (Indigenous health) and the School in developing an effective Indigenous student pathway in medicine. (Standard 7.1)

The clear support pathways that are separate to progression and assessment, which are in place at all sites. (Standard 7.3)

The promotion of a preventive approach to mental health and wellbeing. (Standard 7.3)

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

Recommendations

- W Develop effective risk mitigation practices in consultation with students, to ensure personal safety for travel between Box Hill and Maroondah Hospital or William Angliss Hospital. (Standard 8.1)

- X Extend the use of innovative teaching methods such as the DigiLabs, the in-house 3D printed anatomical sections, and the use of SECTRA anatomical imaging, to the Year A graduate-entry cohort. (Standard 8.3)
- Y Establish additional, appropriate placements to improve Indigenous health learning to better facilitate culturally competent Indigenous health care. (Standard 8.3)
- Z Develop processes to enhance safe delivery and promote student learning in the clinical years through ensuring appropriately low numbers of students are in attendance at clinical sessions at all sites. (Standard 8.3)

Commendations

The clinical facilities and the ongoing reinvestment in facilities. (Standard 8.1)

The use of innovative teaching methods such as the DigiLabs, the in-house 3D printed anatomical sections, and the use of SECTRA anatomical imaging. (Standard 8.3)

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 the Medical Deans of Australia and New Zealand. The Committee also includes a member of the Council, a member with background in, and knowledge of, health consumer issues, a Māori person and an Australian Aboriginal or Torres Strait Islander person.

The AMC appoints an accreditation assessment team to complete a reaccreditation assessment. The medical education provider's accreditation submission forms the basis of the assessment. The medical student society is also invited to make a submission. Following a review of the submissions, the team conducts a visit to the medical education provider and its clinical teaching sites. 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 2017*. 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

Monash University was established in Victoria in 1958, and is one of Australia's leading research universities.

Monash University offers a large number of courses across a broad range of faculties including:

- Science
- Pharmacy and pharmaceutical science
- Law
- Information Technology
- Engineering
- Education
- Business
- Arts, humanities and social sciences
- Art, design and architecture
- Medicine, nursing and health sciences.

In 2016, 73,807 students were enrolled in Monash University programs. Of these, 44,330 were domestic students, 19,076 were international students and 10,401 students were offshore.

Monash University has multiple campuses both in Australia and internationally. Monash campuses in Victoria include Clayton, Berwick, Caulfield, Parkville and Peninsula, while international campuses are located in Malaysia and South Africa.

The Faculty of Medicine, Nursing and Health Sciences contains 11 discrete functional units of which Medicine is one. The Monash medical program is the largest in Victoria and includes foundation year programs at Clayton, the Jeffrey Cheah Medical School at Monash Malaysia and a graduate-entry program in Gippsland. The School has a footprint across metropolitan Melbourne, rural Victoria and Malaysia, organised into clinical schools. The medical program has three main campuses:

- Clayton (Metropolitan Melbourne) is the central Australian campus with overall management of the medical program across all sites
- Gippsland (Rural)
- Malaysia.

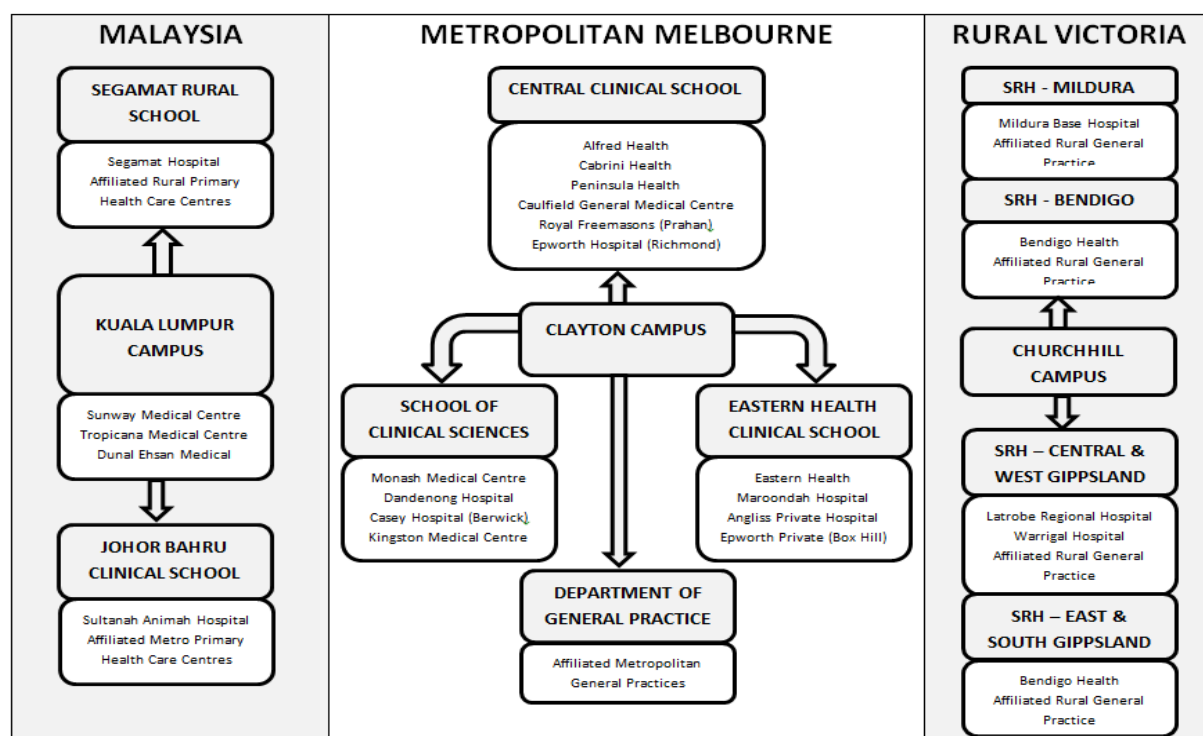
The Metropolitan Melbourne Campus includes three metropolitan clinical schools:

- Central Clinical School (based at the Alfred Hospital)
- Eastern Health Clinical School (based at Epworth Private Hospital and Box Hill Hospital)
- School of Clinical Sciences (based at Monash Medical Centre).

Additionally, the program has a geographically dispersed Rural Clinical School and a Malaysian Clinical School. Each of these clinical schools with their affiliated clinical academic units is coordinated by its respective campus. Figure 1 describes the relationship between the campuses, clinical schools and affiliated sites.

Affiliated general practices and primary health care centres are managed through the Department of General Practice in metropolitan Melbourne, through Johor Bahru and Segamat in Malaysia and through the School of Rural Health in rural Victoria. The central Australian campus at Clayton has an overarching responsibility for the governance and management of the entire medical program.

Figure 1: Relationship between Campuses, Clinical Schools and Affiliated Sites



The student intake has remained relatively stable over the past five years, with Australian places being predominantly Commonwealth Supported Places (CSP). Table 1 shows enrolment numbers at each Campus for 2017.

Table 1: Student numbers for 2017

	Total CSP	Fee paying domestic	Fee paying International	Total
Clayton	1187	9	311	1507
Gippsland	294	1	44	339
		Malaysia domestic	Malaysia International	Total
Malaysia		526	56	582

There is a planned increase in student numbers for Monash Malaysia from 582 in 2017 to 650 in 2021, due to an increasing number and variety of clinical placements becoming available.

Monash University has a vision of medical graduates who are “knowledgeable, skilled and compassionate and advocates for the individuals and communities they serve”. They aspire to graduate doctors who are culturally and socially representative of the communities in which they practise.

Accreditation Background

The AMC first assessed the Monash University’s Faculty of Medicine, Nursing and Health Sciences’ six-year undergraduate medical program in 1993, and granted the maximum period of accreditation until June 2003.

In 2001, the AMC conducted a major change assessment of the Faculty’s proposed change to a five-year Bachelor of Medicine, Bachelor of Surgery (MBBS) program and accreditation was granted until 31 December 2008.

In 2006, the AMC assessed plans to offer the Monash medical program offshore in Malaysia. The AMC granted the changed program accreditation to 2010 subject to an additional assessment visit to the Jeffrey Cheah School of Medicine in Malaysia in 2008, and annual reports on operations at both Monash Malaysia and the Monash program as a whole.

In 2007, the AMC assessed plans to introduce a four-year, graduate-entry MBBS program at the Gippsland Campus. The AMC granted accreditation of the entire Monash University medical program at all three schools until two years after the first cohort graduation from the new graduate-entry program; that is until 31 December 2013, subject to a number of conditions, including follow-up visits to Malaysia in 2008 and Gippsland in 2009. In 2008 and 2009, the AMC conducted follow-up assessments, and confirmed the 2007 accreditation decision.

The MBBS programs (both the five-year and four-year graduate-entry streams) were assessed in 2013 in conjunction with the Faculty's comprehensive report. The Faculty was granted an extension of accreditation until 31 December 2017, subject to satisfactory progress reports and reports on conditions.

The Faculty submitted satisfactory progress reports in 2014, 2015 and 2016.

In October 2015, Monash notified the AMC of its intention to transition its MBBS program to a Bachelor of Medical Science / Doctor of Medicine (BMedSci/MD) program, commencing in 2017. The AMC determined that the proposed changes did not constitute a major change to the program.

This report

This report details the findings of the 2017 accreditation assessment.

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

The members of the 2017 AMC team are at **Appendix One**.

The groups met by the AMC team in 2017 in Malaysia are at **Appendix Two**.

The groups met by the AMC team in 2017 in Melbourne are at **Appendix Three**.

Appreciation

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

1 The context of the medical program

1.1 Governance

- 1.1.1 The medical education provider's governance structures and functions are defined and understood by those delivering the medical program, as relevant to each position. The definition encompasses the provider's relationships with internal units such as campuses and clinical schools and with the higher education institution.*
- 1.1.2 The governance structures set out, for each committee, the composition, terms of reference, powers and reporting relationships, and allow relevant groups to be represented in decision-making.*
- 1.1.3 The medical education provider consults relevant groups on key issues relating to its purpose, the curriculum, graduate outcomes and governance.*

The Monash medical program is very large and dispersed, and is conducted at both metropolitan and rural sites across two countries. The program includes direct-entry programs at Clayton, Victoria, the Jeffrey Cheah Medical School at Monash Malaysia in Kuala Lumpur and a graduate-entry program in Gippsland, Victoria.

To manage this large dispersed program, the Faculty has developed a robust governance structure that closely maps to the high-level management processes required to deliver quality teaching and learning across streams and sites. The governance model has undergone significant change as a result of feedback from the 2013 AMC review, and the current structure now places key responsibilities and decisions in the hands of a nine-member Medical Executive group. The new structure extends to the Monash Malaysia program with effective representation on the Medical Executive. The Medical Executive is chaired by the Deputy Dean who in turn reports to a supportive Faculty Dean. The team was confident that this new structure has significantly improved high-level decision making, replacing the previous cumbersome and large committee approach. Strong unity and purpose within the Medical Executive was clearly evident.

The Medical Executive group appears to be working well with the structure being understood by most staff and students but perhaps less well understood by clinical staff at some of the rural sites. The School acknowledges that effective governance remains a work in progress. For example, the functions of the central governance structure were not always well understood or connected with all sites.

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 Faculty has an appropriate level of autonomy with the authority to design a program that meets the needs of both Australian and Malaysian communities while remaining within the bounds of the University policies and procedures. The Malaysian curriculum mirrors the Australian curriculum, with informed contextualisation supplied by Australia to the Malaysian context and vice versa. This ensures graduates are prepared for practice in both Australia and Malaysia. The Jeffrey Cheah School of Medicine and Health Sciences (JCSMHS) is required to meet Malaysian Medical Council (MMC) standards as well as Australian accreditation standards.

The Monash program has exemplary leadership through the Deputy Dean who reports directly to a supportive and engaged Faculty Dean.

A great strength of the program is that it exists within an internationally renowned research faculty that has enormous capacity across a range of disciplines, particularly in biomedicine. In this regard, substantial funding is available, much of which is used to support the training of Monash medical students. This has further influenced the appointment of high-quality, research-led academics and

clinical staff who take pride in producing Monash medical graduates. This pride was readily apparent in Australian and Malaysian students.

1.3 Medical program management

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

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

The Medical Executive group has overall authority for the planning and implementation of the programs. It includes appropriate representation from JCSMHS in Malaysia. Strategy, design, and change of the medical program is overseen by a small but effective Medical Executive comprised of the Deputy Dean, the Directors of each of the main MBBS management committees - Curriculum, Early Years, Clinical Years, Assessment - as well as the Director of Rural Health, Head of Monash Malaysia, and the Senior Manager and Finance Manager. The future governance structure of the BMedSci/MD program is yet to be articulated, but is likely to mirror the MBBS structures somewhat. The committee members are competent and engaged senior academics who take responsibility for their domains, reflecting the effective delegation evident in the new governance structure.

Overall curriculum design and integration is overseen by the Curriculum Committee, which has 20 members representing all areas of the program. The Deputy Dean currently chairs the Curriculum Committee, although the Director of Curriculum is expected to become the chair in 2018. The Curriculum Committee works in parallel with the Assessment Committee to ensure there is alignment between curriculum and assessment. Malaysian representation is integral to all curriculum committees, so there is a single, integrated structure, rather than a parallel governance structure with effective engagement between leads in the two countries.

While the governance structures are robust and the committee membership is appropriate, the team notes that there is still work to be done to bed down the new governance arrangements across the distributed program particularly in the area of communication.

The accreditation standards set by the Malaysian Medical Council (MMC) prescribe slightly different requirements to the AMC accreditation standards and the program must undergo additional accreditation by the MMC in order to demonstrate that these are also met. Interprofessional learning is not as strongly emphasised by the MMC and the expectations of the MMC in Indigenous health outcomes are also different between the MMC and the AMC. There was general agreement on the need for adaptation of content to conform to the MMC standards and expectations while still meeting the requirements for AMC accreditation. The MMC requires providers to use external examiners to ensure assessment quality. This is met through Australian examiners observing clinical examinations at the JCSMHS, and vice versa. These minor variations in accreditation requirements do not pose a significant difficulty, rather they provide opportunities for mutual benefit and improvement of program delivery across two countries.

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.

Monash University introduced new Education Performance Standards in 2016. These consist of six defined teaching and learning criteria. New academics must undergo a foundation training program unless they have an equivalent accredited certificate or degree.

There is considerable diversity of expertise available for the development of the medical program. The Monash Centre for Scholarship in Health Education (MCSHE) was launched in 2017 to replace HealthPEER, which did not meet the program's needs for curriculum expertise and professional development. MCSHE will provide staff training and development opportunities, although the team notes that MCSHE's role in faculty development is yet to be fully realised. Opportunities for

professional development for staff in education-focused roles could be realised through this structure. The recent appointment of a Deputy Director with responsibility for short course development will assist in this regard.

There is a strong interprofessional program led by a team of committed academics which has strong support from faculty leadership. A structured Interprofessional Education (IPE) framework has been developed and several examples were provided of its successful implementation across the three levels of novice, intermediate and preparation for practice. The assessment team looks forward to hearing more as this work progresses.

There are seven Indigenous academics in the medical program who have worked with staff to develop an Indigenous health curriculum. The Indigenous health program is the responsibility of the Faculty Indigenous Curriculum Committee. The committee has representation from all health professions and a strongly collaborative approach has been adopted for curriculum development. The Gukwonderuk Unit was established in 2015. Development and implementation of the Indigenous health curriculum into the medical program is led by the medical program's Indigenous health Curriculum Assessment Lead (CAL) who is responsible for embedding new Indigenous learning outcomes into the medical curriculum. The unit Director is a member of the Faculty's Coursework Approvals and Program Committee. While still evolving, there is clear evidence that the work of the Gukwonderuk Unit is now becoming integrated into the curriculum design.

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 roles, responsibilities and lines of reporting are well articulated across the program. At the highest level, the Deputy Dean reports directly to the Faculty Dean who has ultimate responsibility for budget casting and annual financial allocation. Funding flows directly to the Clinical Schools which are each responsible for their own budget. The Deputy Dean is involved in new business plan developments for initiatives that affect the medical program and influences how resources might be allocated to benefit the teaching and learning of medical students. The Faculty finances are sound and significant funding is directed towards the medical program. Benefits of this support were seen in many innovative projects across the themes and years, such as anatomy teaching and the DigiLabs.

Recruitment and retention of staff is sound despite the Faculty operating within a highly competitive global market. This reflects the willingness of the Dean to approve necessary appointments at competitive remuneration. There has been significant investment in new appointments across the Faculty and the medical program has ultimately benefited with high-quality academic, research and professional staff.

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.

There is a strong relationship between the Faculty and health service providers with effective partnerships in place with many teaching hospitals. There is a rational and equitable model for the employment of experienced clinical educators by the University. Formal agreements exist with all hospitals that provide clinical training placements as well as many community-based placements. There is active involvement of community groups, an example of which was observed in Segamat in Malaysia and the School of Rural Health program through community-based attachments, community care and aged care visits.

1.7 Research and scholarship

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

The Faculty has an exceptional reputation in research and scholarship and this is reflected in the high-quality, research-active staff that contribute to the medical program. Research and scholarship permeates through all levels of the medical program including the students, many of whom choose to do a research degree at some stage during their medical training. The move to an MD program reflects a desire to ensure all medical students engage in research during their training.

While research is exceptionally strong at the Clayton campus where there are extensive facilities and resources, it is understandably less strong in Malaysia and at the rural sites although there is a clear intention to offer high-quality BMedSci Hons projects in the School of Rural Health. A program of rural health research is under development, with some opportunities being presented by the planned BMedSci/MD qualification.

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 Faculty has expertise in the diverse range of disciplines required to implement such a dispersed medical program - both at the academic and professional staffing levels. Fractional appointments for an MD lead have been made at all sites. Despite this, the implementation of the BMedSci/MD program should be monitored to ensure that there is adequate capacity to meet project supervision requirements. Resourcing of the program may need to be adjusted as the BMedSci/MD program is progressively implemented.

The Faculty has appointed four Indigenous academics who actively contribute to the development of the Indigenous health curriculum. These staff report that they are well supported by the Faculty.

The School has appropriate processes for the recruitment and training of simulated patients. Word of mouth makes a significant contribution to the recruitment of simulated patients in both Malaysia and Australia. Generic information is available via the School website and formal training is given at a date that is close to the session in which the simulated patient will participate.

The team was impressed with the active involvement of skilled clinical educators that it met and of a variety of community groups through the community-based attachments, community care and aged care visits in the clinical years.

The University indemnifies all staff.

1.9 Staff appointment, promotion and 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 appointment and promotions policies and procedures are well established and appropriate.

The traditional 40:40:20 workload model has given way to a more flexible approach whereby staff may be appointed and promoted on a "relative to opportunity" basis, which assists in making critical appointments to roles where specialist teaching may dominate over research. This is particularly relevant with clinical educator appointments to formal Professional Practice roles, however there is still a strong expectation of active research for higher level appointments at Associate Professor and Professor level. This does not appear to impact on the staffing profile of the program and the ability to recruit and retain high-quality clinical academics and clinical educators.

2 The outcomes of the medical program

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

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 stated purpose of the medical program is to prepare 'graduates for medical practice with a strong focus on patient safety as well as enhanced research and professional practice skills to equip Monash Graduates to improve the health of our communities locally and globally.' Safety is emphasised as an important part of the program, and coverage of this aspect has been enhanced in the BMedSci/MD program. The School describes a commitment to internationally-recognised excellence and innovation in research and research translation, and teaching, aiming for international impact with research and teaching scholarship. The range of stakeholder groups is therefore broad.

Additionally, each Clinical School describes their strengths or purpose. Clear attention is given by some Clinical Schools to their contribution to internationally-recognised high-impact research and 'improving rural health and developing a sustainable rural health workforce.' The purpose of the Rural Clinical School is to improve the rural workforce and health of rural communities.

The Monash Malaysia iteration of the program has a stated purpose to train doctors for Malaysian Society, with the website noting that the JCSMHS offers programs (including Medicine) 'that provide a global perspective and research-intensive focus to address important theoretical and practical challenges in the field of medical and health-sciences.' The JCSMHS notes that it places 'great emphasis on the quality of its education and research that will go a long way to improve human life and enable its graduates to excel in the increasingly globalised world.' The purpose is also to offer an international standard of teaching and learning with an integrated curriculum, and 'critical thinking, self-directed learning, reflection and professionalism', which is a style that differed favourably from many of the other medical programs in Malaysia.

The collaboration with the JCSMHS has grown from a longstanding relationship between Malaysia and Monash University. Malaysian students have been coming to Monash University in Australia to train for many years, however training in the medical program has increasingly been challenging because of the financial and social costs to students. In addition, there were significant resources in Malaysia, which were not being utilised. The program appears to meet the needs of Malaysian students as approximately two thirds remain in Malaysia after graduation.

In acknowledging the importance of Aboriginal and Torres Strait Islander people and their health, and in response to feedback from the 2013 AMC assessment, the Monash Faculty of Medicine, Nursing and Health Sciences has established the Gukwonderuk Unit, which has achieved significant development of the Indigenous health curriculum in a short period of time. The Faculty is working with the Gukwonderuk Unit and Aboriginal elders to better define graduate attributes and produce a statement of commitment to Aboriginal and Torres Strait Islander peoples and their health. This will help guide the curriculum development and implementation.

There is an acknowledgment of societal and community responsibilities through a strong international focus on scholarship and research with a lasting impact. Monash Malaysia has a stated desire to influence the health services of Malaysia. Public health, basic research, exposure of students to Aged Care and General Practice in Australia, which are not well developed in Malaysia and novel clinical attachments are seen to be significant components of working towards achieving that aim.

The stakeholders for the School include both Australian and international communities. Examples of close and ongoing consultation include Aboriginal Elders, consumer representatives, many health-related organisations at a state level, including the Prevocational Medical Council of Victoria (PMCV), the individual health services that train students and employ graduates, and rural communities.

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 objectives and outcomes of the program are well stated and align with the AMC Graduate Outcomes. The outcomes for the Malaysian iteration of the program are exactly the same as those for the program run in Australia. The emphasis is on producing graduates who are able to work under supervision with the appropriate foundation upon which to build and develop their expertise during further training.

The mapping of program outcomes is useful for academic staff in terms of planning and blueprinting assessment but is not always available in a usable way to the students. Clear learning outcomes, linked with curriculum activities have been articulated in the newly developed Year 3B curriculum document. This has been very helpful for students in Year 3B and a similar approach would be welcomed by students in other years to help guide the depth of study required.

The program has been implemented equitably across the sites, with shared outcomes, equivalent clinical experience and coverage of core topics. The team notes a number of differences across clinical sites including the support material available through Moodle, attention to recording attendance, and the practice of workplace-based assessments, where variation was noted both between assessors and across sites. For example, some Clinical Schools named the assessor and time for the assessment whereas other centres implemented the assessment more flexibly. Malaysian students did not voice any concerns about being disadvantaged in comparison with colleagues at any other site. The Monash Case Review (MCR) assessments were also felt to vary as much across assessors as across sites.

General practice looks very different in Malaysia and Australia and an equivalent experience cannot occur, however Malaysian students advised they felt prepared to work as an entry-level doctor in

both countries and considered understanding the two systems allowed them better insights into the strengths and limitations of each system.

Although many Schools did not wish to share Moodle resources with students from other sites for fear of overburdening and stressing them with excess content, allowing access to resources may encourage students to evaluate their needs and take responsibility for their learning, which is an aim of the medical program.

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.

Monash is an extensive medical program, which includes a five-year direct-entry cohort, a four-year graduate-entry program and a Malaysian offshore program that mirrors the direct-entry program exactly. Overall, the program caters for about 2,400 students.

The program is delivered as an integrated curriculum, with semester-long units taught by staff across the faculty in a range of teaching environments including both campus and clinical settings. The early years of the program are largely campus based and cover an introduction to the basic medical and social sciences. The clinical years of the program are conducted in clinical settings in metropolitan Melbourne, rural Victoria or in Kuala Lumpur, Johor Bahru or Segamat for Malaysian students.

Additions to the curriculum since the last AMC assessment in 2013 include the Indigenous health curriculum, the Collaborative Care Framework and the online Monash Eye, Nose Ear Throat (MEyeNET) resource. These additions have strengthened the program.

While originally designed to attract graduates from any degree or university, the graduate-entry program now draws students primarily from selected Monash science-based degrees, with the majority now coming from a Monash biomedical science degree, the content of which is very similar to the Years 1 and 2 of the MBBS program. The Years 1 and 2 (direct-entry) and Year A (graduate-entry) programs contain comparable content and are assessed similarly, but have different intended learning outcomes. The team notes that outcomes for Years 1 and 2 are clearer and more specific than some for Year A. As the cohorts move into Year 3B however, their subsequent assessments and progress are not separable.

The curriculum is comprehensive and there is suitable time to deliver it.

Monash is implementing a BMedSci/MD program to supersede the current MBBS program. From 2020, Year 5 will include a Scholarly Intensive Project (SIP). The SIP will be scaffolded by a series of modules designed to develop an understanding of research methods and skills in Year 3B. These modules provide a practical foundation to the SIP, which takes the form of a formal, 12 credit point research or professional practice project. The program includes sufficient time for this to occur without impacting on clinical teaching.

3.2 The content of the curriculum

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

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

3.2.2 Clinical Practice: The medical graduate as practitioner.

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

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

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

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

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

The curriculum includes the scientific foundations of medicine to equip graduates for evidence-based practice and the scholarly development of medical knowledge.

Pathology has been substantially revamped and organised, and students report that the extension into clinical years is relevant and helpful. The assessment of learning demonstrates improved outcomes and positive student evaluations.

Pharmacology has been reviewed in Years 1 and 2, and Year A and is to be enhanced in Year 3B, noting that safe prescribing, use of medicine-wise and use of the UK-based PSA tool is well covered in Year 5D.

Testing in Years 3B and 4C suggests that the outcomes from the anatomy curriculum are equivalent for the Year A graduate-entry cohort, despite apparently having less access to resources via the LMS than the direct-entry cohort. However, equal access to resources for each cohort would be beneficial and may ease student concerns of perceived differences.

Year 3B is mapped to the four Monash themes and is described in the comprehensive 3B curriculum document. This document maps core medical and surgical conditions to systems. This document also serves as a template for subsequent years, and describes the clinical practice curriculum for Years 3B to 5D. The document maps common conditions and presentations and ascribes ratings related to how common and how relevant to practice the condition is. The clinical practice of medicine and surgery is well covered.

The patient safety module of the program has good applicability in Year 5D. The module has core content that is covered across the year at each site and it is suitable for interactive teaching and learning.

The Medicine of the Mind curriculum description, assessment tasks, and the readiness of the students for the psychiatry rotation could be enhanced. Learning principally occurs during the clinical placement, so a well-described curriculum would assist students in achieving the outcomes associated with the rotation. The team notes that an internal review of the Medicine of the Mind curriculum is currently underway and is interested in the outcomes.

The MD Research Methods Module provides students with the research-biostatistics learning required to support the SIP, as well as preparing them for future work as an intern and beyond. The SIP will extend the current research learning opportunities and enhance literature review and clinical research knowledge and skills for graduates through research modules in Year 3 and through the project itself. Plans for the SIP are well developed and the School has begun to employ staff to support the projects at each site.

There is extensive teaching of ethics in the early years, which evolves in the clinical years into student learning about ethics and ethical dilemmas in clinical practice and professional standards. The program has a detailed ethics curriculum, led by clinicians, and ethics and professionalism is taught from year one. Monash has responded to current health system professionalism issues.

The School has a great number of innovative teaching initiatives that it employs as a core component of its curriculum. Two specific examples include the partnerships and collaborative teams that have developed the Indigenous health curriculum, and the Collaborative Care Committee. These initiatives involve multi-disciplinary teams, shared learning outcomes and community stakeholder involvement. The Collaborative Care curriculum speaks to patient-centred care and respect for other health care team members. The Women's Health Interprofessional Learning through Simulation (WHIPLS), delirium and interprofessional workshop days are other positive developments that are explicitly concerned with collaboration and teamwork skills.

3.3 Curriculum design

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

Pre-clinical teaching is campus-based, with the direct-entry program run in Malaysia and at the Clayton campus. The graduate-entry program is conducted in Gippsland. The year is divided into two, 12-week semesters, in which students cover:

- Theme 1, Ethics and Law
- Theme II, Social Determinants of Health (population science), Research Skills and Community engagement
- Theme III, Clinical Sciences, consisting of Anatomy, Biochemistry, Immunology, Microbiology, Pathology, Physiology, and Pharmacology
- Theme IV Clinical Skills.

Purposeful design of the curriculum is aligned to the four Monash themes which, in turn, are aligned to the AMC graduate outcomes. The themes are explored primarily through case-based learning (CBL) tutorials, supported by a range of participation structures including lectures and online resources.

Curriculum Assessment Leads (CALs) are working well and they reported a great deal of collegial and collaborative work. These key positions provide links between the School's committees and disciplines across multiple sites to enable cohesive and consistent curriculum delivery and the incorporation of assessment across domains and disciplines. The CALs also have an important role in curriculum development.

Since the last AMC accreditation, the School has reviewed Themes I, II and IV. The School is currently reviewing Theme III.

The School has developed five longitudinal maps to support skill acquisition across the program. These maps cover clinical skills broadly and are separated into five separate areas:

- learning outcomes
- history, examination and communication
- diagnostic procedures and test interpretation
- management and clinical reasoning
- procedural skills.

The maps provide recommendations about whether students should be observing the skill, performing it in the simulated setting, or performing it in the clinical setting with clinical supervision, each according to year level. The maps seem conceptually sound but are not yet in widespread use. Currently students make reference to clinical skills logbooks and the timetable.

Year 5D, the final year of the program, is structured to reflect a trainee internship model which is designed to facilitate the transition of graduates into the intern role on graduation. Alongside the core rotations of medicine, surgery, emergency medicine and aged care, students may select a specialty rotation that is of personal interest. These aspects of Year 5D have made a positive impact with students and enable suitable preparation towards 'work-readiness'. In addition, the spread of patient safety learning opportunities through Year 5D is appropriate and timely.

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.

Learning outcomes, objectives and assessment for each unit are described in the unit outlines, which are available to all students via the LMS. The learning outcomes for each CBL scenario are likewise included in the relevant CBL guide.

The curriculum for Years 3B to 5D is generally well described. Curriculum documents for all years, akin to the Year 3B curriculum document, will guide students regarding the expected level of

learning and are under development. These will assist faculty and clinical teachers in integrating content throughout the program, including at the clinical interface.

3.5 Indigenous health

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

The Indigenous health curriculum has been progressively expanded and embedded since the last AMC accreditation, especially in the first three years of the program. Key staff have been appointed and the Gukwonderuk Unit has been a major contributor to the effectiveness of the developing Indigenous health curriculum. Content for Malaysia includes Australian content but also material related to Malaysian Indigenous peoples, which students found helpful. The team looks forward to updates on the implementation of the Indigenous health curriculum across all years of the program.

While the Indigenous health curriculum is embedded in case-based learning (CBL), strengthening the focus on this important aspect would be beneficial. Faculty development to support this for CBL teachers may be beneficial. Similarly, clinicians would benefit from training in the Indigenous health curriculum to reinforce learning in clinical years.

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.

Diversity of clinical sites is a feature of the program. The School has a footprint in urban, regional and rural sites in addition to sites in Malaysia and it is possible to move between urban and rural settings during Years 3B to 5D. Malaysian students have a 12-week clinical rotation to an Australian clinical setting.

Currently students undertake a six-week elective rotation in Year 5D of the program. The introduction of the BMedSci/MD program will see the loss of the elective term after 2019, which will represent a notable decrease in student choice for rotations. However, diversity and choice could be developed through the range of SIPs and students will continue to have the opportunity to undertake a selective or specialty rotation of their choice from 2020 as is the case with the current program.

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 School utilises a range of learning and teaching methods across all years of the program to achieve the program outcomes. This is deliberately driven by the recognition that students learn in different ways. The team was impressed with the pedagogical principles that underpin many of these methods and the innovative way in which technology enhances the student experience and scaffolds learning. The School is innovative in this area and is well supported and encouraged by the Faculty and the University. Technology enhancement of learning and teaching is well supported and resourced by eLearning services, the Education Design Unit and the Teaching Resource Support Unit. Across the program a blended learning and teaching approach is used at both the Australian and Malaysian campuses. Resources, available on the Moodle LMS, support the face-to-face learning and teaching.

Teaching methods used in Years 1 and 2 align closely between the Malaysian and Clayton campuses. The postgraduate Year A at the Gippsland campus is less closely aligned, creating some challenges for this student cohort. In particular, the teaching of anatomy in Year A of the course at the Gippsland campus is viewed by students as not equivalent to the Clayton experience.

In the pre-clinical years, lecture-based delivery is supported by audio-visual online access to the lecture material for students across the Malaysian and Australian sites. Lecturers at both sites use the same basic slides with local contextualisation or additional content to ensure relevance to Malaysia. Individual learning is supported by online modules and self-directed tasks. A notable example of this is the newly designed Pathology curriculum. Students have access to core pathology lectures, self-assessment quizzes and the Online Virtual Museum of Pathology. Small group teaching occurs in the form of seminars, PBL sessions, clinical skills tutorials, simulation sessions and practical classes. Students can access resources such as pre-reading material and self-directed formative assessments to guide understanding prior to and following delivery of some sessions. Technology such as the Verso software application is used effectively to trigger peer-to-peer and student-to-tutor discussions.

A flipped classroom model is introduced early in the course. PBL sessions begin in Year 1 / Year A of the course and continue throughout the program. This density of content in the graduate-entry program means that this form of delivery provides some challenges for the Year A cohort.

The recently introduced DigiLab sessions have been well received by students. The team commends these interactive, immersive large group teaching sessions, with IT enhancement. These sessions are conducted in a large, flat teaching and learning space and allow an academic, multi-disciplinary team to introduce new concepts and consolidate learning. Students find these sessions very useful to help integrate the clinical sciences into patient care and to define the depth of knowledge required, particularly the Year A cohort. New, flat teaching and learning spaces, which are currently under construction, will enable the expansion of these sessions.

The students hold the anatomy teaching at the Clayton campus in Years 1 and 2 in high regard. Learning is enhanced by a well-constructed program underpinned by good pedagogical principles and delivered by dedicated and passionate staff. In Malaysia, the MAPEL (Medical Anatomy and Pathology E-learning) Lab, including "smart tables" is similarly well received by students. Students in Year A come to the graduate-entry program with some knowledge of anatomy, therefore teaching in this area involves less contact time than that which is experienced by students in Years 1 and 2. There is also no dissection component for Year A students. Commencing in 2017, graduate-entry students will become more homogenous in their exposure to anatomy, as the cohort will mostly be drawn from Monash Biomedicine graduates and this could result in the program becoming better tailored to student needs. The team is interested in developments in this regard.

The three clinical years (Years 3B, 4C and 5D) of the program are delivered over a number of dispersed sites, broken into two, 18-week semesters. Teaching and learning is primarily hospital and community-based. In Year 3B, students cover Medicine, Surgery, Pathology and Population Health. Students also complete an Evidence-Based Clinical Practice module. In Year 4C, students cover General Practice, Medicine of the Mind, Children's Health and Women's Health. Year 5D is a pre-intern, preparation for practice year. Currently this year consists of Medicine, Surgery, Acute Care (Emergency), Aged Care, a specialty elective and a patient safety module.

As noted previously, the introduction of the BMedSci/MD program will see the loss of the elective term, with this being replaced by a SIP. The Patient Safety Module will also be enhanced to enable students a degree of choice in exploring an area of personal interest. During the clinical years, the teaching and learning methods used are more dependent on capability at the different sites, but align with respect to learning objectives and summative assessment, which are the same across all sites. The team commends the innovative improvement in teaching and learning, such as the development and introduction of the MEyeNET online resource to enhance teaching in ENT and Ophthalmology.

Students are primarily based in the clinical environment (hospital or community) in the clinical years. Clinical immersive learning is supported by back-to-base teaching sessions at the metropolitan campus or clinical school sites. The curriculum and associated learning objectives for the individual clinical attachments are available on a common Moodle site, administered from the central Clayton campus. Individual clinical sites have additional content on Moodle which is only available to students at that site. Learning opportunities could be improved for all students if all of these resources were made available to the whole student cohort.

Teaching methods are similar across the clinical sites and include lectures, PBL, small group tutorials, bedside teaching, skills and simulation sessions, and case-based discussions. However, the delivery of individual components of the curriculum varies across sites for some of the required learning objectives, which is problematic for students for some parts of the curriculum. For example, delivery of the Evidence-Based Clinical Practice unit occurs in a shorter block in rural sites than in the metropolitan sites, and rural students therefore considered this placed them at a disadvantage. Some students in Year 4C also reported that teaching of Medicine of the Mind was different between the metropolitan and rural campuses. Consequently, students felt disadvantaged in the final assessment. The team notes that a review of curriculum for Year 4C is planned and that this represents an opportunity to address these issues.

All students have the opportunity to access opportunistic teaching within the clinical setting in both Australia and Malaysia. Students are encouraged to participate in the health services education programs such as, junior doctor teaching sessions, grand rounds, and X-Ray meetings amongst other opportunities in both the acute and community settings.

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.

Several teaching methods focus on approaches that are inquiry-orientated. This includes PBL and Clinical Skills Sessions, as well as the large group DigiLab sessions. Through these tasks and sessions, students develop problem-solving skills, skills in teamwork and collaboration, intrinsic motivation and approaches to self-directed learning. Ultimately, this lays the foundations for students to take responsibility for their own learning.

Students are supported to become self-directed learners early in the course. Two one-hour PBL teaching sessions commence in Year 1 and Year A of the course. In the first one-hour session, students are given the case study or problem and are encouraged to generate learning issues. The students then report back on these issues in the second session. Students from Malaysia reported that this was quite different from typical Malaysian high school teaching and enjoyed the change. The PBL, flipped classroom model, continues throughout the course, with the level of supervision and guidance given by the facilitators reducing over time.

The Moodle platform is populated with multiple resources. Material is arranged week by week, as well as by themes. This enables students to take responsibility for their own learning. Some resources, generated at the clinical sites, are only available to students located at that clinical site. Equity of access to all material on Moodle, across clinical sites, would enhance self-directed learning for all students.

The program encourages students to evaluate their learning – for example the quarterly online self-assessment modules in pathology. DigiLab sessions are supported by pre-session, in-session and post-session quizzes. Students can use these quizzes to evaluate their performance and test it against the cohort. In Anatomy, students are allocated scenarios and questions prior to teaching sessions. This is supported by the Verso active learning app. Questions are circulated to students via this app prior to the session. During the session, students work through the questions in small groups, facilitated by roving tutors.

The Evidence-Based Clinical Practice program is appreciated by students and helps them develop life-long skills in searching and appraising the literature. The introduction in 2018 of the online Research Methods Modules in Year 3C, as part of the BMedSci/MD program, will also enhance learning in this area.

4.3 Clinical skill development

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

The program features a well-developed clinical skills component, which promotes the progressive accumulation of the students' clinical and technical skills in a safe environment prior to use in clinical practice.

Clinical skills teaching is well articulated across the program. In the early years, clinical skills are taught in tutorials and workshops, although in Gippsland, Year A students also have early exposure to real patients. The focus in the pre-clinical years is on body systems, and the approach to history taking and examination skills is highly structured. Simulated patients and Clinical Teaching Associates are used for novice training in history taking and examination skills, while procedural skills are taught using part-task trainers in the simulation setting. The School is currently trialling the use of Pebble pad technology to record clinical skills in Year 1. This cloud-based learning space is being used in the delivery, assessment, feedback and remediation in clinical skills and competency assessments. Students track and reflect on their progress, particularly on their competencies within the clinical skills domain. The School plans to extend its use beyond Year 1 to become an integrated clinical skills and competency logbook.

In the clinical years, clinical skills teaching is based in the clinical environment, however, workshops, tutorial and simulation sessions continue throughout the course. There are currently five stand-alone clinical skills logbooks to support skills teaching and learning for the clinical years.

In Year 3B, bedside teaching is structured, with students encouraged to practise history taking and examination skills at the bedside with real patients. Simulated practice continues and students are observed three times with patients for each skill before being able to perform the skill unobserved. The recently revised Year 3B curriculum map and booklet link clinical skills to body systems and conditions, and describes the level of competency expected for clinical and procedural skills. These will be very useful documents for students and academics in the future to guide clinical skills learning and teaching. Similar documentation is planned for Years 4C and 5D and the team looks forward to seeing these.

4.4 Increasing degree of independence

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

The use of simulated patients and Clinical Teaching Associates in the pre-clinical years allow students to develop core skills prior to using these in the clinical setting. Simulation is used for learning procedural skills. In the early years, students are initially introduced to patients through supervised GP visits and a hospital visit. Students in Year A at Churchill have early supervised exposure to real patients with regular hospital visits.

The community- and hospital-based clinical immersion from Year 3B onwards provides students with many opportunities for direct patient contact in hospital wards, outpatient departments, community clinics and in general practices. Students are exposed to a great variety of patients and conditions, as well as health care teams and settings. Lectures, tutorials and simulation sessions continue throughout these clinical years. Some students report that these scheduled sessions sometimes detract from their ability to fully integrate into the clinical team. Clarification for both students and staff of the expectations for scheduled learning during clinical placements may be beneficial in ensuring adequate student exposure to opportunities that arise in the clinical environment.

Supervision is gradually reduced over the course, with the pre-intern program in Year 5D allowing students to work more independently and make an active contribution to the health care team. In Year 5D, students shadow the intern and residents of the unit to which they are attached, taking part in all the activities of that unit. Students report feeling well prepared for internship.

4.5 Role modelling

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

The School recognises the importance of role modelling in both clinical practice as well as research. Role modelling for academics and students is set and led through the leadership of the School and Faculty. Careful selection of clinicians to academic positions ensures good clinical behaviour can be modelled by staff.

In Malaysia, students in Years 1 and 2 reported that they were impressed with the academic credentials of their teaching staff and considered them to be approachable and encouraging, unlike their previous experiences as (school) students. The team met with enthusiastic and committed research leads in Malaysia, who taught in the program. In Years 3 to 5, the Heads of Department and full-time academic staff, who lead key components of the curriculum, as well as providing clinical services in the hospital, general practice and community settings, provide role modelling for clinical practice. The student cohort reports similar experiences in Australia.

While the School acknowledged it cannot always control the behaviour of all role models in the hospital and community setting, students are equipped with the knowledge and skills to recognise and deal with inappropriate behaviour and attitudes in themselves, their peers and their role models. In cases where students report concerns to the School regarding unprofessional behaviour in the clinical setting, the University works with the relevant health service to ensure the behaviour is managed through an appropriate HR process. Students reported that the majority of teaching clinicians are of outstanding quality.

As a university well known for its research excellence, students are also exposed to role modelling in this area, with some students choosing to undertake a full year of supervised research between Years 4C and 5D. The BMedSci/MD program will provide further scope for role modelling in research.

The team commends the School on the many clinical and academic role modelling opportunities provided to students.

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.

Many formal aspects of teaching within the program promote the concepts of patient-centred care and collaborative engagement. The course has a strong focus on patient safety and ethical practice. The revision and enhancement of the Ethics curriculum since 2014 provides a strong framework for students to guide patient-centred decision making in their clinical practice. The principles of patient advocacy are embedded in the patient cases early in the PBL program and continue throughout the program. Discussion, using scenarios, is used to explore dilemmas such as speaking up about errors and near misses, informed consent, advanced care planning and the role of family in medical decision making.

In the clinical years, the students observe patient-centred care being modelled by clinical staff. During their placements, students see allied health staff, medical staff of different specialist areas, the patient's family, friends, carers and the patient themselves; collaborating to decide on the most suitable management.

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 Faculty has established a multidisciplinary Collaborative Care Curriculum Committee to develop a curriculum to prepare all students across the Faculty for collaborative interprofessional practice. The team notes the work of this newly established committee in developing the curriculum framework, which will inform interprofessional teaching and learning across the Faculty and in the medical program.

The Collaborative Care curriculum framework is developed around four themes:

- Person-centred care
- Understanding role
- Interprofessional communication, and
- Collaboration within and across teams.

The curriculum is structured as a continuum rather than aligned to years of study. Competencies are related to three levels of learning outcomes – Novice, Intermediate and Entry to practice. The Collaborative Care Lead for medicine has input into existing discipline activities via standing membership on the Medicine Curriculum Committee.

In Australia, in the clinical years, students at all campuses are encouraged to use opportunities in the clinical setting to work with other health professionals, learn from different professions and understand how teams work. Given differences in the Malaysian health care system, there were fewer opportunities in Malaysia for informal learning. Staff reported that role modelling is the key method by which students learn interprofessional practice. For example, in ICU rounds, the pharmacist is a key team member; midwives usually teach students basic skills including reading cardiotocographies. In Malaysia, there are relatively few allied health staff, and they do not work on the wards. Students have more opportunity to learn about other health professions during their 12-week Australian placement in Year 5, often in an Aged Care setting.

Isolated examples of structured interprofessional learning exist, including the Women's Health Interprofessional Learning through Simulation (WHIPLS) program for Year 4C students in metropolitan campuses and the Interprofessional Learning Day and Delirium workshop in Year 5D. These opportunities are well regarded by the student cohort.

There are other examples of interprofessional learning including simulation sessions with nursing students and an early pilot of Monash Malaysia medical students working with pharmacy students. Co-delivery of teaching occurs in the metropolitan General Practice program by other professional groups such as occupational therapists, pharmacists and physiotherapists. Students are assessed on their understanding of the role of other health professionals in their written assessment during general practice.

Further work is required to increase and embed interprofessional teaching and learning vertically, so that all students experience interprofessional teaching and learning linked to assessment, throughout the program. The team recommends ongoing and increased resourcing into interprofessional teaching and learning to achieve this and looks forward to updates on the progress of this.

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.

In recent years, the School has developed the Assessment Policy and Procedure Manual. This policy document aligns the design and conduct of assessment with the Faculty of Medicine, Nursing and Health Assessment Policy and the Monash University Assessment Policy. The development of this document, and the close alignment with Faculty and University policy, is seen by academic staff as a benefit to the program, particularly in guiding progression decisions and in managing student appeals.

The Faculty assessment document defines several overarching principles for assessment in its programs. These principles address the need for alignment of the policy with University and Faculty level processes; alignment with learning objectives; the ethical conduct, and participation in, assessment; and the use of different assessment formats to address assessment for, of and as learning.

The policy includes a philosophy of assessment that acknowledges the adult learning design of the program. Student learning is aligned to learning objectives that are consistent with the student's level of development of knowledge and skills. The policy recognises that multimodal assessment is necessary to support validity of assessment and subsequent progression decisions and that there is a focus on using assessment to support the aim of graduating 'fit for purpose' interns.

The Assessment Policy and Procedure Manual contains information regarding the organisational structure and the decision-making process for progression decisions in the medical program. This manual is not currently available to the students, however, the Faculty and Monash University policies are readily available online. Making the core elements of the assessment policy available to students via the LMS may be beneficial to enhance transparency in the assessment processes.

Detailed information regarding individual assessment items, including weighting and assignment rubrics is contained in the unit guides, along with information regarding the standards for passing hurdle assessments. The assessment policy refers to the University Grading Scale Policy as the basis for awarding grades, however this information does not appear to be easily accessible from the unit guides. This could be addressed by directing students to the policy via the unit guides.

Academic staff have access to unit guides via the LMS and the University and Faculty Policies are available via the websites, however not all clinicians teaching in the program have access to the LMS, and access to the internet at some clinical sites is limited by local IT systems.

Students at Monash Malaysia have access to the same information as Australian-based students. All students receive emails regarding assessment requirements.

A recently published document providing a program overview of assessment has been well received by the students and would be a valuable document for academic staff and clinical educators as a reference document.

Students reported that the formative assessments that were introduced as part of the review of pathology were very useful. Academic staff report a 100% completion rate of these formative assessments, which is likely to be in part due to the inclusion of some formative questions in the summative assessment.

The use of formative assessments is included in the pedagogy of the DigiLab sessions as a pre-test to consolidate recent learning and as a post-test to monitor understanding during the session.

These are focused on Theme III at this stage, however the planned extension of this learning activity into Year 1 from 2018 will enhance formative assessment for this cohort. In Year A, there are pre-class quizzes as part of the flipped classroom pedagogy; the students find these quizzes contribute positively to their learning experience.

The revised Year 1 clinical skills program introduced this year includes opportunities for feedback on formative examination skill performance through the adoption of an extended model of competency assessment.

In Year 3B there are two formative Monash Case Record (MCR - mini-CEX format) activities prior to the students completing six summative MCRs. Students receive a formative extended matching questions (EMQ) paper of 100 questions in preparation for the end of Year 3 assessment. There is less overt formative assessment in Year 4, although the students report that the feedback they receive from the clinical preceptors fulfils this aspect of their learning. This continues in the workplace-based focus of Year 5 with the students commenting that they generally receive sufficient feedback on their day-to-day performance in the clinical environment to support the completion of the summative pre-intern assessment.

The students organise a formative objective structured clinical examination (OSCE) in Year 3B. The School has recently released the OSCE station template to aid with the writing of questions with similar structure. The Head of Assessment has offered to review and provide feedback on these questions to help make them representative of questions that may arise in the summative paper. Formative OSCEs are held at Johor Bahru, and are organised with the help of school staff. The School uses these as compulsory training for new examiners and standardised patients prior to their participation in a summative OSCE.

To enhance formative assessment, the School plans to release the summative assessments from 2010 to 2013 with the national benchmarking questions redacted prior to release. There are plans to release the 2014 to 2016 papers in February 2018, following the completion of the 2017 assessment cycle. There are plans to collaborate with other schools to generate new questions to replenish the question bank.

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 Assessment Policy includes a list of acceptable assessment formats and the School utilises a range of these throughout the program to support student learning and progression decisions. The chosen assessment methods are varied, with a balance of knowledge and competency-based assessment selected for the assessment of intended learning outcomes.

Assessment methods are selected to best support the knowledge or skill being assessed to ensure they are fit for purpose. Students in clinical years nominate examiner standardisation and equitable implementation of the MCR as a significant assessment concern. As the cohort size and distribution creates challenges for examiner standardisation in this assessment, there may be benefits in the Assessment Committee evaluating the fit for purpose role of the MCR.

There is a clear process that aligns each assessment with the learning outcomes. The development of assessment items is a collaborative task undertaken by academic staff in Clayton and Malaysia for the Years 1 and 2 multiple choice questionnaires (MCQs), and for OSCE questions staff at Clayton, Gippsland and Malaysia participate. Approximately 40% of the Years 1 and 2 MCQs are written by Monash Malaysia academic staff. Assessments are identical for students at Monash Malaysia and Australian sites.

The team commends the School for the collaborative process used to develop and quality assure the assessment program.

The School has a process for managing examination security risks that may arise as a result of time zone differences. The greatest challenge in this regard are OSCEs. This is managed by close collaboration between the administrative teams in Malaysia and Clayton, and is achieved by quarantining students without access to electronic devices to prevent communication.

The School is planning a pilot of open resource assessment in the Year 5D Clinical Knowledge Test assessment in 2017.

Assessment of professionalism is a component of a number of assessment items throughout the program and directly contributes to progression decisions.

The School has a process for blueprinting written examinations and OSCEs. This occurs in December in preparation for the upcoming academic year. The process focuses on alignment with learning outcomes and is undertaken as a collaborative exercise between the Melbourne- and Malaysian-based Year Leads, Theme Leads and Curriculum Assessment Leads, either face-to-face or via videoconferencing.

Each assessment is blueprinted to the learning outcomes for the themes and year. Topics assessed in previous assessments are considered to limit over or under assessment.

The assessment of the new Indigenous health curriculum and interprofessional learning are areas where development is occurring.

Ongoing monitoring of assessment load, including the timing of assessment items is important. For example, students expressed concern at the assessment load in Year 4C relating to the weekly online tasks and the high stakes end-of-year load.

The School uses a cross campus collaborative process for standard setting assessments.

Written assessments are standard set using Ebel's method. In Years 1 and 2, the question writers nominate a standard, while the Discipline Lead and Year 1 and 2 working group decide on the final standard for each question. In the clinical years, approximately eight experts participate in the standard setting process.

OSCE are standard set using the Angoff Method and the pass mark for each OSCE station is set using the Borderline Group Method. A sequential testing process is employed for students who fall in the borderline range where an additional 50% of proven test items are undertaken and incorporated into the original marks.

Information regarding standard setting methods have been made available to students.

Assessments are benchmarked through participation in national assessment collaborations, engagement with assessment experts and through staff attendance at assessment workshops and medical education conferences.

5.3 Assessment feedback

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

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

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

The School has a process for identifying students at academic risk. Students at risk may be identified following summative assessments, unsatisfactory attendance or where students demonstrate behavioural or professionalism concerns. The process utilises the Faculty's 'early warning system' with at risk students receiving standardised written communication that describes the area of

academic concern and any required remediation or academic consultation. This process is separate from pastoral support pathways.

Tutors are able to identify students who require academic support prior to summative assessments. These students are referred to the relevant Preclinical or Clinical Years Lead for appropriate support.

There is a process of communicating specific student needs between years and between clinical rotations. At the transition to Year 3B, the Clinical Years Lead discusses at risk students with the clinical schools' Directors of Clinical Training (DCT) who then assume responsibility for providing support. At the end of Semester 1, the Results Review Committee meets to identify students in Years 1 and 2A who are at risk, in order to be able to provide support prior to the next assessment block and well before any progression decisions. In Years 3B and 4C student performance is reviewed at the end of semester one and the DCT is notified of students who may require support. Apart from 'flagged' students, no individual results are available to academic staff or clinical educators.

The process of remediation is dependent on the number of times a student receives a fail or borderline result with remediation for a single fail usually occurring during the end of year break.

Academic support workshops and counselling support are available for students at the main campuses in Victoria and Kuala Lumpur, and the students indicated they know how to access these if required. In Malaysia, the student support staff have a part-time presence and are able to hold learning support workshops for students at the major clinical site as needed.

The change to feedback in Years 1 and 2 for the mid-semester assessments has been well received by students and enhances support for their learning. Implementation of this process to other written assessments may be beneficial. Students indicated that the provision of qualitative feedback for OSCEs is one area of feedback that could be enhanced.

Students in clinical years state that they receive sufficient and timely feedback to guide their future learning within the clinical teaching environment, although this is variable following the MCR assessments. Students are aware of the process to access further feedback from academic staff. The feedback provided on assignments varies between discipline and clinical site and the School may consider an approach that could support a more consistent feedback process.

Feedback following formative assessments occurs via written explanations or discussion in small group sessions and in DigiLab sessions in Year 2 at Clayton. Students in Kuala Lumpur and Johor Bahru reported they have very good access to academic staff both during teaching sessions and for consultation during office hours to allow for clarification of learning and academic support as required.

The Clinical Schools receive data on student assessment performance in Years 3B, 4C and 5D. The Heads of Clinical Schools are provided with this information, although feedback to clinical teachers to inform their teaching appears to vary by site. For example, clinical educators at Segamat commented they did not receive information regarding cohort performance, whereas those at Johor Bahru considered they were adequately informed regarding this aspect of the program.

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 Committee oversees the review of assessment in the program. A range of staff are involved in assessment development, implementation and quality assurance processes. The governance structure has facilitated a focus on linking assessment with any proposed change to the curriculum. The introduction of the Clinical Academic Lead role has been described as effectively fulfilling this intention. The review process includes the use of psychometric data and provision of

feedback to question writers. The School reported in 2015 that it engages an external psychometrician to review the data and remove poorly performing items prior to the release of results to students.

The School monitors assessment outcomes at the various teaching sites, including the Year 5D General Practice rotation, and while there has been no significant variations in assessment reporting, ongoing monitoring is encouraged. The assessments for the graduate- and direct-entry programs in Year 2 and Year A show no significant difference in cohort performance.

The School has consulted with external experts in assessment including from the University of Otago to guide its review of assessment. The School engaged Professor Lambert Schuwirth to review the assessment program and associated processes in February 2017. The Assessment Committee has addressed two of the seven recommendations to date, evidenced by the invitation for a Monash University Medical Students' Society (MUMUS) representative to sit on the Assessment Committee and the release of summative assessment items from previous years.

The School has dedicated administrative support for assessment data management, which includes checks to ensure the accuracy of assessment data prior to its discussion at results and progression meetings.

The School monitors the academic progress of students from different entry pathways and this information is discussed at the Curriculum Committee. Attrition rates are monitored but given the low numbers, trends are difficult to identify.

With a large distributed cohort, the standardisation of clinical assessment practices is a challenge for the School.

Assignment rubrics are developed collaboratively between Australia and Malaysia in Years 1 and 2. Sample assignments from each third of the student cohort in Malaysia are cross-marked by academic staff in Melbourne as a moderation process. Exemplar assignments are also developed for markers and these are made available to students.

The School produces exemplar videos of OSCE stations that are used for examiner calibration across all sites. There is no feedback to examiners on their individual performance in relation to the examiner cohort, although these videos are used for training new examiners.

Clinical educators report being aware of the standards that they should apply to the completion of the pre-intern assessment form (PIA) in Year 5. The documented standards are available for reference during the assessment. The Clinical Year Lead in Malaysia meets personally with each new clinician educator and demonstrates the PIA form to them and is also available to support the educators and students in this process should a need arise.

There is variability in the administration of MCR between clinical schools. The majority of examiners at Monash Malaysia have attended training workshops and there is a stable examiner cohort that demonstrates good engagement with the Clinical Year Leads. Clinical Year Leads provide feedback to examiners, and if necessary, remove assessing privileges. Variation was also noted in the organisation of the MCR across the Australian metropolitan clinical schools with some schools organising times and examiners and others requiring students to approach clinicians to assess them. For some students this led to an increased level of anxiety and some students reported difficulty in finding a clinician. Differences were also noted in the conduct of the assessment in terms of length of time, presence or absence of questions, clinician familiarity with the assessment item and knowledge of the expected standard. Year 3B students reported clinicians who said they did not know the standard assessed them at an intern level.

There is no feedback to clinical examiners in the OSCE or MCR regarding student performance or benchmarking.

Benefits may be gained through collaboration between the Assessment Committee and the clinical sites to evaluate the site-specific uses of the MCR assessment and establish a process that includes faculty development and ongoing monitoring to ensure the assessment is fit for purpose.

A standardised approach to the assessment of the variable constructs for the SIP in the BMedSci/MD program in 2020 is under consideration by the School and the team looks forward to hearing further details as these processes are developed.

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 School utilises the Student Evaluation of Teaching and Units (SETU) survey through Monash University's central evaluation processes. The course feedback gained from these surveys is disseminated back to the School through the Pre-Clinical and Clinical year's Academic Directors. In some instances, individual teachers receive feedback directly from SETU. It was clear to the team that examples of student and staff feedback had been utilised to influence changes or refinement of the curriculum. This included feedback on current and new PBL, and Year 5 students' completion of surveys in week five of each six-week clinical placement. This feedback has assisted the School in its monitoring of program components and has influenced curriculum reviews across disciplines, years and programs.

The Monash University Medical Student Society (MUMUS) noted a high level of survey fatigue, reflected in low response rates to formal surveys, and identified the need for other evaluation mechanisms to be put in place to obtain student feedback on the program. MUMUS also requested a clearer communication process in order for the School to disseminate both overall student feedback and planned curriculum changes as a response to student feedback.

There is currently no systematic approach to identifying teaching excellence that aligns with formal recognition and academic promotion. Teaching quality is currently monitored by Discipline and Theme leads. The Monash Centre for Scholarship in Health Education (MCSHE) is planning to undertake consultation to identify the professional development needs of teaching and supervision within the School. The team looks forward to an update on a systematic approach to identifying teaching excellence that aligns to recognition and promotion pathways within medical education.

MCSHE is in the early stages of developing a School evaluation strategy, which will draw on best practice principles of evaluation and will be designed specifically for the Faculty, which will be of specific benefit to the School. MCSHE representatives reported that their goal was for the evaluation strategy to capture a more 'product-orientated' rather than process model in order to support improvements in overall quality of the Monash medical program by focusing on mapping progress towards graduate outcomes. The evaluation strategy is being developed within a consultative framework with members of Faculty, including staff from both Australian and Malaysian Schools.

Given the early stage of development, the roles and responsibilities on the overall governance and monitoring of the evaluation strategy are not yet clearly established. The team identifies that this needs to be developed. The team looks forward to updates on the final governance and leadership structure of the School evaluation strategy. This must include a clear role in leadership and oversight of the strategy.

The School has actively engaged with other education providers to monitor the medical program outcomes, the teaching and learning methods and assessments. This has included: an independent review of assessment by Professor Lambert Schuwirth from Flinders University; participating in assessment benchmarking processes with Deakin and Flinders Universities; and working alongside the University of Otago in the development of the School's assessment policy.

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 monitors the student cohort performance across each year and across each campus. This data is reported directly to the Heads of School and relevant Directors of the clinical schools.

The data gained through monitoring activities demonstrates that:

- There is consistency of delivery of learning outcomes across years and sites.
- Retention rates have remained high through the 2014–2016 academic periods.
- There is recent growth in the recruitment and retention of Indigenous students within the medical program.
- Students who entered the program through the Dean's Rural List and the Early Rural Cohort options were also successfully being recruited and retained through the current student pathways developed by the School.

Although the School has placed an emphasis on student feedback for evaluation, the lack of an evaluation strategy has meant the outcome data has not been positioned in a framework that supports clear alignment to content, learning methods or teacher quality. The proposed evaluation strategy should promote clearer outcome evaluations that comprehensively support renewal of the medical program. It is hoped that a clear plan and purpose to outcome evaluations will better provide:

- A clear picture of the current strengths and weaknesses of the program to those responsible for governance and administration of the program.
- A considered approach to access to students and staff for participation in surveys and/or focus groups.
- A format for informing students and staff of evaluation results, and documenting the implications and impact of the findings.

The team looks forward to future reports on how the School evaluation strategy will provide direction to enhance the School's interface with the Faculty and other stakeholders.

The School uses various mechanisms to track graduate outcomes, including through the Medical Schools Outcomes Database and graduate surveys. It is clear that the program produces graduates that are both desired and retained as interns in both rural and urban Monash teaching sites.

6.3 Feedback and reporting

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

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

The School provides the annual Medical Student Outcome Data report to the four key medical program committees, and ensures its distribution to the broader health service and general practice stakeholder group.

Graduate feedback has identified the need to address preparedness in prescribing skills, an area which has now been incorporated in the curriculum. This process of utilising feedback to improve

quality teaching is a strength, although a clear feedback loop between the School and students is required. Likewise, feedback loops with current clinical teachers and community sites would be beneficial. The team is also interested in how student outcomes might influence student selection and support. The team looks forward to an update on the development of the School evaluation strategy with particular regard to how feedback loops may be embedded in evaluation processes.

Clarification on who the School sees as its stakeholders will be beneficial to allow the School evaluation strategy to appropriately engage and inform stakeholders.

7 Implementing the curriculum - students

7.1 Student intake

- 7.1.1 The medical education provider has defined the size of the student intake in relation to its capacity to adequately resource the medical program at all stages.*
- 7.1.2 The medical education provider has defined the nature of the student cohort, including targets for Aboriginal and Torres Strait Islander peoples and/or Māori students, rural origin students and students from under-represented groups, and international students.*
- 7.1.3 The medical education provider complements targeted access schemes with appropriate infrastructure and support.*

The School regularly reviews and refines the size of the student intake in relation to its capacity to deliver the program, as well as specific targets for defined groups, including direct- and graduate-entry students, and students from rural, Aboriginal and Torres Strait Islander, low socioeconomic status and international backgrounds.

The team commends the work by the Faculty's Gukwonderuk Unit (Indigenous health) and the work of the School in developing an Indigenous student pathway in medicine that has supported growth in the recruitment and retention of Indigenous students.

Outcomes from the recent introduction of the specified entry requirements from biomedical and other Monash degrees to the graduate-entry program, and their impact on applicants of rural background, are yet to be realised. The School is monitoring these closely and the team looks forward to updates on the graduate-entry pathway selection criteria and processes.

There are support strategies at Faculty and University level for international students. The recent appointment of a Faculty Director of International Student Welfare enhances these aims. There is a designated academic staff member to prepare, orient and monitor Monash Malaysia students for their final year Australian placements. A number of University financial scholarships and other support services are available for rural background students.

The Jeffrey Cheah Foundation, on advice from the Monash Malaysia academic leadership, oversees the size of the Monash Malaysia intake. Currently the intake is matched to clinical teaching capacity. As a private university, this international site does not have targets for students of Indigenous or other specified backgrounds. The academic leadership in Malaysia have expressed a desire to increase enrolments from less well-developed areas of Malaysia. Up to 40% of students are supported by Malaysian government scholarships, of which a proportion will have low socioeconomic status backgrounds. Monash Malaysia provides support for international students in its cohort.

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 team commends the strong program of research and scholarship in student selection, and its evidence-based approach to selection procedures. Selection policies and processes are reviewed regularly to ensure that they remain rigorous, consistent and fair, and innovations are monitored carefully. Multiple Mini Interviews are conducted at international sites, with contextual adaptations

to ensure fairness and cultural appropriateness. The range of multiple selection pathways across multiple sites is complex but well established and appears sustainable. Procedures for regular training of interviewers and standardised interpretation of applicant performance in interview stations are in place.

Non-standard entry pathways are carefully documented, with the authority for final decisions about entry to both Australian and Malaysian programs residing at the School level.

The admission and support of students at all campuses with disabilities and infectious diseases is in accordance with University policies and Australian laws. Students are expected to self-disclose as a professional obligation condition, which may affect their study.

The team was impressed with the School's efforts to increase recruitment, and learning and community support for students of Aboriginal and Torres Strait Islander backgrounds. The establishment of the Gukwonderuk Unit has provided a clear focal point for Indigenous student support and connections to community. The support program continues to grow, with the recent introduction of an engagement interview appearing to have a positive effect on enrolments.

The website pages, at both University and Faculty level, provide clear and comprehensive information about student selection processes. A separate site for the Monash Malaysia iteration of the program is likewise clear and comprehensive. Appeals are managed in accordance with the University complaints policy, which is publicly available on the Australian (but not Malaysian) site.

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 team was impressed with the commitment to the health and wellbeing of students shown by teachers and professional staff at all sites. Students who met with the team confirmed that they felt supported and valued being part of a community of collaborative learners.

The work done to establish and develop the consultation and advisory components of the role of Associate Dean Professionalism and the developing role of the Senior Administrative Officer (Clayton) to recruit and support the Student Advisors, are positive endeavours. The Faculty Student Assessment and Support Unit also provides learning support tailored to the needs of health professions students across the Faculty. The team looks forward to updates on the development and sustainability of the new roles (some of which have responsibility for all programs in the Faculty).

Efforts to clarify and develop support pathways separate to progression and assessment throughout all sites, and to promote a preventive approach to mental health and wellbeing are commendable. Students with whom the team met were able to identify at least one person at each site, generally an academic, from whom they would be comfortable seeking assistance, or raising

concerns about themselves, a peer, or about teaching. Support is consistent, yet tailored to the unique needs and resources at each site. There were variable levels of awareness about the full range of supports available, and the team recommends continuing efforts to ensure that students and staff are aware of the full range of support services and processes.

In addition, there are university counselling and academic advisory services at both the Australian and Malaysian sites. Each Clinical School and rural school site also provides a suite of social and cultural activities. Students reported feeling safe on their rural placements and welcomed by local communities.

At the commencement of Year 3B, students who require academic support are provided with support via a closely mentored six-week block, which is undertaken in addition to their clinical rotation commitments.

Students at risk of not completing the program are identified at least annually. A list of these “flagged students” is compiled, including students who are required to repeat a year, or who are coming back into the program after leave. There is a process of forward feeding, where the list is discussed in a closed meeting of the Directors of Early Years, Clinical Years and Clinical Training. The list is updated during the year as new students are identified, with the process being managed by the Clayton-based Senior Administrative Officer.

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.

Policies and procedures for managing students with concerns about fitness to practise as a result of impairment have been reviewed through the recently established Faculty Professionalism Unit, with advice from University legal services to ensure compliance with Australian law. The School recognises the complexity of fitness to practise concerns, and students with disability are managed in conjunction with University disability services and appropriate adjustments are provided.

Students with professionalism concerns which may affect their ability to interact with patients are managed under the Faculty Professional Behaviour Intervention Procedure. This three-step procedure may involve staff referring the student to the Associate Dean Professionalism, or to the Director of Early Years or Clinical Years Program, or to the Deputy Dean Education for the purposes of investigation by a Faculty level Professional Behaviour Review Panel. Students may be referred sequentially for repeated behaviours, or directly to the Panel for serious concerns. The Panel has the authority to recommend to the Board of Examiners that the student fail the unit, with the Board having the authority to recommend exclusion from the program.

Identification of professionalism and fitness to practise concerns may occur through multiple routes. These are most commonly non-attendance, or concerns raised by tutors, teachers and other staff. In the early years, these may be reported to the Director of Early Years, in the clinical years to the discipline leads or DCT at each site, or to the Director of Clinical Years. In the clinical years, there is a “pre-internship” clinical placement appraisal which includes professional behaviours. The processes and structures have been applied differently in different years, and the program has identified assessment of professionalism as an area for further work. With permission of the student, the Associate Dean Professionalism may also inform the appropriate Director about ongoing concerns.

Students who are identified as being at risk through non-attendance or through raising other academic concerns may also be managed under disciplinary procedures or academic misconduct processes as per University policy, and referred to the Board of Examiners. The University devolves the authority for decision making about misconduct to the Faculty.

Expectations for the standard of behaviour required have been clarified and are explicitly set out under the Code of Professional Conduct for Medical Students, and the Faculty Guideline for Clinical Placements. All students are introduced to the Code as part of an induction ceremony. On commencement, students are asked to read and sign a Statement of Expectations, stating that they have understood and will comply with these policies and with other program requirements, such as immunisation.

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.

Formal student representation is in place on all curriculum management committees in the Australian iteration of the program. Representatives are nominated through the student society, MUMUS. These student representatives provide a strong voice and their views are respected in committee discussions. Unless specifically requested, student representatives do not appear to have a formal responsibility for ensuring that the general student body is aware of committee decisions and developments. Within the general student body there was variable awareness of key initiatives such as the new student support referral processes, and different mechanisms for reporting teaching concerns. Otherwise students felt well informed about program information, including assessment.

While Monash Malaysia staff are represented on all curriculum committees, there is no parallel formal representation from Monash Malaysia students. Nevertheless, Monash Malaysia students felt that staff were accessible and responded to their concerns.

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.

Insurance policies are in place to indemnify students at all campuses. A separate Malaysian malpractice insurance policy is in place for Monash Malaysia students.

8 Implementing the curriculum – learning environment

8.1 Physical facilities

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

The School has excellent modern physical facilities across the Victorian and Malaysian sites. Building works, funded from the Faculty's incentive fund, are progressing at Clayton and are planned for Sunway to increase the maximum Malaysian intake by around 30 places. The School has access to excellent facilities at each Clinical School, with building works to benefit students and staff at the School of Rural Health in West Gippsland planned for the start of 2018.

The team noted potential personal safety concerns from some Box Hill students who travel after sunset to Maroondah Hospital or William Angliss Hospital. School staff are encouraged to engage with students and mutually agree on risk mitigation practices to ensure personal safety where students travel between Box Hill and Maroondah Hospital or William Angliss Hospital.

The Team commends the School for the high standard of clinical facilities and the ongoing reinvestment in the maintenance and improvement of sites.

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 University provides high quality information communication technology (ICT) infrastructure and applications to deliver programs, facilitate clinical learning and enable achievement of learning objectives. Information technology, including, videoconferencing and library services are available at all Malaysian campuses. Students have access to Australian resources via Eduroam but there is still limited access in some clinical sites.

Students have encouraged the broad publication of slides and materials on Moodle to improve student access to resources, as some materials are only available on site- or rotation-specific Moodle sites. As discussed previously, it may be beneficial to consider ways to optimise sharing of relevant content between the overlapping, stand-alone Moodle sites.

Investment of financial and personnel resources in ICT in recent years has enhanced systems, benefiting the majority of students. Core functionality is of a high standard and the School recognises further opportunities to enhance user experiences. Malaysian students have full access to Moodle.

The library's recent subscription to UpToDate has provided students with an extensive point-of-care clinical database, which has been well received by the student society. Library services at Johor Bahru are being upgraded and relocated and should be completed in 2018. The use of innovative teaching methods such as the DigiLabs, the in-house 3D printed anatomical sections, and the use of SECTRA anatomical imaging is commendable and the team notes that the Year A cohort could also benefit from access to such experiences. This is particularly important for international students.

Some adjunct staff are unaware of their access to online Monash University library materials, and it may be beneficial to reinforce this on appointment and at other times as opportunities present.

Overall, the infrastructure and resources utilised in the program are highly functional and well utilised by staff and students.

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 currently provides comprehensive clinical skills teaching facilities, labs, simulation suites and lecture facilities across sites, although staff at Segamat felt more resources to support skills teaching would be helpful.

The School has positive partnerships with clinical sites and community-based health services, which has resulted from active engagement by Monash staff. Rural students clearly value the extensive range of clinical experiences available at regional clinical schools. The clinical learning environment supports achievement of the outcomes of the program.

Students expressed appreciation for the expertise and enthusiasm of the majority of the lecturers. Rural students clearly value the extensive range of clinical experiences available at regional clinical schools. For example, Churchill Year A students were grateful for the Deputy Dean speaking to the cohort onsite from time to time, and delivering consolidation lectures that provided important context and learning guidance.

In some clinical areas, clinicians felt they had reached capacity in terms of student numbers. For example, more than three students are sometimes in attendance at some clinical sessions at Monash Medical Centre, with some staff expressing dissatisfaction. In contrast, some areas felt they could cope with more students. It will be important for the School to work with local clinicians to ensure student numbers are matched to educational capacity and sites are equitable in terms of clinical learning opportunities and supervision.

The clinical learning environment provides Years 4 and 5 students with experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples, although there may be opportunities to achieve additional placements to improve Indigenous health learning, to better facilitate culturally competent Indigenous health care.

The team noted the successful integration of Melbourne University students into the Monash teaching program in Bendigo, and relationships with La Trobe University are evolving in this co-located site.

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.*

Clinical supervision adequately supports safe student participation in clinical practice, with active involvement by academic and administrative staff. Each Clinical School and discipline provides orientation and training for their clinical supervisors, and monitoring of student and supervisor performance is undertaken by appropriate staff and committees. The recently introduced handover process from year to year should improve communication, although this is yet to benefit some clinical sites. In addition, the School's imminent delivery of a curriculum database will assist clinical teachers and supervisors to better understand the background learning of the students, in the context of their teaching.

The School has individual Clinical Placement Agreements in place with its clinical teaching partners and works to identify new placement opportunities.

Appendix One Membership of the 2017 assessment team

*** Professor Fiona Lake (Chair)** MBBS, MD, FRACP
Eric Saint Professor of Medicine and Respiratory Physician

*** Professor John Fraser (Deputy Chair)** PhD, FRSNZ
Dean, Faculty of Medical and Health Sciences, University of Auckland

*** Associate Professor James Fraser** MBBS, MSpMed, MHed, Cert EM (ACEM)
Associate Professor of Medical Education, School of Medicine, Griffith University

*** Professor Wendy Hu** MBBS, DipPaed, MHA, PhD, FRACGP
Deputy Dean, Professor of Medical Education, School of Medicine, Western Sydney University

Mr Fergus Leicester BBus, MBA, GradDip Applied Corporate Governance, FCPA, FGIA, FAICD
Chief Operating Officer, St Michaels Collegiate School, Hobart

Associate Professor Suzanne Pitama MA, PhD, PGDipEdPsych
Associate Dean Māori, Director Māori / Indigenous Health Institute, School of Medicine and Health Sciences, University of Otago

Associate Professor Stephen Tobin MBBS, FRACS, FRCS, GradCertClinEd, MSurgEd, FRCSI, FCSSANZ
Dean of Education, Royal Australasian College of Surgeons / Consultant Surgeon Ballarat Health Services / Associate Professor University of Notre Dame Australia, School of Medicine Sydney and Deakin Medical School

Associate Professor Deborah Wilson MBBS, FANZCA, GradCert T&L
Rural Clinical School Co-Director, School of Medicine, University of Tasmania

*** Mr Alan Merritt**, Manager, Medical School Assessments, Australian Medical Council

Ms Chrissy Arnaoutis, Program Administrator, Australian Medical Council

**Indicates team members who participated in site visits to Malaysia*

Appendix Two Groups met by the 2017 assessment team- Malaysia

Jeffrey Cheah School of Medicine and Health Sciences (Monash University Malaysia)

President and Pro Vice-Chancellor

Vice President (Research and Development)

Executive Director, Monash Malaysia

Deputy Dean MBBS

Deputy Dean Education

Chief Examiner MBBS

Academic Lead MD Program

Director Quality Assurance & Compliance

Professional Executive

Deputy Dean MBBS

Deputy Dean Education

Chief Examiner MBBS Program

Academic Lead MD Program

Curriculum Assessment Leads and Year Coordinators

Early Years Management Coordinator, Theme I & II, Health Enhancement, Medical Law & Health Promotion

Early Years Management Coordinator, Theme III & Biochemistry

Year 1 & 2 Assessment Lead and Assessment Chair

Deputy Head of School (Graduate Research) & Biochemistry

Year 1 & 2 Theme IV Coordinator

Associate Professor in Anatomy

Theme IV Coordinator & Physiology

Deputy Head of School (Education) & Pharmacology

Lecturer in Microbiology

Associate Professor in Community Health

Professor in Ethics

Year 3 Coordinator & Pathology

Associate Head Clinical School JB & Year 4 Coordinator

Year 5 Coordinator & Patient Safety

Lecturer in General Practice & Family Medicine.

Lecturer – rural

Senior Manager, Education and Course Management

Medical Education

Co-Chair Medical Education

Deputy Dean Education

Director of Curriculum

Associate Professor in Medical Education

Students

Year 1

Year 2

Year 3

Year 4

Year 5

Graduates

Finance

President and Pro Vice-Chancellor (Interim)

Executive Director

Financial Controller

Senior School Manager

Admissions

Professor of Medical Microbiology

Director, Marketing & Future Students

Senior Administrative Executive

Student Support

Consultant Clinical Psychologist

Director of Student Services

Senior Counsellor

Senior Manager, Education and Course Management

SEACO Office & Precinct

Deputy Head of School (Research & Development)

Professor of Population Health

SEACO Platform Manager

Lecturer in Public Health

Health Service management, consultants and GPs

Segamat Hospital Director

Public Health Director Consultants

General Practitioners

Health Service Management and Consultants

Sultanah Aminah Hospital Director

Sultanah Aminah Hospital Deputy Director

Permai Hospital Director
Mahmoodiah Clinic Director Consultants
Clinical School Leadership
Associate Head Clinical School JB
Associate Head Clinical School JB
Finance and Resource Manager

Curriculum and Year Leads

Associate Head Clinical School JB & Year 4 Coordinator
Year 3 Coordinator
Year 4 Coordinator & Women's Health
Year 5 Coordinator & Patient Safety
Year 3 Coordinator & Medicine
Clinical Associate Professor in Surgery
Senior lecturer in Paediatrics
Professor of Public Health

Years 1 to 5 Assessment

Year 1 & 2 Assessment Lead and Assessment Chair (Malaysia)
Chief Examiner and Director of Assessment
Year 3 Assessment Lead
Year 4 Assessment Lead
Year 5 Assessment Lead
Chair of Year 5 Assessment Working Group
Year 1 & 2 Assessment Lead
Manager, Education Support (Assessment)

Staff involved with supporting and assessing students

Student Support
Student Counsellor
Student Services
Senior Counsellor
Acting Manager, Clinical Education Support
Clinical Site Coordinator

Appendix Three Groups met by the 2017 assessment team - Melbourne

School Executive Committee

Deputy Dean FMNHS

School Executive Committee

Deputy Dean FMNHS

Director of Monash Centre for Scholarship in Health Education (MCSHE), Director of Curriculum (Medicine)

Head of School of Rural Health

Director of Early Years Programs 1/2A

Director of Clinical Years Programs

Chief Examiner and Director of Assessment

Manager, Special Projects

Senior Manager, MBBS Program, Clayton

Manager, School of Medicine Budget

Head of School, Malaysia (KL)

Senior Leadership in the Faculty of Medicine, Nursing & Health Sciences

Dean FMNHS

Deputy Dean FMNHS

Senior Deputy Dean and Deputy Dean Research

Deputy Dean (External Relations)

Deputy Dean (Education)

Associate Dean (Research Strategy)

Finance

Dean FMNHS

Deputy Dean FMNHS

Manager, School of Medicine Budget

Deputy Vice-Chancellor and Vice-President (Education)

Curriculum and Assessment Lead Committee

Deputy Dean FMNHS

Director of MCSHE and Director of Curriculum (Medicine)

Senior Academic Lead, Curriculum (Co-Chair)

Director of Early Years Programs 1/2A

School of Rural Health, Churchill

Director of Clinical Years Programs

Chief Examiner, Director of Assessment

Senior Manager, Medicine Program, Clayton

Deputy Head of School (Education), Malaysia

CAL – Internal Medicine

CAL – Pathology

CAL – Surgery

CAL – Children’s Health

CAL – Women’s Health

CAL – Medicine of the Mind

CAL – General Practice

CAL – Acute Care

CAL – Continuing Care

CAL – Theme 1

CAL – Theme 2

CAL – Theme 3

CAL – Theme 4

CAL – Patient Safety

MD Lead

Faculty Indigenous Health Curriculum Lead, Medicine

Student Representative, MUMUS President

Student Representative MUMUS Vice President

Head of School, Malaysia (KL)

Associate Head of Education (CSJB) Malaysia (JB)

Associate Head of Clinical School (Research), Malaysia (JB)

Senior Manager, MBBS Program, Malaysia (KL)

Theme Leaders

Senior Academic Lead, Curriculum (Chair Theme 1)

Theme 1 & 2 Rep (Malaysia)

CAL – Theme 2

CAL – Theme 3

CAL – Theme 4

Discipline leads

CAL – Internal Medicine

CAL – Pathology

CAL – Surgery

CAL – Children’s Health

CAL – Women’s Health

CAL – Medicine of the Mind

CAL – General Practice

CAL – Acute Care
CAL – Continuing Care
CAL – Patient Safety
Faculty Indigenous Health Curriculum Lead, Medicine

Assessment committee

Chief Examiner and Director of Assessment
Director, Medical Student Programs, Eastern Health
Director of Medicine Curriculum
Director of Clinical Years Programs
Director of Early Years Programs 1/2A
Senior Manager, MBBS Program, Clayton
Program Exchange Convenor, Medicine, Paediatrician
Lecturer, Department of General Practice
Assistant Director Peninsula Clinical School
Student Academic Support Unit – Director
CAL – Medicine of the Mind
Head of School, Malaysia (KL)
Professor of Medical Microbiology (KL)

Admissions

Director Monash Institute for Health & Clinical Education
Director, Student Admissions
Deputy Dean, Education
Manager Admissions
Student Admissions

Student support

Associate Dean, Professionalism, Student Liaison
Associate Dean, Professionalism, Staff Liaison
Senior Student Services Lead
Student Academic Support Unit – Director
Director, International Student Welfare
Director of Early Years Programs 1/2A
Director of Clinical Years Programs

Interdisciplinary Indigenous Health Curriculum Committee Gukwonderuk Indigenous Unit

Faculty Indigenous Health Curriculum Lead, Medicine
Indigenous Health Lecturer
Representatives from all the health committees

Students

MUMUS President
MUMUS Academic Vice-President
MUMUS BMedSci Representative
Monash Research Students' Society Chair
MUMUS Pre-Clinical Vice-President
MUMUS Year 5 Academic Representative
MUMUS Year 2 Academic Representative
MUMUS Community & Wellbeing Subcommittee Chair
MUMUS Clinical Publications Officer
Monash AIDA Representative
Other Non-Rep students

Early Years management committee

Director, Early Year Programs (Chair)
Early Year Programs (Co-Chair)
Director, Year A Program
Senior Manager, MBBS Course, (Clayton)
Senior Academic Lead, Curriculum, (Medicine Course)
Senior Manager, Rural Education Program
Theme I CAL
Lecturer in Ethics
Theme I Rep (Ethics/Law/Personal development)
Theme I & II Rep (Malaysia)
Theme II CAL
Theme II Rep (Population Health/Health Promotion/Knowledge Management)
Theme III Rep (Physiology)
Theme III Rep (Anatomy)
Theme III Rep (Biochemistry)
Theme III Rep (Malaysia)
Theme IV Rep (Year 1)
Theme IV Rep (Year 2)
Theme II Rep (Year A)
Senior Manager, MBBS Program, Malaysia (KL)
Theme IV Rep (Malaysia) (KL)

MD implementation and Research

MD Lead
Director Medical Student Research

Convenor of the Bachelor of Medical Science

Senior Curriculum Lead

CAL – Theme 2

Director of Medicine Curriculum

Head of School, Malaysia (KL)

Blended learning group (MED E Learning), Virtual pathology museum, Moodle Med Units Overview, Moodle Quizzes

Manager, eLearning Services, MNHS

Senior Educational Designer, MNHS

Manager, Teaching Resources Support Unit, MNHS

eLearning Support Officer, MNHS

Year A Management Committee

Director MRH Churchill

Director of Early Years Programs 1/2A

Year 1 and 2 program representatives

Senior Assessment Lead (Medical Curriculum) (Clayton)

Theme II

CAPs Coordinator/Theme I

Theme III Lecturer, Assessment

Theme IV

Campus Library representative

Regional Manager MRH Churchill

Administration Support

Year A staff, sessional clinicians, placement staff

Tutor (Clinical skills, Anatomy, CAPs)

Tutor Clinical skills, Population health, CAPs)

Tutor (Anatomy)

Moe life Skills (Community-based placement)

GCASA (Community-based placement)

Clinical Nurse Educator (Clinical placement)

Latrobe Regional Hospital

Acting Director, Academic Coordinator Year 4C, MRH: Latrobe Valley & West Gippsland

Manager, MRH: Latrobe Valley & West Gippsland

Acting Year 3B Coordinator

Year 3B Educators

Acting Year 3B Coordinator

Pathologist

Pharmacy

General Surgeon

West Gippsland Hospital Group Executive

CEO

DMS

Acting Director

Year 5D Clinical Educators

General Medicine, Year 3B Clinical Dean

General Medicine

Aged Medicine

Emergency Medicine

Anaesthetics

Year 4C Clinical Educators

Year 4C Academic Coordinator

Year 4C Clinical Dean, Children's Health Discipline Lead

General Practice Discipline Lead

Medicine of the Mind Discipline Lead

Women's Health Discipline Lead

Midwifery Educator

Year 3B, 4C and 5D students

Representatives from each Year Level

Students at Warragul

LRH Executive (Traralgon)

DMS

Acting Director

Students (Mildura)

Year 3 and Year 4 students

Professional Staff (Mildura)

Regional Manager

Year 4C program co-ordinator

Year 5D program co-ordinator

Senior Contracts Coordinator

Student Support Officer

Administration – Facilities & Finance

Clinical Skills Lab Technician

Bendigo Health Executive

Acting Chief Executive Officer (CEO)

Acting Chief Medical Officer (CMO)

Executive Director People and Culture

Executive Director Acute Health

MRH Bendigo Academic Leadership team

Year 4C Academic lead

Radiology

Year 4C Medicine of Mind

Director Anaesthetics

Students-School of Rural Health, Mildura

Students Year 3

Students Year 4

Students Year 5

Clinical Supervisors and Hospital Executive

Director of Medical Services MBH

Aboriginal Liaison Officer

Nurse Educator

Tutors and RHM Academic Staff

Director, School of Rural Health, Mildura

GP Anaesthetist and Lecturer

Paediatrics

Consultant Psychiatrist

ED Physician

General Practitioner

Obstetrician and Gynaecologist

ED Registrar

Mildura Staff

Regional Manager

Academic coordinator Years 3 and 5

Clinical skills lecturer

The Alfred Centre

Chief Executive, Alfred Health

Executive Director, Medical Services & Chief Medical Officer

Dr Director Medical Services Alfred Health

Central Clinical School

Head, Central Clinical School, Monash University

Director Medical Student Programs, Central Clinical School

Clinical Supervisors (Alfred Health staff)

VMO in Endocrinology and General Medicine

VMO in Alfred Psychiatry

Consultants as per ward availability

General Practitioners**Central Clinical Students**

Years 3B, 4C, 5D students

Teaching team and Head of School

Head of School of Clinical Sciences

Director, Undergraduate Medical Education, SCS

Clinical Dean, SCS - Monash Medical Centre

Clinical Dean, SCS - Casey Hospital

Year 5D coordinator, SCS - Dandenong Hospital

Clinical Supervisor, Monash Medical Centre

Head of Surgery program, SCS

Procedural skills nurse educator

CEO and CMO

CEO Monash Health

CMO Monash Health

Students

Year 3 students

Year 4 students

Year 5 students

Senior Health Service Leadership- Eastern Health Clinical School

Chief Executive Officer, Eastern Health, Adjunct Clinical Associate Professor, Deakin University

Director, Medical Services (Maroondah Hospital) & Acting Director, Medical Services, Eastern Health

Medical Student Programs academic and professional staff

Monash University Head of School, Eastern Health Clinical School, Professor of Medicine

Director, Medical Student Programs, Eastern Health Clinical School, A/Professor, Monash University and Deakin University

Senior Lecturer, Clinical Skills

Teaching Associate

Senior Lecturer, MBBS Curriculum and Innovation

Team Leader

Executive Officer

Clinical teachers

Selected Clinical Teachers

Administration

Senior Manager, MBBS Program, Clayton

Senior Administrative Officer

Administrative Officer, Student Liaison

PBL Administrative Officer

Education Support Officer

Assistant Data Analysis Officer

Administrative Officer - Medicine Assessment

Clinical Skills Administrative Officer

MBBS Assessment; Data Management and Quality Assurance, Lecturer, Pharmacology

Inter-professional Learning

Chair, Collaborative Care Committee

MCSHE and Evaluation- Monash Centre for Scholarship in Health Education- Program Evaluation

Director of MCSHE and Director of Curriculum (Medicine)

Deputy Director of MCSHE

Senior Academic Lead, Curriculum, (Medicine Course) (MCSHE Affiliate)

Deputy Head of School (Education), Malaysia

Malaysia Affiliate, MCSHE (KL)

