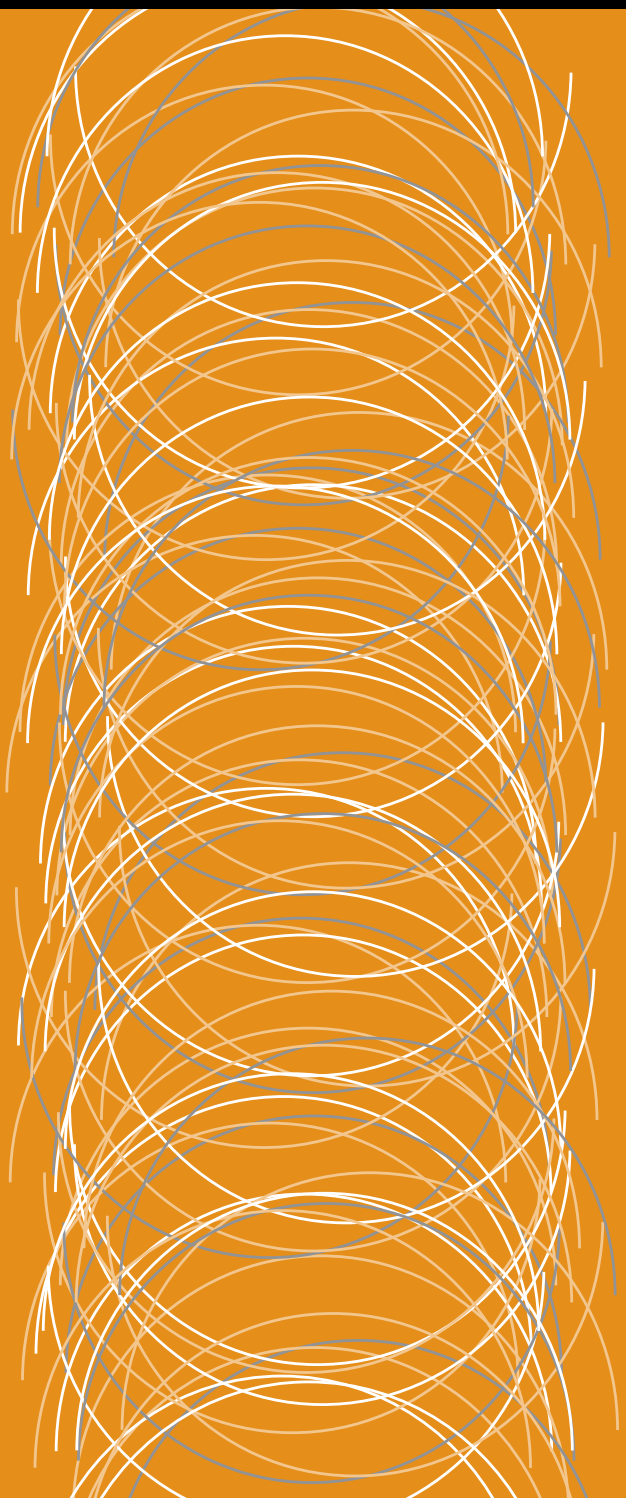
Australian Medical Council Limited

Accreditation of University of Western Australia Faculty of Health and Medical Sciences

AMC



Medical School Accreditation Committee
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Accreditation process

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

In the final year of accreditation, an education provider may seek extension of accreditation through a comprehensive report. The UWA comprehensive report described a number of changes to the program, and the AMC determined that these changes met the definition of a major change to the medical program as described in the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2019*. As a result, the AMC recommended an extension to the period of accreditation, to allow the AMC to conduct a reaccreditation assessment of the medical program.

Accreditation of the four-year Doctor of Medicine (MD) medical program of the University of Western Australia, Faculty of Health and Medical Sciences expires on 30 June 2020.

Accreditation of the Bachelor of Medicine/Bachelor of Surgery (MBBS) medical program of the University of Western Australia, Faculty of Health and Medical Sciences expires on 31 March 2021. The MBBS medical program is currently in teach-out.

An AMC team completed the reaccreditation assessment. It reviewed the Faculty's submission and the student report, and visited the University of Western Australia and associated clinical teaching sites in the week of 21 October 2019.

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

Decision on accreditation

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

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

Reaccreditation of established education providers and programs of study

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

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

(ii) Accreditation for shorter periods of time. If significant deficiencies are identified or there is insufficient information to determine that the program satisfies the accreditation standards, the AMC may grant accreditation with conditions and for a period of less than six years. At the

conclusion of this period, or sooner if the education provider requests, the AMC will conduct a follow-up review. The provider may request either:

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

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

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

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

The AMC is satisfied that the medical program of the University of Western Australia substantially meet the approved accreditation standards.

The 6 March 2020 meeting of AMC Directors agreed:

(i) that the four-year Doctor of Medicine (MD) of the University of Western Australia, Faculty of Health and Medical Sciences is granted accreditation for two and a half years to **31 March 2023**, subject to the following conditions, and AMC monitoring requirements including satisfactory progress reports; and a follow-up assessment in 2022.

July 2020 conditions

1	Provide a detailed plan and timeframes for addressing the identified program needs including those covered by AMC accreditation conditions. (Standard 1.3)

2020 conditions

2	Provide evidence that the Medical Program Committee and its sub-committees have a clear commitment from the Academic Senate of autonomy and capacity to deliver the medical program. (Standards 1.2 and 1.3)
3	Demonstrate that the School and the Faculty are able to enact decisions relating to support services, recruitment and resources in a timely manner. (Standards 1.2 and 1.8)

4	Demonstrate that there is adequate operational support for both the Dean and MD Program Director roles. (Standard 1.2)
5	Confirm that the recruitment schedule for key appointments is progressing as planned. (Standards 1.4 and 1.8)
6	Elevate the positioning of Centre for Aboriginal Medical and Dental Health (CAMDH) in the organisational structure to optimise the opportunities for influence and educational leadership at the Faculty level. (Standard 1.4)
9	Extend consultation on the program to include the perspectives of Aboriginal and Torres Strait Islander peoples to ensure that the teaching and research activities of the program relate to the health care needs of the wider communities it serves. (Standards 2.1.2 and 2.1.4).
10	Explicitly acknowledge Aboriginal and Torres Strait Islander peoples and their health in the purpose statement of the School. (Standard 2.1.2)
11	While completion of the Medical Science Undergraduate Major of the Bachelor of Medical Sciences provides entry into Year 2 of the medical program, demonstrate that the School is an active partner in the governance, management, content and delivery of the Medical Science Undergraduate Major to ensure ongoing alignment of this course with the medical program. (Standards 3.1, 3.2 and 3.3)
12	Demonstrate effective structures and processes to connect clinical teachers with the content of the curriculum, the School's expectations of them, and with the students themselves. (Standard 3.4)
14	Provide evidence that direct supervision of students' clinical practice skills is adequate and consistent across clinical settings to meet the requirements of the medical program. (Standard 4.4)
15	Develop a framework to guide the delivery and assessment of interprofessional learning throughout the program. (Standard 4.7)
17	Appoint an assessment lead to facilitate an effective approach to the comprehensive, coordinated governance of assessment throughout the program. (Standard 5.4)
18	Resource and implement formative assessment to support student preparation for summative assessment. (Standard 5.1.3)
19	Implement formal communication to all supervisors and teachers to provide feedback on student performance within and across cohorts. (Standard 5.3)
23	Ensure evaluation expertise is in place to lead the design, development, implementation and administration of MD evaluation as planned. (Standards 1.8 and 6.1)

24	Develop the strategy and articulate timelines for systematic evaluation of the program and for action on issues identified. (Standard 6.1)
25	Describe the approach to the systematic provision of evaluation results to academic and clinical staff, and relevant committees of the program. (Standard 6.3)
26	Demonstrate that adequate small group teaching/clinical skills facilities are available for all students on the QEII health precinct. (Standard 8.1)
27	Demonstrate that the clinical placement capacity is adequate for students to continue to have sufficient patient contact to achieve the program outcomes. (Standard 8.3)
28	Demonstrate that students have sufficient opportunities to provide care to Aboriginal and Torres Strait Islander people in a variety of clinical settings. (Standard 8.3)
29	Provide evidence that clinical supervisor performance is monitored and that underperformance is appropriately addressed and that clinical supervisors are provided with feedback on their performance. (Standard 8.4)
30	Develop strategies to ensure that clinical supervisors and staff are aware of the current curriculum and assessment requirements of the medical program. (Standard 8.4)

2021 conditions

7	Revise the time allocation for the Dean so that it is commensurate with the wide range of strategic and operational roles associated with the position. (Standard 1.3)
8	Revise the time allocation for the MD Program Director so that it is commensurate with the wide range of roles and functions that are currently associated with this role and is sufficient to ensure effective oversight of the medical program. (Standard 1.3)
13	Complete the development of the curriculum mapping software, and its application to the program to facilitate vertical and horizontal integration of curriculum content, teaching and learning activities, and of assessments. (Standard 3.3)
16	Demonstrate the educational value and improved user acceptance of the e-Portfolio. (Standard 4.1)
20	Implement a fully resourced standard setting process for summative assessments. (Standard 5.2)
21	Provide evidence of a functional assessment blueprint linked to the program's learning outcomes at all stages. (Standard 5.2)
22	Ensure that adequate resourcing is in place for the ongoing quality assurance of assessment practices and processes. (Standard 5.4)

Key findings

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

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

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

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

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

Standards 1.2, 1.3, 1.4 and 1.8 are substantially met.

Conditions

July 2020

1 Provide a detailed plan and timeframes for addressing the identified program needs including those covered by AMC accreditation conditions. (Standard 1.3)

2020

2 Provide evidence that the Medical Program Committee and its sub-committees have a clear commitment from the Academic Senate of autonomy and capacity to deliver the medical program. (Standards 1.2 and 1.3)

3 Demonstrate that the School and the Faculty are able to enact decisions relating to support services, recruitment and resources in a timely manner. (Standards 1.2 and 1.8)

4 Demonstrate that there is adequate operational support for both the Dean and MD Program Director roles. (Standard 1.2)

5 Confirm that the recruitment schedule for key appointments is progressing as planned. (Standards 1.4 and 1.8)

6 Elevate the positioning of Centre for Aboriginal Medical and Dental Health (CAMDH) in the organisational structure to optimise the opportunities for influence and educational leadership at the Faculty level. (Standard 1.4)

2021

7 Revise the time allocation for the Dean so that it is commensurate with the wide range of strategic and operational roles associated with the position. (Standard 1.3)

8 Revise the time allocation for the MD Program Director so that it is commensurate with the wide range of roles and functions that are currently associated with this role and is sufficient to ensure effective oversight of the medical program. (Standard 1.3)

Recommendations

A Review the process for reappointment of Clinical Academic staff to ensure a timely, well understood and effectively communicated approach. (Standard 1.4)

B Consider establishing an identifiable group of experts at the School level, with whom staff can consult for educational design, assessment, evaluation, faculty development (including peer teaching), educational innovation and research. (Standard 1.4)

C Expand strategies to establish effective partnerships with Aboriginal Communities and Indigenous health service providers. (Standard 1.4)

D Improve the recognition of teaching as a valid pathway to academic promotion. (Standard 1.9)

Commendations

AA The Rural Clinical School is a strength, and an excellent example of collaboration between medical schools and the healthcare sector. (Standard 1.6)

BB The community member is a valuable addition to the Leadership, Educator, Advocacy, Professionalism and Scholar committee. (Standard 1.8)

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

Standard 2.1 is substantially met.

Conditions

2020

9 Extend consultation on the program to include the perspectives of Aboriginal and Torres Strait Islander peoples to ensure that the teaching and research activities of the program relate to the health care needs of the wider communities it serves. (Standards 2.1.2 and 2.1.4).

10 Explicitly acknowledge Aboriginal and Torres Strait Islander peoples and their health in the purpose statement of the School. (Standard 2.1.2)

Commendations

CC The School is commended on the online platform utilised to support the delivery of the curriculum in the Rural Clinical School. (Standard 2.2)

3. The medical curriculum	**Substantially Met**

Standards 3.1, 3.2, 3.3 and 3.4 are substantially met.

Conditions

2020

11 While completion of the Medical Science Undergraduate Major of the Bachelor of Medical Sciences provides entry into Year 2 of the medical program, demonstrate that the School is an active partner in the governance, management, content and delivery of the Medical Science Undergraduate Major to ensure ongoing alignment of this course with the medical program. (Standards 3.1, 3.2 and 3.3)

12 Demonstrate effective structures and processes to connect clinical teachers with the content of the curriculum, the School's expectations of them, and with the students themselves. (Standard 3.4)

2021

13 Complete the development of the curriculum mapping software, and its application to the program to facilitate vertical and horizontal integration of curriculum content, teaching and learning activities, and of assessments. (Standard 3.3)

Commendations

DD The Professional, Leader, Advocate, Clinician, Educator and Scholar (PLACES) framework provides effective guidance for students in developing the required graduate outcomes. (Standard 3.2)

EE The Centre for Aboriginal Medical and Dental Health's collegiality and preparedness to proactively develop an integrated Aboriginal health curriculum is a strength of the program. (Standard 3.5)

4. Teaching and learning	**Met**

Standard 4.7 is substantially met.

Conditions

2020

14 Provide evidence that direct supervision of students' clinical practice skills is adequate and consistent across clinical settings to meet the requirements of the medical program. (Standard 4.4)

15 Develop a framework to guide the delivery and assessment of interprofessional learning throughout the program. (Standard 4.7)

2021

16 Demonstrate the educational value and improved user acceptance of the e-Portfolio. (Standard 4.1)

Recommendations

E Consider utilising a greater range of learning and teaching methods in the MDY1 program in order to make the clinical significance of biomedical science content more accessible and explicit. (Standard 4.1)

Commendations

FF Graduates of the program have a strong reputation for their competence in procedural skills. (Standard 4.3)

GG The provision of near-peer and clinician mentors for students is commendable. (Standard 4.5)

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

Standards 5.2, 5.3 and 5.4 are substantially met.

Conditions

2020

17 Appoint an assessment lead to facilitate an effective approach to the comprehensive, coordinated governance of assessment throughout the program. (Standard 5.4)

18 Resource and implement formative assessment to support student preparation for summative assessment. (Standard 5.1.3)

19 Implement formal communication to all supervisors and teachers to provide feedback on student performance within and across cohorts. (Standard 5.3)

2021

20 Implement a fully resourced standard setting process for summative assessments. (Standard 5.2)

21 Provide evidence of a functional assessment blueprint linked to the program's learning outcomes at all stages. (Standard 5.2)

22 Ensure that adequate resourcing is in place for the ongoing quality assurance of assessment practices and processes. (Standard 5.4)

Recommendations

F Consider procuring an enterprise solution to assist with the management of assessment data. (Standards 5.3 and 5.4)

G Review the balance and timing of formative and summative assessments, and consider how these can best support student learning. (Standard 5.1)

H Evaluate the performance of assessments across the program and provide feedback to the Medical Program Committee, supervisors and students. (Standard 5.4)

6. The curriculum – monitoring	Met

Standard 6.1 is substantially met.

Conditions

2020

23 Ensure evaluation expertise is in place to lead the design, development, implementation and administration of MD evaluation as planned. (Standards 1.8 and 6.1)

24 Develop the strategy and articulate timelines for systematic evaluation of the program and for action on issues identified. (Standard 6.1)

25 Describe the approach to the systematic provision of evaluation results to academic and clinical staff, and relevant committees of the program. (Standard 6.3)

Recommendations

I Develop the relationship with the Postgraduate Medical Council to enhance student preparedness for internship. (Standard 6.1)

Commendations

HH The scholarly approach to tracking student performance by entry pathway is commendable. (Standard 6.2)

7. Implementing the curriculum – students	Met

Recommendations

J Ensure good governance, oversight and review of the selection and admissions pathways for the medical program as planned. (Standard 7.2)

K Mitigate the risk of a relationship with the student society that is based around it fulfilling some of the School's functions, and realign the relationship to one of partnership. (Standard 7.5)

Commendations

II The Rural Clinical School is commended for the comprehensive personal and academic support and in particular, their proactive support to students around mental health issues. (Standard 7.1)

JJ The School is commended on its continued dedication to graduating Indigenous Australian doctors. (Standard 7.1)

KK The School has a strong relationship with its student cohort. The lines of communication are such that students feel empowered to provide feedback and help to foster change. (Standard 7.5)

8. Implementing the curriculum- learning environment	Substantially Met

Standards 8.1, 8.3 and 8.4 are substantially met.

Conditions

2020

26 Demonstrate that adequate small group teaching/clinical skills facilities are available for all students on the QEII health precinct. (Standard 8.1)

27 Demonstrate that the clinical placement capacity is adequate for students to continue to have sufficient patient contact to achieve the program outcomes. (Standard 8.3)

28 Demonstrate that students have sufficient opportunities to provide care to Aboriginal and Torres Strait Islander people in a variety of clinical settings. (Standard 8.3)

29 Provide evidence that clinical supervisor performance is monitored and that underperformance is appropriately addressed and that clinical supervisors are provided with feedback on their performance. (Standard 8.4)

30 Develop strategies to ensure that clinical supervisors and staff are aware of the current curriculum and assessment requirements of the medical program. (Standard 8.4)

Commendations

LL The opportunities that students have to develop clinical skills by interacting with simulated patients and low-fidelity clinical training models is a strength of the program. (Standard 8.1)

Introduction

The AMC accreditation process

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

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

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

The AMC's Medical School Accreditation Committee oversees the AMC process of assessment and accreditation of primary medical education programs and their providers, and reports to AMC Directors. The Committee includes members nominated by the Australian Medical Students' Association, the Confederation of Postgraduate Medical Education Councils, the Committee of Presidents of Medical Colleges, the Medical Council of New Zealand, the Medical Board of Australia, and the Medical Deans of Australia and New Zealand.

The 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 2019*. The granting of accreditation may be subject to conditions, and requirements for follow-up assessments.

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

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

The University, the Faculty and the School

The University

The University of Western Australia is governed by the University of Western Australia Act 1911. The 21-member Senate is the University's governing body, empowered with the authority to make statutes, regulations and by-laws, while the Academic Board is the chief academic body. The University is led by the Vice-Chancellor, Professor Dawn Freshwater, and an Executive. The University is comprised of four Faculties namely: Health and Medical Sciences; Science; Engineering and Mathematical Sciences; and Arts, Business, Law and Education.

The Faculty

The medical program was first established in 1957, as part of the Faculty of Medicine.

The Faculty of Health and Medical Sciences offers courses, training and research opportunities in a range of scientific and clinical disciplines. The mission of the Faculty is to advance the life-long health and welfare of society through world-class student education, research and innovation. The Faculty states that this is achieved through education and innovation in:

- The diagnosis of illness and restoration of human health.
- The scientific basis of health and disease.
- Translating discoveries from research discoveries to improve health care.
- Health promotion and disease prevention strategies to ensure the maintenance of the well- being of individuals and society.
- Supporting the well-being of individuals and society through allied health services; and
- Outreach addressing health education, practice and delivery in rural and resource-constrained areas of the State, the nation and countries in the region.

The structure of the Faculty of Health and Medical Sciences comprises five Schools and underlying academic units called Divisions. The five Schools are:

- Medical School.
- Dental School.
- School of Allied Health.
- School of Biomedical Sciences.
- School of Population and Global Health.

Each School is led by a Head of School and has a distinct profile based on the main focus of its academic pursuit. For both the Medical and Dental Schools, the Head of School is also called “Dean” for outward focused relationships and activities.

The Medical School aims for a maximum cohort size of 239 medical students per year, which is composed of 209 Commonwealth Supported Places for domestic students, and 30 places for International fee-paying students. 30% of the CSP places are offered under the Bonded Medical Places scheme.

Accreditation background

The AMC first assessed the six-year undergraduate medical program of the Faculty for the purposes of accreditation in 1990. In 2003 the Faculty advised that it intended to introduce a stream to enable graduates to complete the six-year program in four and a half years. The graduate entry stream was assessed in 2004 and granted accreditation until December 2007 which was later extended to December 2010.

In 2010 the Faculty underwent a reaccreditation assessment. At this time, the Faculty also advised the AMC that it intended to seek accreditation for a major course change. The new program would replace the existing four and a half, and six-year MBBS programs with a graduate-entry four-year, Masters level Doctor of Medicine (MD) program, with a first intake planned for 2014.

A Stage 1 major change submission was accepted by AMC Directors in August 2012 enabling the Faculty to proceed to an assessment by an AMC team in 2013.

In June 2013 an AMC team conducted an accreditation visit. At the October 2013 meeting of the AMC Directors they determined that the four-year program of the University of Western Australia, Faculty of Medicine, Dentistry and Health Sciences leading to the award of Doctor of Medicine (MD) be granted accreditation for five years until 31 December 2018 subject to satisfactory progress reports and a follow-up assessment in 2015 to review the implementation of the first two years of the program.

They also recommended that accreditation of the six-year MBBS and four and a half year MBBS program of the University of Western Australia, Faculty of Medicine, Dentistry and Health Sciences be extended until 31 December 2017, to allow for teach-out of the course.

In August 2015 an AMC team conducted a follow-up assessment of the MD program. Following this visit accreditation was confirmed until 31 March 2019, subject to satisfactory progress reports.

In 2018 the University of Western Australia, Faculty of Health and Medical Sciences submitted a comprehensive report to the AMC Medical School Accreditation Committee seeking extension of accreditation. The Committee considered the 2018 comprehensive report and the commentary of an AMC reviewer along with the report from the Western Australian Medical Students' Society.

After considering the information available, the Committee decided that it could not recommend an extension of accreditation to AMC Directors because a number of significant changes had been made to the program since the last assessment and it was now unclear whether the program continued to meet AMC standards.

There had been fundamental changes to the program structure, the content and the duration (including the apparent introduction of an accelerated pathway). While some proposed changes were introduced in the Faculty's 2017 progress report, the comprehensive report did not provide sufficient evidence of how the AMC standards would continue to be met following these changes. The comprehensive report and the Students' Society report indicated that these changes had had unintended consequences for both student learning and for staff.

The Committee considered the progress on the conditions set in the accreditation assessment report of 2015 and noted that while some conditions were satisfied, the Faculty had not made progress on a significant number of conditions.

The Faculty also had made or was planning a number of other significant changes that affected the delivery of the program. Specifically the Committee identified the restructuring of the Faculty, changes

and reductions in staffing and resourcing, and changes to budget processes as giving rise to questions about whether the Faculty continued to have the capacity, expertise and resources to meet the accreditation standards.

The Committee determined that the changes described in the Faculty's comprehensive report met the AMC definition of a major change. It further determined that the changes were too extensive to be considered within the program's current accreditation.

Having considered the Committee's recommendation, the March 2019 meeting of AMC Directors, agreed that the Doctor of Medicine medical program of the University of Western Australia, Faculty of Health and Medical Sciences met the approved accreditation standards for the cohort graduating in 2019. The Committee agreed that the changes to the Doctor of Medicine medical program were of comprehensive impact that required reaccreditation of the whole program (as per AMC procedures) and invited the Faculty to submit its program for assessment by an AMC team in 2019. The Directors extended accreditation to 30 June 2020 to allow a reassessment to determine if subsequent years of the program were consistent with the accreditation standards.

This report

This report details the findings of the 2019 reaccreditation assessment.

Each section of the accreditation report begins with the relevant accreditation standard.

The members of the 2019 AMC team are at **Appendix One**.

The groups met by the AMC team in 2019 in Perth and Albany, Western Australia are at **Appendix Two**.

Appreciation

The AMC thanks the University and the Faculty of Health and Medical Sciences 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.

Since the last AMC review of the UWA Medical Program (MD 2014) there have been significant changes to both the internal University and the external healthcare environment that have had an impact upon the ability of the Medical School to meet some of the requirements outlined within the first accreditation standard which relates to the Context of the Medical School.

While the team acknowledges that the structural and budgetary decisions made by the University and Health Department are outside the remit of this assessment, there have been downstream consequences of these decisions that have affected the medical program. As the Medical School looks to move forward with a new MD Program, the impact and influence of these changes need to be acknowledged and this assessment offered as an opportunity for the School, Faculty, University and Health Department to consider effective solutions.

This accreditation standard requires that there is a rigorous governance structure in place that is well understood by key stakeholders. The University of Western Australia is governed by the University of Western Australia Act 1911. The 21-member Senate is the University's governing body, empowered with the authority to make statutes, regulations and by-laws, while the Academic Board is the chief academic body. The University is led by the Vice-Chancellor, and a University Executive group that is comprised of the Vice Chancellor; Senior Deputy Vice Chancellor; Deputy Vice Chancellors of Education, Research, and Global Partnerships; four Executive Deans; and the Chief Operating Officer. The University is comprised of four Faculties namely: Health and Medical Sciences; Science; Engineering and Mathematical Sciences; and Arts, Business, Law and Education.

The Faculty of Health and Medical Sciences is led by the Executive Dean. The Executive Dean reports to the Senior Deputy Vice-Chancellor and sits on the University Executive. The structure of the Faculty of Health and Medical Sciences comprises five Schools and underlying academic units called Divisions. The five Schools are: Medical School, Dental School, School of Allied Health, School of Biomedical Sciences, and School of Population and Global Health.

The Faculty of Health and Medical Sciences is supported by five Associate Deans: Learning & Teaching, Research, International, Student Affairs, and Community & Engagement.

The primary functions of the Faculty of Health and Medical Sciences are to deliver educational programs, undertake research in the field of health and medicine, and foster community and health sector engagement and service. The University of Western Australia Medical School brings together ten clinical disciplines called 'Divisions', all of which contribute to teaching the MD, the core of the educational Program. Areas that are specifically involved with organisation and governance of the MD Program

include the Centre for Aboriginal Medical and Dental Health and the Rural Clinical School. While the Faculty's Stage 2 submission also included the MD Education Unit under these resources, this entity does not currently exist beyond its notional existence in the governance structure.

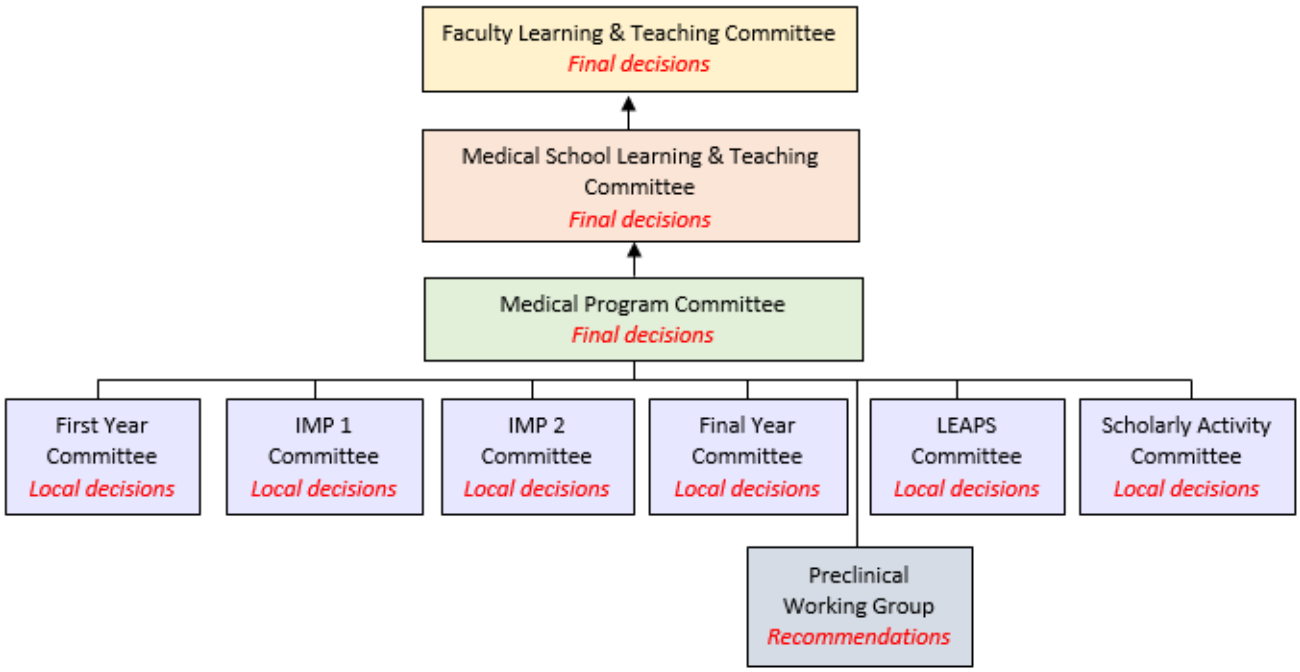
The Faculty of Health and Medical Sciences operates under a governance and decision making framework which is common across all faculties. The key Faculty-level committees are: The Faculty Board, Faculty Learning and Teaching Committee, Board of Examiners, Research Committee, and the International Advisory and Coordination Group. In addition, there are several advisory committees which include the Faculty Executive, Community and Engagement, Health and Safety, Student-Staff Consultative Committee and the Dean's Council.

The Medical School, like all schools in the Faculty, is governed by a similar committee framework including a Learning and Teaching Committee, Research Committee and School Executive.

The Medical Program Committee (MPC) is the overseeing management committee for the MD course. It is seen as the parent committee of the MD Program, a forum for discussion for educational innovation and an avenue for communication with outside agencies. There are six subcommittees of the MPC; the First Year Committee, Integrated Medical Practice 1 (IMP1) Committee, Integrated Medical Practice 2 (IMP2) Committee, Final Year Committee, and the, Leadership, Educator, Advocacy, Professionalism and Scholar (LEAPS) Committee, which includes the Portfolio Working Group and the Scholarly Activity Committee.

The MPC sub-committees are able to make recommendations and local decisions. The MPC is a committee that is empowered to make final decisions, although this committee reports up to the Medical School Teaching and Learning Committee who then report to the Faculty Learning and Teaching Committee. Both of these Teaching and Learning Committees are also able to make final decisions. While there appears to be a lot of overlap in the roles of the MPC and the Medical School Teaching and Learning Committee, the key difference is that the Medical School Teaching and Learning Committee also has oversight of the School's other educational activities in addition to the MD.

Figure 1 - Medical Program Committee, sub-committee structure and decision map.



While this structure is well described and appears to be well understood by those involved in managing the program, it is poorly understood by those teachers who are not involved. This is particularly apparent at clinical sites where both paid and unpaid clinical teachers frequently were unable to articulate how they would escalate issues and which committees were responsible for various elements of the curriculum design or delivery.

The membership of these committees appears to be appropriate, although the team noted that there were a few key people, including the Dean and the MD Program Director, who were present on most committees. This is a risk for the program moving forward. The team also noted that the only committee that included a Community Representative in its membership was the LEAPS committee.

Professional services to support the Faculty of Health and Medical Sciences and the Medical School are now centralised and led by the Head of Faculty Service Delivery. The Service Delivery Centre amalgamates all the professional support services across the University into devolved units within each Faculty. In this model, services are consolidated into functional areas including academic services, technical support, finance, human resources and student life. The Team Leader for each function has responsibility for the delivery of that service to the Faculty and Schools. While the aspiration is that this model will more efficiently deliver services, the current model has been noted to be significantly less efficient than previous models, and the changes appear to have been poorly communicated to key stakeholders, particularly at clinical sites.

While the School appears to have attempted to consult key groups on issues relating to its purpose, the team did not see evidence that the central University had consulted widely, or considered advice provided, on the potential impact of the changes to support service structure on the program.

There are key differences between medical programs and many other educational activities offered by universities. Amongst these is the need to deliver the course across many sites, with a large volunteer workforce and multiple modalities of assessment. Because of these differences, there are elements of the centrally-mandated governance committee structure and accompanying centralised service delivery model that has been noted as not always fit-for-purpose to support a medical program.

In addition, the centralised model of service provision appears to have added layers of complexity to approval processes leading to significant delays in important administrative processes involving staff contracts, staff appointments and reappointment, reimbursement and payments to simulated patients.

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 AMC has adopted the definition of education provider from the Health Practitioner Regulation National Law 2009. While it is acknowledged that the term 'medical education provider' may also be interpreted as being 'the Faculty' or 'the University', the education provider for the purpose of this report is primarily 'the Medical School' as this is the notional entity that is most proximate to the medical program. While the primary focus is the School, each level of governance contributes to the overall provision of the program, and is discussed where relevant in this report.

The University Senate has provided written assurance that the Medical Program Committee (MPC) and its sub-committees will have autonomy for the AMC review process, and that the role of the MPC will be

recognised as having joint leadership for managing the process between the Chair of the MPC and the DVC (Education). Written assurance that the principle of autonomy will be extended beyond the period of this current AMC assessment is required.

Despite the provided assurance from the University Senate, it appeared to the team that centralised educational directives and policies can be perceived to override local decisions made by committees who are, according to the organisational structure charts provided, at a level that should be final decision-making bodies. In addition, the central control of support services and resources reduces the capacity of the School, and the Faculty, to enact decisions in a timely fashion. It is important that this conflict be recognised, and a solution found as a matter of urgency.

The role of the Academic Head of the Medical School (externally known as the "Dean") is well described, however, this substantive role is currently funded as a 0.5 EFT position. There is a 0.8 EFT MD Program Director supporting the Dean, which includes 0.2 EFT teaching time. The team considers that the demands of each role are greater than the substantive allocation allows. There is insufficient time for the effective delivery of the large number of operational roles each are undertaking, as well as the provision of strategic leadership. In addition, there is no dedicated administrator to support either role. Pathways to improve support to both the Dean and MD Program Director should be urgently considered.

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 MPC is the overseeing management committee for the MD course. This committee has the responsibility and authority to plan, implement and review the curriculum to achieve the objectives of the medical program. The MPC is designated a final decision making body, and reports up to the School Teaching and Learning Committee, and ultimately the Faculty Teaching and Learning Committee. Despite its designation as a final decision-making entity, decisions made by the MPC can be difficult or cumbersome to enact due to difficulty accessing centrally controlled resources.

This Standard requires that the overseeing management committee has capacity to undertake the required functions. As noted above, the centralisation of professional services along with the loss of academic staff has meant that the MPC does not always have the resources available to fulfil its functions as described in the Terms of Reference.

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.

A number of key academic positions are currently vacant. The School has a recruitment plan, and has indicated the appointments that are considered high priority. Amongst the high priority vacancies identified are, Evaluation officer, MD Assessment and Portfolio Academic Lead, IMP3 coordinator, and the Preparation for Internship Coordinator. The team acknowledges the risk that these vacancies create for the program and supports the School's view that these high priority appointments, especially those relating to Assessment and Evaluation, be expedited.

The WA Department of Health devolved responsibility for funding Clinical Academic appointments to health services in 2017. In the transition to the changed funding environment, support was withdrawn from a substantial number of positions. The Executive Dean was able to negotiate an arrangement with the VC to cover much of this funding shortfall with the result that the University was able to support the majority of these positions.

Despite these efforts, the change in the funding formula has led to an overall loss of paid FTE and shortfalls in some teaching areas. In addition, it appears that the Faculty processes result in contract renewals and renegotiations being drawn out, and changes are poorly communicated. It is recommended that the reappointment process be strategically reviewed and any further changes carefully communicated.

There is currently no dedicated facility to support the educational endeavours of medical teaching staff, paid and unpaid. Many important educational functions relating to teaching, assessment and learning are now delivered centrally at University level. While the MD Program Director and Dean have accessed these resources, other UWA academics and clinician teachers appear to be unaware of their existence.

The establishment of an identifiable group of experts at the School level, with whom staff can consult for educational design, assessment, evaluation, faculty development (including peer teaching), educational innovation and research would be beneficial.

The Centre for Aboriginal Medical and Dental Health (CAMDH) currently provides support across a broad range of issues within the Medical School including student selection, student support, curriculum design and delivery, and curriculum assessment. CAMDH is ostensibly positioned under the Medical Education Unit on the organisational structure chart, a Unit that no longer exists. Opportunities for CAMDH to positively influence many of the activities of the Faculty would be optimised if it was realigned at a higher level within the organisational structure.

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.

While there is an identified line of responsibility and authority for the program, the current model of professional service provision, along with the loss of professional staff and academic staff in accordance with budgetary constraints, has meant that resource issues can prevent the timely enacting of the School's strategic and operational decisions. One example of this is the process for appointment to vacant positions. There appear to have been multiple delays and administrative hurdles to realising these positions, although no one could fully articulate where the delays are occurring.

The team was provided with a budget that indicates sufficient resource for the program, however, the team noted that the amount allocated to salary reduces over the next five years, which may have implications for the resourcing of the program.

1.6 Interaction with health sector and society

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

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

The School has a strong relationship will all key collaborators and has effective partnerships mostly underpinned by formal agreements with government, clinical sites and community partners. The School also describes a strong working relationship with Curtin University and the University of Notre Dame, Fremantle medical schools, although there is not a tripartite agreement between these organisations.

The Rural Clinical School is a strength, and an excellent example of collaboration between a medical school and the healthcare sector. The efficacy of this collaboration is underpinned by an independent governance structure chaired by a former Minister of Health.

There are currently no formal partnerships between the School or Faculty and the Indigenous health sector. Most clinical teaching involving Aboriginal and Torres Strait Islander peoples occurs in the hospital setting, and is opportunistic rather than planned. The School is encouraged to continue its efforts to establish effective partnerships with Indigenous communities and health service providers.

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.

UWA is a member of the Group of Eight Universities and ranks highly in all ratings of research activity in Australia and internationally. The School also has a research program that rates highly.

The scholarly program affords students the opportunity to participate in research as they progress through the third and fourth year of their training. While there can be logistical issues completing the program within the notional and flexible one day per week during clinical rotations, overall the activity is rated highly.

Researchers teach into the medical program and the curriculum content is underpinned by latest evidence.

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.

As noted above, there has been a University wide change in staffing, with professional staffing services being centralised. This has led to an impression, by both academic staff and students, of a lack of support, with processes underpinning appointments, re-appointments and other critical University functions now noted to be cumbersome and inefficient. Many processes require sign off by the Dean, placing an increased administrative burden on this position, and reducing available time for strategic leadership.

The decisions around re-appointment have also been slow, and academic staff describe working without contracts, and at times having renewals provided at lower fractions, without prior discussion. The reliance on short-term contracts builds uncertainty into the system, and is a risk in an environment where staff are already disenfranchised. The challenges around strategic appointments and recruitment to vacant positions have been outlined previously. It is critical that the Faculty and University review the strategic recruitment plan and find efficient pathways to recruit and retain appointment to these key positions.

The School includes six academic staff members who identify as being Aboriginal or Torres Strait Islander, in addition to Aboriginal or Torres Strait Islander staff employed through CAMDH. It appears there is support for these Indigenous staff, however, there are limited resources to fund staff development, and the inadequate staffing level in CAMDH makes it difficult for staff to take leave to benefit from these opportunities.

Community members acting as simulated patients appear to receive some training, however, there is opportunity to better integrate them into the student learning activities. The community member on the LEAPS committee was well briefed and her input was valued and valuable.

Appropriate indemnification is in place under the University Statutes.

1.9 Staff appointment, promotion & development

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

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

As noted throughout this Standard, the changes to the funding and administrative environment have led to the loss of many academic and professional support positions, either through natural attrition, non-reappointment or resignation. These critical losses, combined with cumbersome and opaque reappointment processes and the reliance on short-term contracts leads to the risk of further resignations from key positions. The University, Faculty and School need to attend to their relationships, improve communication and have adequate resources to mitigate this risk.

Promotion is currently perceived to be more dependent upon research activity rather than teaching input. This is not true at the Rural Clinical School. It is recommended that there be improved recognition of teaching excellence for those academics in teaching intensive positions, especially in the current environment when keen and able teachers are in high demand.

2 The outcomes of the medical program

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

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

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

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

2 Clinical Practice: the medical graduate as practitioner.

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

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

2.1 Purpose

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

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

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

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

The School's mission statement has remained the same since the course was introduced in 2014. The mission is to produce graduates who will be committed to the well-being of the patient, community and society as accountable, responsible, scholarly, capable and caring doctors.

The School has also outlined the goals of the MD Course as:

- Commitment to the profession of Medicine.
- A focus on well-being, rather than only health and illness.
- A broad vision of improving health outcomes, not only in individual patients, but also for the local community and global society, which includes leadership and advocacy skills.
- Accountability and responsibility for clinical and professional behaviour.
- Having scholarly knowledge and skills to use the best scientific evidence in healthcare.
- Being capable in terms of clinical, research and educational skills.
- Showing care, respect and empathy to others.

The purpose of the School is reviewed and communicated in consultation with internal (e.g. Medical Program Committees) and external stakeholders (e.g. Alumni and WA Health Chief Executives and Directors). However, consultation should occur more widely to ensure that the Program is responsive to

the needs of Aboriginal and Torres Strait Islander peoples and that health, teaching, service and research activities relate to the health care needs of the wider communities it serves. Explicit recognition of Aboriginal and Torres Strait Islander peoples, and their health should be formalised in the purpose of the School.

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 program's 24 Graduate Outcomes continue to be grouped in six themes as shown in table 1.

Table 1 – Medical Program Outcomes

Themes		Strand	Graduate Outcome
Professional	1	Professional Behaviours	Display individual, interpersonal and work based professionalism in all aspects of professional life
	2	Self-Care and Self-Awareness	Display critical and insightful self-awareness of own personal values, wellbeing, personal difficulties and professional performance and implement effective management strategies when necessary
	3	Medical Ethics and Law	Comply with and apply ethical, legal and regulatory frameworks in medical practice
Leader	4	Teamwork and Leadership	Display appropriate medical leadership, management and effective team skills and behaviours
	5	Collaborative Practice	Participate effectively in collaborative health care
	6	Health Systems and Careers	Discuss health organisations, healthcare systems and career pathways; and display the ability to assist patients/carers/families navigate their healthcare journey
Advocate	7	Health Advocacy	Demonstrate advocacy for individual patients, groups, communities or populations
	8	Indigenous Health	Display culturally secure communication and comprehensive health care for Aboriginal people and communities taking into account the historical, geographical and socio-cultural context
	9	Diversity and Inequality	Provide sensitive and individualized health care to patients/carers/families/communities recognising diverse backgrounds and situations
	10	Health Promotion	Evaluate and apply health maintenance, promotion and prevention strategies

Clinician	11	Scientific Knowledge	Inform medical practice with critical evaluation and application of biomedical, behavioural, epidemiological, clinical and translational sciences
	12	Patient Assessment and Clinical Reasoning	Perform an accurate, relevant, timely and prioritised patient assessment; apply justifiable diagnostic reasoning strategies to formulate a relevant and prioritized differential diagnosis and diagnostic strategy for core presentations and medical conditions; and apply logical clinical judgement and decision-making in individual clinical situations
	13	Patient Management	Demonstrate the formulation, negotiation and implementation of a prioritised management plan in partnership with the patient/carer/families and other health professionals displaying logical clinical judgement and decision-making
	14	Patient Perspective	Assess and respect the patient's values, preferences, context, perspectives and impacts of their health and health problems, and involve and inform the patient/carers/families during the decision-making and management process
	15	Clinical Communication	Display caring, compassionate and empathic behaviours with patients/carers/families and communicate professionally, respectfully, courteously and effectively with patients, carers, families and other health professionals
	16	Quality Care	Apply a quality framework to medical practice and display a commitment to high quality clinical standards
Educator	17	Life-long Learning	Display capacity for critical self-reflection, life-long learning and continuous professional development
	18	Mentoring relationships	Establish effective mutually beneficial mentoring and support relationships
	19	Patient Education	Demonstrate effective teaching, education and counselling of patients/carers/families
	20	Effective Teaching and Learning	Implement teaching sessions guided by the principles of effective teaching and learning
	21	Assessment and Evaluation	Display effective self-assessment skill, seek and effectively respond to constructive feedback, provide constructive feedback to others, and evaluate different assessment methods and strategies
Scholar	22	Research and Biostatistics	Evaluate and apply scientific, research and biostatistical methods and information and demonstrate a commitment to generation and dissemination of knowledge
	23	Evidence-Based Practice	Apply evidence-based practice to individual patient, community or society health care
	24	Information Literacy	Use clinical information and support systems and resources in a relevant, effective and professional manner

These themes and outcomes are integrated into the teaching, learning and assessment activities and form the content of the Program. The defined graduate outcome statements are consistent with the AMC's goals for medical education.

Students are able to enter the Program via completion of a specific Major in Medical Sciences (MJD-MEDSC) as their undergraduate degree. Completion of this major confers Advanced Standing for recognised prior learning equivalent to the first year of the MD course. These students enter the MD program directly in MD Year 2. While the Major in Medical Sciences (MJD-MEDSC) final year and the first year of the Doctor of Medicine (MD) are considered to be equivalent, it was noted that the assessment processes differ. Assurance that the outcomes of the final year MJD-MEDSC and first year MD are equivalent is required.

The School is commended on the Rural Clinical School (RCS) and the online platform, REFLEX, that supports the delivery of the curriculum in the rural settings. RCS Staff who met the team were confident that they knew their discipline's learning outcomes and ensured students across sites had equivalence of clinical content and outcomes. Assessment results across the RCS have been reviewed and were reported as comparable to students in urban sites.

3 The medical curriculum

3.1 Duration of the medical program

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

The University of Western Australia's MD program, introduced in 2014, is a standard four-year professional masters (AQF9 Extended) course, requiring a three-year undergraduate degree to precede it and thus a minimum of seven years of tertiary study to obtain an MD. Graduate students spend the first year learning a compressed version of the curriculum of the University's undergraduate Major of Medical Sciences (MJD-MEDSC) degree and begin clinical placements in the second year of the medical course after an intensive 12-week clinical preparation program.

Several factors had aligned in 2015 to lead the University to construct a direct entry pathway to the medical course, which took its first intake in 2017. The AMC was informed of this change via progress reports in 2017 and 2018, and the School was asked to report on the evaluation of the direct entry pathway. High achieving domestic secondary school students became eligible to apply to join the medical course's second year after satisfactorily completing the University's undergraduate Major of Medical Sciences (MJD-MEDSC) in the Bachelor of Biomedical Sciences degree, earning advanced standing and recognition of prior learning for the first year of the MD course. Thus, there began two streams of students entering the MD, one of which will complete the course in three years (making a minimum of six years of tertiary study) and the other in four. The newly launched medical course at Curtin University is a five-year school leaver program.

The team considered the impact of this change on the duration of the course and looked for any evidence that students were entering clinical training via either pathway without having sufficient time to lay the necessary foundation of biomedical knowledge and basic clinical skills. No such evidence was forthcoming, but the team did note that there was widespread dissatisfaction amongst students, staff and other stakeholders that clinical context, basic clinical skills development, and the commencement of professional identity formation were largely absent from MDY1, having been moved to MDY2.

The Faculty undertook a review of this decision early in 2019 and a new curriculum has been designed for introduction in 2021 that addresses these concerns. Several changes have been immediately instituted in Years 1 and 2 for the current cohort, and further changes will be made for the 2020 cohort, such as the introduction of Team-Based Learning cases and some clinical role plays.

The alignment of learning objectives and taught content within MJD-MEDSC and MDY1 make it likely that the medical course will be of sufficient duration for students to achieve the defined graduate outcomes. It is important, however, that the Medical School have significant input to the "crossover" third level of the MJD-MEDSC course so that a clinical context is provided to direct entry students at the same level as the graduate students undertaking MDY1. The MJD-MEDSC is not a medical program, but consists of teaching and learning in the biomedical sciences that aligns with the scientific knowledge of the MD program.

The Faculty has recognised the unintended consequences of removing clinical context, basic clinical skills and the commencement of professional identity formation from the first year of the medical program (MDY1) and has made immediate changes for 2019 and 2020. It has also obtained the necessary university approvals for a redesigned curriculum from 2021 that should assist all students to achieve the defined graduate outcomes within the course's duration.

The entry of Curtin University as the third provider of a medical course in Western Australia places increased pressure on clinical placements throughout Western Australia. This raises the possibility that some students might not be able to access the prescribed range of clinical placements and thus the required graduate attributes within the course's duration. The team heard from multiple stakeholders that this is a concern, although it was unable to determine the likelihood of this outcome and noted that those responsible for managing the program were confident of access to sufficient clinical placements.

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.

Year 1 consists of two, 15 to 18 week units, titled Integrated Medical Sciences 1 and Integrated Medical Sciences 2. These units provide the scientific foundation for medical practice and include learning in medical sciences, and body systems.

Year 2 comprises, 40-week unit, titled Integrated Medical Practice 1. This consists of a 12-week intensive Clinical Preparation block, followed by four 7-week clinical attachment rotations. Year 2 includes learning in clinical preparation, internal medicine, geriatrics/rheumatology, surgery, psychiatry and general practice.

Year 3 comprises a 40-week unit, titled Integrated Medical Practice 2; for urban students, this consists of five eight-week clinical attachment rotations and for rural students, one 40 week clinical attachment at a rural site where students are exposed to the disciplines taught in the discrete urban attachments. Rotations include paediatrics, obstetrics and gynaecology. A scholarly activity is also undertaken in this year

Year 4 commences with an elective unit, followed by a 30-point, 30 week unit, titled integrated Medical Practice 3. A Scholarly Activity unit is taken concurrently. Following an examination period in September, students undertake a Preparation for Internship unit prior to graduation.

The course structure from 2021 is represented in Figure 2.

Figure 2 - MD Course Structure

Doctor of Medicine 91850 (Masters Extended – Level 9, Volume of Learning - 192 points (2021 course structure)

<table>
<tr><th></th><th>Semester 1</th><th>Semester 2</th><th></th></tr>
<tr><td>YEAR 1</td><td>IMED 3111 (24 points)
Integrated Medical Systems 1</td><td>IMED 3112 (24 points)
Integrated Medical Systems 2</td><td></td></tr>
<tr><td>YEAR 2</td><td>IMED 4220 (24 points)
Integrated Medical Practice 1 Part A</td><td>IMED 4222 (24 points)
Integrated Medical Practice 1 Part B</td><td></td></tr>
<tr><td></td><td colspan="2">(Clinical Preparation, Internal Medicine, Geriatrics/Rheumatology, Surgery, Psychiatry, General Practice)</td><td></td></tr>
<tr><td>YEAR 3</td><td>IMED 5311 (18 points)
Integrated (Rural) Medical Practice 2 Part A</td><td>IMED 5312 (18 points)
Integrated (Rural) Medical Practice 2 Part B</td><td></td></tr>
<tr><td></td><td colspan="2">(Paediatrics, Obs & Gynae, Medicine, Surgery/Psychiatry, Gp/Ophthal)</td><td></td></tr>
<tr><td></td><td>Scholarly Activity 1 (6 points)</td><td>Scholarly Activity 2 (6 points)</td><td></td></tr>
<tr><td>YEAR 4</td><td>IMED 5411 (18 points)
Integrated Medical Practice 3 Part A</td><td>IMED 5412 (12 points)
Integrated Medical Practice 3 Part B</td><td rowspan="3">IMED 5421 (12 points)
Preparation for Internship (Extension/Transition to Internship/Break)</td></tr>
<tr><td></td><td colspan="2">(Emergency Medicine, Medicine, Surgery, Rural GP, Selective, Anaesth/Palliative care/Pain/Oncology)</td></tr>
<tr><td>Effective</td><td colspan="2">Scholarly Activity 3 (6 points)</td></tr>
</table>

Changes in course structure as well as increased pressure on clinical placements carry some risk of students not meeting the required attributes within the course duration. In terms of curriculum content, the team noted that the attributes of the medical graduate as a scientist, scholar, practitioner, health advocate, professional and leader were well-expressed within the "PLACES" framework overseen by the LEAPS committee and that the students' portfolio was an important part of tracking their progress towards competence in these domains.

3.3 Curriculum design

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

The current medical course and the version proposed for 2021 both demonstrate purposeful design. Horizontal integration is enabled by year-level committees through which both curriculum content and assessments can be aligned. It was apparent to the team that collegial relationships on these committees enhance their work.

A list of core conditions and presentations (starred to indicate relative priority) provides students and teachers with a rough guide for focusing learning. A curriculum mapping database is under development that assists with tracking where key topics appear throughout the course and provides the learning objectives for specified learning activities. When fully functional, designers, students and teachers will be able to navigate the curriculum to revisit earlier topics and ensure coverage of key areas. This resource would be greatly enhanced by further investment to allow mapping of assessment items and thus better integration and blueprinting of assessments across the course.

Students have two general practice terms, one metropolitan and one rural, at which the patient-centred integration of other medical specialties can be seen. The Rural Clinical School provides an excellent guide to study while on placement.

The lack of integration of key themes caused by the introduction of direct entry in 2018 has been addressed in the new course design for 2021 and by a range of interim measures before then. The risk remains, however, that the ultimate stage of the direct entry course loses alignment with the first year of the MD course, for which it provides advanced standing. The team considered that a formal arrangement between the Faculty of Health & Medical Sciences' medical school and the Faculty of Science to co-manage the MJD-MEDSC may help ensure that students' learning is appropriately integrated across all years of both courses.

The School has proposed a redesigned curriculum that reintroduces basic clinical skills and clinical relevance to the first year of the course.

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.

Students and staff have access to the MD course guidebook via the University's learning management system. A curriculum map is currently being developed with the intention of clearly identifying learning and teaching, assessment and learning outcomes across the Program.

The team heard from multiple stakeholders that there was significant inconsistency in the teaching provided at different sites, with some teachers saying that they were uncertain what was expected of them and so they taught what they thought was most appropriate, even though they felt they did not come to know the students' needs over short rotations. It was said by some clinicians that communication from the School was variable and often lacking, while others, who were more engaged, were clearly aware of the requirements of the course and of them as clinical teachers.

Medical courses are logistically complex and the University of Western Australia's is no different. Students are scattered over a wide range of clinical placements, being supervised and receiving tuition from multiple teachers with varying levels of engagement with the School. It is recommended, however, that the School consider adequately resourced processes or organisational structures that might better connect clinical teachers with the content of the curriculum, the School's expectations of them, and with the students themselves.

The Rural Clinical School was seen as a good example of an organisational structure within which students were well-known and where a clear understanding of expectations of teachers was evident.

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 School works with Centre for Aboriginal Medical and Dental Health to integrate the Aboriginal Health Curriculum into the program. The curriculum is composed of both stand-alone Aboriginal health content, and content integrated with other program learning. Specific assessments include an Aboriginal case report in year 2; short answer questions in exams; multiple choice questions; and an OSCE station in Year 4.

The team was deeply impressed by the collegiality of members of the Centre for Aboriginal Medical and Dental Health and their desire to be proactive in the teaching of Aboriginal health and the inclusion of Indigenous knowledge within the course. However, limited resourcing and restricted opportunities to influence curriculum decisions mean that their educational input is necessarily reactive to requests from course planners. The proactive role of Aboriginal educators would be made more effective by addressing these factors. Inappropriate positioning within the School's organisational structure raises questions about CAMDH's independence.

Notwithstanding these limitations, the team noted the appropriateness of the students' portfolio including an Aboriginal patient and the opportunity for students to extend their learning through a scholarly activity extension. The Rural Clinical School's focus on Aboriginal health was also recognised.

3.6 Opportunities for choice to promote breadth and diversity

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

There are several opportunities for students to choose breadth and diversity, including a choice of undergraduate study pathways before entering the medical course.

Within the medical course itself, a clinical elective at the commencement of the final year provides the greatest opportunity for students to explore medicine locally, interstate or overseas. Students also have the opportunity to choose scholarly activity and service-learning opportunities during the semester that expose them to unique aspects of medicine and life.

Other opportunities for choice include clinical electives and selectives, work in the Scholarly Activity, and specialisations in Aboriginal or rural health.

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.

Although a range of learning and teaching methods are employed during the program, those in MDY1 are predominantly lecture-based at present. These often provide little clinical context for the biomedical information. Providing this would facilitate students' learning. Further, because the lecture theatre facilities are inadequate to accommodate all students, streaming to adjacent teaching rooms is necessary. The School recognises the unsatisfactory impact of these factors on fostering effective learning by students; developing a sense of professional identity through direct personal contact with faculty; and early identification by staff of students requiring additional support. Preliminary information about the proposed 2021 MDY1 program indicates that a wider range of teaching methods will be employed to address these concerns and to ensure that the clinical context of learning will be explicit.

Students in the later years of the program valued the standardised teaching around core topics provided by some disciplines, particularly obstetrics & gynaecology, paediatrics, general practice, and the Rural Clinical School. It is recommended that all disciplines review how they can best facilitate student learning of core information during clinical attachments to ensure consistency of learning outcomes across all sites.

The utilisation of digital learning resources was variable across the program and there did not appear to be a process to curate recommended eLearning packages. The School may wish to consider a whole-of-program eLearning strategy and facilitation of blended learning methods.

Some students and their teachers viewed the portfolio as a passive repository for records of set tasks requiring only superficial reflection in order to meet the assessment requirement, and that there was little educational benefit extracted from it. Further work is planned to maximise the value of the learning portfolio in light of the importance of the portfolio in not only documenting students' progress towards attainment of the attributes but also supporting it.

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.

As a graduate entry program, most students are already attuned to self-directed learning and life-long learning. This is reinforced by elements of the LEAPS program and through student peer education tasks. Some students expressed a wish for some clearer direction of their self-directed learning, particularly in the clinical phase of the program. While completion of the Curriculum Map is likely to assist with this, it is suggested that explicit attention is directed towards this during clinical supervision.

4.3 Clinical skill development

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

The School utilises simulation in the learning of procedural and clinical skills during the clinical preparation block that begins Year 2 in particular, with further utilisation during MDY2 and MDY3. If necessary, one-off workshops are provided during Year 4 if the School received feedback that students appeared to have difficulty in a specific area of examination. The School owns a range of mostly low

fidelity models. Video facilities are available for some interview training sessions but these are not utilised routinely. High fidelity models are available on campus, but are utilised almost exclusively for postgraduate training. The School may wish to review the potential of this resource for clinical skills development.

Some West Australian hospitals have indicated to the School that they will soon require students to be credentialled to perform certain procedures prior to graduation. The School is encouraged to clarify and collate these expectations, develop appropriate training, and to identify the associated resource requirements.

The School's relationship with simulated patients is strong. However, enhanced, formal training for the simulated patient role may be beneficial to enable these contributors to be more effective co-educators.

Graduates of the program have a strong reputation with clinicians as being particularly competent in procedural skills.

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.

Students have access to a wide range of clinical settings, including the relatively recently opened Fiona Stanley Hospital. Although at times there are excessive numbers of students in a given placement or on a ward round, this appeared to be the exception rather than the rule, and was generally not a planned event. Concerns were expressed that this is likely to change with the increase in the number of medical students in Western Australia in the coming years and that specific strategies to address this are still a matter of discussion.

Students reported that direct observation of their clinical skills during clinical attachments, other than during designated assessments, was uncommon.

4.5 Role modelling

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

The School is exceptional in providing each student with an individual clinician mentor throughout their course, and near-peer mentoring by a senior student during their first year. Additional mentoring and role modelling occur during the Scholarly Activity or alternative Service-Learning elements of the capstone experience.

These activities are valued by the students and there is good engagement in the program by staff and students alike. The support that these schemes provide was well received by students and the team heard examples of the positive impact that the program has had.

4.6 Patient centred care and collaborative engagement

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

The School and related services are committed to the provision of patient centred care. This is a particular focus in general practice, the Rural Clinical School and certain hospital specialties. The students' learning portfolio was seen as a valuable tool in encouraging reflection on the patient experience.

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.

Students are exposed to working in multidisciplinary teams across a range of specialties during their clinical attachments. There have been some efforts to establish formal interprofessional learning (IPL) opportunities although these are yet to be sustained. In particular, efforts to collaborate with Edith Cowan University final year nursing students have been explored, but are yet to be realised. The School has plans to progress this and has identified an IPL lead, who is yet to take up this role.

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.

The School's assessment approach is governed by the UWA Assessment Policy. This is clearly articulated and is based around fairness, validity, efficiency and the concept that assessment is integral to the learning process. The policy is readily accessible for all staff and students.

The team commends the School on its awareness of the concerns around assessment quality and recognition of the need to prioritise assessment as an area for improvement. It is clear that policies and principles are in place, but implementation of some approaches have been precluded by the absence of an assessment lead. Given the amount of changes that have been undertaken in the university structure and in the program curriculum, ongoing communication around assessment is fundamental to engagement of stakeholders. The School is aware of the importance of sound assessment approaches and the need to communicate effectively.

Assessment and progression requirements are documented, and no specific concerns were raised about the transparency of the approach. The MPC reviews the progress rules on an annual basis. Units meet to discuss student results and conduct any required moderation. The Faculty Board of Examiners is the final decision-making body in terms of student progress decisions. The process is enhanced by having the Associate Dean for Student Affairs at the Board of Examiners meetings to present relevant information on special consideration for any particular students. Any student who has been deemed to have failed following an Board of Examiners meeting is contacted by the Student Experience Manager, and the relevant unit coordinator is included in that correspondence so they can offer a meeting with the student.

The School's attempts to provide students with formative assessment have been of varied success and on occasion were led by the student society. The Rural Clinical School (RCS) is commended for its holistic approach to balancing formative and summative assessments for students. The RCS OSCE early in Year 3 provides targeted feedback and directed learning for students. In comparison, the sequential OSCE for all MD students in final year created a significant amount of stress for students who were left with little information on how to direct their learning if they were required to sit part 2 of the OSCE.

The School is encouraged to review the balance of formative and summative assessments and how these can best support student learning, and subsequently implement changes as required. The review could consider how best to support assessment for learning rather than assessment of learning.

5.2 Assessment methods

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

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

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

The medical program employs a range of assessment methods aligned to the learning settings of the students. Written assessment methods include single best answer multiple choice questions, extended matching questions, visual aided examinations, short answer questions, and modified essay questions with progressive release of clinical information. Clinical assessment formats include traditional short case history and examination stations, Structured Clinical Assessments, case-based discussions, and a multi-station OSCE in Years 2 and 4.

The year committees produce a summary of unit assessments and these are tabled at the Medical Program Committee for approval. In the absence of a comprehensive curriculum map, it is not possible to demonstrate the degree of alignment with the intended learning outcomes. Unit specific assessments allow for timely feedback to students on their performance, but this puts an extra burden on unit coordinators and therefore needs resourcing. The Rural Clinical School has aligned its assessment approach to match the method of learning in the rural setting.

There are various sources of data to show where assessments are in the medical program and how they align to the intended learning outcomes. An overarching MD Assessment Blueprint has been provided and it would be useful to review the utility of this for rationalising current assessments or introducing new ones and ascertain whether the amount of detail provided in the blueprint is sufficient. It will be important to review the accuracy of the blueprint across the whole of the Medical Program, irrespective of entry pathway and whether the student is of an urban or rural origin, on an annual basis, given that specific assessments such as the OSCE will only sample a limited number of learning outcomes each year.

With the changes planned to the curriculum for 2021 entrants, there needs to be a clear strategy around review of assessment approaches to ensure that they are fit for purpose, particularly in the preclinical phase. The use of the portfolio could assist directing student learning, but it was not seen as valuable by the students. There seemed some confusion about the extent to which the portfolio contributed to overall student assessment. A review of its utility would be beneficial.

The AMC standards requires that medical programs use validated methods of standard setting for all assessments. It has been suggested that those previously used by the medical program were viewed as norm-referenced and do not satisfy the University of Western Australia standards. Although marking rubrics are provided for some in-year assessments, these do not demonstrate that an effective criterion-referenced standard setting process is being applied. The current approach, to align with the University policy of a pass mark of 50%, does not demonstrate an acceptable standard setting process, as required by the AMC Accreditation Standards. There may be resource implications in introducing an acceptable standard setting process and so Faculty level support for resourcing this is imperative.

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 processes for identification and support for students who were not performing to the expected standard appears satisfactory. Remediation is the responsibility of Unit Coordinators and the Sub-Deans facilitate overall student support and communication across terms and sites. Comments from supervisors, clinicians and professional staff generally suggested a broad-based approach to identification of students in difficulty and awareness of the processes for remediation etc. In the rural general practice settings, there was a sense that sequential assessment helped drive student learning effectively.

Students' main concern was the lack of effective feedback to guide their learning. Opportunities such as the portfolio and the REFLEX online record of learning opportunities in rural settings were not always used in a timely fashion to guide student learning. Students noted it could be some time before a comment was made on their reflections in the REFLEX record and this limited the benefit for further learning.

Students noted that an injunction printed on one assessment schedule against discussing those assessments removed opportunities to share reflections on exam performance among students and for them to use this as a learning opportunity. The Program Director recognised this issue and indicated that this was being addressed. A review of the examination feedback process is recommended, with a focus on how this can support student learning.

Given all the changes to the curriculum, progressing and planned, a formal systematic communication to all supervisors and teachers on student cohort performance would be of great value, particularly to those who have contributed test items. This is currently only done on an ad hoc basis so may not be as effective as it could be.

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.

In 2016 the University underwent a Faculty restructure resulting in the loss of the Assessment and Feedback Committee, which held governance of the School's assessment program, in conjunction with other Program committees. Recent ad hoc quality assurance activities around assessment, have been useful and are commended. The absence of an Assessment Lead and having no dedicated Assessment Committee have made a comprehensive approach to assessment quality assurance difficult. Attempts have been made to undertake some quality assurance activities, including a two day 'Assessment Essentials Course' in 2019 to increase skills, although only three academics from the Medical Program attended the course.

It is acknowledged that it is challenging to engage clinicians and geographically dispersed staff in face to face learning, but it will be important to look at ways to achieve this in the future. There is a small pool of academics who are trained in item-writing through their involvement in benchmarking collaborations and expanding this to a broader group would be beneficial. Some quality assurance has been done by commissioning services e.g. a collaboration with the Graduate School of Education to undertake psychometric analysis of the written exam and by using the ACCLAiM collaboration to assist benchmarking of the OSCE stations. There is no formal process in place for the Year 4 OSCE to review the types of competencies assessed year on year to ensure broad coverage.

It is acknowledged that there is some variation in the assessment practices between the urban and rural sites, but this was not seen as a major risk and appeared to reflect alignment with the way the curriculum was delivered, although in the absence of a whole-of-program assessment blueprint aligned with a curriculum map, formal examination of this by the team was not possible. There was no evidence that different standards were applied to the detriment of the decisions about student progress although concerns were raised about the validity of some unit assessments. A more formal collaboration for regular discussion and comparison of assessment data across all urban and rural sites would allow all stakeholders to be informed about any inconsistencies. The procurement of an enterprise solution for assessment data management would be of significant benefit for quality assurance of assessment across the Medical Program.

It is also necessary to determine whether differences in assessments between Year 3 of the MJD-MEDSC and Year 1 of the MD disadvantage students in either pathway, and this could be captured in evaluation of the medical program.

It is not clear where accountability for assessment quality assurance and quality improvement sits in the current governance structure. At present there does not appear to be a process to ensure efficient resource utilisation in provision of assessments that support student learning.

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.

Monitoring of the medical program is currently undertaken at multiple points at University, Faculty and Discipline level, and this has been supplemented by an external review in 2019. At the University level, a longitudinal student evaluation is undertaken at the unit level. Units that are regarded as unsatisfactory by students, undergo a further unit analysis, which is considered by the Associate Dean of Learning and Teaching. The Faculty administers annual, year-based surveys aimed at assessing the learning outcomes for that year. Individual disciplines complete an evaluation activity at the end of each rotation or at the end of the clinical placement. These take the form of on-line, written evaluation, and are concerned only with the teaching in the particular rotation or site. In addition to these evaluation activities, the Student Society solicits feedback from the cohorts, which is fed back to the School via the relevant committees.

The School notes the challenges to implementing a strategic, coordinated, and responsive approach to evaluation of the Program with the loss of an academic lead for evaluation and the absence of an Evaluation Committee. Any course review is now the responsibility of the Medical Program Committee, and the Learning and Teaching Committee and there is no formal process for evaluation of staff who teach into the Medical Program. The Western Australia Medical Student Society (WAMSS) is to be commended for taking a lead role in program evaluation, but this should not replace a strategic role taken by the Medical Program or broader institutional authority. The commissioning of an external review is positive, and it will be important for someone or a specific committee to have oversight of implementation of its recommendations. There is clear evidence of those involved in leading the Medical Program being agile and responsive where major concerns have been raised but there is a risk of a reactive culture around ad hoc evaluation. When an evaluation lead is appointed, a more systematic approach could ensure that any proposals for change can be implemented with appropriate consideration of project management, resource implications, communication strategy and risk mitigation. The medical program staff are to be commended for their recognition of the need for improvement and a desire to take a more effective approach.

Various external data sources for evaluation are drawn on such as QILT data and the AMC preparedness for internship survey. A more formal mechanism to feed these data back to committees and stakeholders would be beneficial.

There is currently no clear link with the Postgraduate Medical Council, or the health department more generally, to ensure that graduates are well prepared for internship, enabling timely changes to the curriculum when required. The new chair of the Postgraduate Medical Council will be an important stakeholder in this process and it is recommended that this relationship be developed in a timely manner.

A key priority for evaluation is the quality assurance of the assessments in the Medical Program as it will be difficult to ascertain how best to reallocate assessment resources without robust evaluation data. Given the multiple sources of evaluation data being collected, it is not surprising that some response rates are low. Streamlining surveys and using other ways to collect timely feedback could be considered. Given the Medical Program is embedded in a Faculty with similar courses, there could be opportunities to share expertise and develop evaluation strategies across the Faculty.

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 Academic Lead on Selection undertakes tracking of student performance by entry pathway. This scholarly approach is to be commended. Given the importance of these data in relation to different admission processes, it is important there is clear accountability in the governance to receive and act on such results. The formation of an admissions committee would be beneficial if they can then make recommendations at the Faculty level about any changes needed in the approach to student selection.

There is currently no ability to capture the outcomes of the medical program although the AMC preparedness for internship survey has provided some data. Given that many graduates remain in Western Australia, there would be value in exploring ways to follow up with graduates and health services, perhaps drawing on the resources of the alumni office.

The Rural Clinical School has had a strong approach to evaluation, including the use of the DREEM survey. These results could provide valuable insights for the program as a whole and so reporting lines back into overall program governance are important.

With the planned changes to the curriculum from 2021, monitoring across cohorts will be important to ensure that curriculum developments have been beneficial.

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 extent of stakeholder awareness of how the graduates are performing is not clear. While clinicians considered that students held good clinical skills, formal feedback on student or cohort performance was not evident.

An evaluation plan to include strategies to engage with stakeholders in increasing their awareness of the Medical Program and seeking feedback on outcomes is required. This approach would strengthen the School's ability to engage with and learn from the community. A systematic approach to providing evaluation data to academic and clinical staff would enhance their engagement with the curriculum and, given the changes and restructure, this could be a priority. The commitment to evaluation of the student

society should be acknowledged and they could be a valuable partner in developing communication strategies with graduates.

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 Medical School aims for a maximum cohort size of 239 medical students per year, which is composed of 209 Commonwealth Supported Places for domestic students, and 30 places for International fee-paying students. 30% of the CSP places are offered under the Bonded Medical Places scheme.

Up to 20 Commonwealth Supported Places (CSP) are reserved for Aboriginal students. To date the School has not been able to reach its aspirational goal of Aboriginal students however in 2020, the School will make progress towards its target with 13 places being filled by Aboriginal Australian students. CAMDH works closely with the School of Indigenous Studies to promote, recruit, prepare and support Aboriginal students in medicine to build on their success in graduating Aboriginal and Torres Strait Islander doctors. In 2019, there were 13 Aboriginal students across all years of the medical program at UWA.

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.

Entry into the course occurs via either a Direct Pathway or a Graduate Entry pathway which are underpinned by University policy and processes. Direct Pathway students are school leavers, initially admitted to a Bachelor degree, and then progress to the Doctor of Medicine subject to achieving satisfactory grades. These pathways both have sub-groups to account for selection of rural students, students from educationally disadvantaged backgrounds (Broadway program) and Aboriginal and Torres Strait Islander students. Those who complete the MJD-MEDSC are awarded advanced standing for the first year of the MD and enter the program directly into Year 2 of the MD. All other students are admitted via a Graduate Entry Pathway. In 2017, the University Academic Council decided that the number of School-leaver pathway places should be increased to 70% of the cohort, which was a decision applied to all direct pathways programs across the University. The remaining 30% are allocated to Graduate Entry Pathway students.

Matters of Academic Selection and Admission are currently the responsibility of the Head of the Medical School. The governance arrangements for admissions are currently under review. A Selection Subcommittee is proposed to form under the Medical School Learning and Teaching Committee, led by the Faculty's Academic Lead of Selection and with representation from the Faculty Admissions Team, Student Affairs, and the academic staff who are familiar with the International, Rural and Aboriginal pathways.

The establishment of such a committee is critically important to ensuring communication, oversight and review of all of the selection and admissions pathways for the medical program. It will also provide a good platform to monitor student performance in the program against selection and admission pathways. It is recommended that an admissions database be established that captures all of the selection and admissions data from each of the selection pathways so that student performance and progression can be monitored overtime and evaluation against the selection criteria can be considered.

Admission to the program is via an admission test, and Multiple Mini-Interview. The criteria on which intake is based includes:

- Explaining Skills/Graduate Presentation Exercise.
- Awareness of social diversity.
- Provision of assistance.
- Self-awareness.
- Working with others.
- Motivation and commitment to a career in medicine; and
- Communication skills.

There may be benefits in reassessing the selection and admission process of International students into the medical program in light of the following:

- The financial cost to undertake face to face interviews in their home country; and
- In light of these students performing at a consistently lower academic level across all years of the program compared to those selected using similar criteria.

The program has a separate admission pathway for Aboriginal and Torres Strait Islander students. Their academic background and capability is reviewed to ensure the best likelihood of success in the program and they attend a three-person panel interview. It is recommended that panel members undertake interview training similar to that conducted by the School for other selection processes.

7.3 Student support

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

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

- *students with disabilities and students with infectious diseases, including blood-borne viruses*
- *students with mental health needs*

- *students at risk of not completing the medical program.*

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

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

Students have access to a range of support services offered by the Faculty and University. The Faculty Student Life office offers practical support with administrative matters such as enrolment, graduation and electives.

A range of academic support services are available at the University level, which includes academic writing, exam preparation and mentoring programs. The UWA MD mentorship program includes additional educational and professional support via a clinical mentor. The student society is also active in supporting students via the Student Med mentoring program, where students of other ears of the program offer support to their peers.

Students felt well supported through the provision of advice and counselling from individuals such as the Associate Dean (Student Affairs) and the Sub-Deans. There are concerns, given the multiple roles of the Sub-Deans, that this may place additional workplace pressure on them and also limit their availability to appropriately fulfil this role.

The team commends the Rural Clinical School for the comprehensive personal and academic support and in particular, their proactive support to students around mental health issues. This support is well received by students and appears to have influenced their preferences to undertake additional clinical placements and training in rural settings.

Aboriginal and Torres Strait Islander students continue to have access to a range of support via the University, School, CAMDH and the School of Indigenous Studies. The team commends the School on their continued dedication and efforts given to graduating Indigenous Australian doctors.

7.4 Professionalism and fitness to practise

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

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

The UWA MD course has clearly defined professional behaviour standards and assessment processes. A strong framework for the management of professional behaviour is in place to monitor, detect and address unprofessional behaviour. Exemplary professional behaviour is also recognised through the School's professionalism processes.

Professional behaviour is a barrier assessment in all units of the MD program and it is assessed in several ways. For example, in Year 1 students complete a mandatory professionalism workbook. There are a number of activities that help to assess fitness for practice. These include the Portfolio as well as clinical practice placements. If professional behaviours are identified that are inconsistent with good clinical practice, the School has adequate processes to address this fairly.

The clinical mentors, through their close engagement with the students, play a key role in identifying issues of professionalism that a student may need assistance to address. In these cases, the mentoring program coordinator will be notified, and the student and mentor contacted to determine if there are issues of professionalism. There are clear processes on how such issues are identified and addressed. The Western Australian Medical Students Society (WAMSS) commented that these assessments are fair and have a focus on learning and improvement.

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.

WAMSS demonstrate commendable leadership, motivation and commitment to quality student experiences. The School's relationship with WAMSS is strong, and extensive student involvement occurs through representation and input on school committees.

WAMSS is very active in evaluation of the program and this has been very helpful to the School. The School needs to mitigate the risks of utilising WAMSS and its activities as a resource that the School relies upon, rather than fostering the relationship as a partnership.

The AMC commends the School for its strong relationship with its student cohort. Whilst there may currently be an imbalance in the partnership, with the Student Society being particularly active in evaluation and student support, it is commendable that the lines of communication are such that students feel empowered to provide feedback and help to foster change.

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.

All students are covered through the University's public liability and professional indemnity cover, as well as by the student plan personal accidence insurance while on work experience/placement.

8 Implementing the curriculum – learning environment

8.1 Physical facilities

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

The University of Western Australia Medical School has plans for the QEII Health Precinct to become the primary site for medical education and teaching as a part of the recently developed UWA Campus Master Plan. There are a number of institutions co-located on the site including the Perth Children's Hospital, Sir Charles Gairdner Hospital, the Harry Perkins Research Institute, the UWA Oral and Dental School, and the J Robbin Warren Library.

However, the limited number of small group teaching rooms/clinical skills facilities restrict the capacity to deliver clinical skills training within the initial phase of the MD 2021 Program, with the loss of rooms previously utilised on the Crawley campus. Additional capital infrastructure and investment will be required in order to support the aspirations of the new program to provide a modern educational experience for the intake of 240 medical students per year.

The current N, M and P Blocks, which house the majority of medical school teaching rooms within the QEII site, do not have sufficient space to deliver the small group teaching currently required for the delivery of the curriculum. Urgent action will be needed to ensure that the necessary capital works can be carried out for the site.

The aging FJ Clarke Lecture Theatre will need attention to ensure that it is able to meet the learning needs of a modern medical student, including access to power points. The team notes the ongoing work of the UWA Campus Master Plan, which provides a framework for the identification of capital and infrastructure priorities for the UWA estate.

The biomedical science laboratories that support the teaching of anatomy and physiology sit within the main UWA Crawley Campus and are well-placed to meet the demands of the current medical program.

Students have significant opportunities to develop clinical skills by interacting with simulated patients and through the use of largely low-fidelity clinical training models on the main campus, and also elsewhere, including at the Perth Children's Hospital and the Albany Clinical School. The Clinical Training and Evaluation Centre (CTEC) provides a resource for development of clinical skills using additional resources, although this is largely committed to postgraduate training. The extent of use of this resource by the MD Program could be reviewed.

The hospital teaching and learning environments are of a high standard, and have been enhanced by recent investments by the WA Government. In particular, the new Fiona Stanley Hospital is a large 783 bed tertiary referral centre that opened in 2015. UWA has a presence on the site through the Harry Perkins Research Institute, which also houses a medical student common room and small group/tutorial room teaching.

Overall, the students were positive about the physical facilities that supported their learning in the clinical environment.

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 recently refurbished J. Robbin Warren Library, on the QEII Campus, represents a strategic investment by UWA to enhance the health library facilities. The building is a technology-rich facility that provides a high-quality study and learning environment. It has vibrant and dynamic learning areas for students, graduates and the community, including an eLearning suite, a seminar room and a technology-enabled training facility. The library is well-resourced and functional, with information technology and communication systems. This is also seen in the Rural Clinical School sites, where students have access to Wi-Fi to allow them to view electronic learning resources.

Medical students have access to a number of online resources that complement and facilitate their learning. The School has a reference collection adequate to meet the School's curriculum and research needs.

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.

At present, the School provides a range of clinical experiences across the breadth of tertiary and secondary, public and private, rural and remote settings in Western Australia resulting in clinical experiences that cover a range of models of care including inpatient, outpatient, hospital, general practice and home visits.

The introduction of a cohort of medical students from Curtin University, to the clinical environment carries the risk of students no longer being able to access the necessary placements during the four years of the course. There will need to be a consideration of local strategies to increase the clinical placement capacity most effectively, in collaboration with other Western Australian medical schools, the WA Health Department and other relevant stakeholders. The Team note the ongoing work towards the creation of a central, state-wide clinical placement system that will allow for the accurate identification of placement capacity, matched with curriculum requirements and the demands of the healthcare system.

Local solutions developed by the School could include the placement of students in underutilised specialties, such as sub-specialty surgery, and novel approaches to student rostering. These will need to be explored and clear strategies around outcomes developed prior to the arrival of students.

Students have variable experiences in the provision of culturally competent care to Aboriginal and Torres Strait Islander communities, particularly in the clinical environment limited to metropolitan teaching sites. The team notes the tremendous work carried out by CAMDH in preparing students for placement, but ensuring that all students have suitable supervised clinical experiences in culturally appropriate care will need to be monitored and developed. Rural clinical sites were readily able to provide such experiences.

At present, UWA shares clinical placement sites with Notre Dame Fremantle and Curtin University across metropolitan and rural clinical sites. The Rural Clinical School co-ordinates rural placements across the state in a single organised identity with known capacity across sites and anticipates being able to meet the demand for increased placements as Curtin University students reach their clinical years.

In the metropolitan settings, each university signs individual agreements with each district health board. This has led to uncertainty regarding the number of students at different sites, and does not provide a cohesive mechanism to ensure effective clinical placements. At present, there is no effective mechanism for the identification of students allocated to hospitals and departments.

8.4 Clinical supervision

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

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

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

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

The University of Western Australia Medical School draws upon a large number of clinical and adjunct staff to support the student clinical placements in a variety of hospital environments. All those that the team met were committed to the School and expressed a strong desire to see the program succeed.

Orientation for clinicians commencing student supervision was brief and left some staff uncertain of the requirements they were expected to meet. The supervisors described limited learning opportunities to develop their teaching and supervision skills.

The present structure, where discipline leads are responsible for the delivery of medical curricula across multiple sites, creates some concern for staff and students as they are often unaware of their point of contact, particularly if their discipline lead is off-site. Students and clinical staff are often unaware of how to escalate matters through formal UWA pathways.

The introduction of a Clinical Dean, as a single point of contact for staff and students at each particular clinical site, may provide an avenue to increase communication between the School and the hospital staff. Such positions would need to be appropriately supported by professional staff.

An ongoing concern, particularly from students and clinical supervisors, has been the limited communication from the central School. This has meant that supervisors are often unaware of the current curriculum, objectives of placements and learning environments. As a consequence of this, they often provide teaching based upon their own individual experiences and perceptions frequently leading to significant variations dependent on rotation site and clinical supervisors.

In addition, clinicians often feel disempowered and unsure how to make changes and contribute to the medical curriculum and are unaware of the University processes and avenues to raise their voices.

From this, the School will need to support clinical supervisors with clear student learning outcomes, strong co-ordination and communication, and opportunities for professional development in clinical supervision. The team encourages the School to strengthen its plans to train and support tutors in the professionalism domain.

Further, there is no effective structure for the School to provide feedback to clinical supervisors on their performance or information regarding the experience of students on their rotations. It is unclear how supervisor performance is monitored, and how sub-optimal performance is addressed.

Ongoing discussion will need to continue between UWA and the Health Department. Negotiations will need to continue to clarify the importance of clinical education and the need for protected teaching time for clinical staff.

Appendix One Membership of the 2019 AMC Assessment Team

Professor Wendy Brown (Chair) MBBS Hons, PhD, FRACS, FACS
Professor and Head, Monash University Department of Surgery, Central Clinical School, Alfred Centre, The Alfred Hospital

Professor Pete Ellis (Deputy Chair) BMBCh, MA, PhD, FRANZCP
Emeritus Professor, Department of Psychological Medicine, The University of Otago, Wellington

Professor Gail Garvey BEd, MEd, PhD
Deputy Division Leader - Wellbeing and preventable chronic diseases; Senior Principal Research Fellow, Menzies School of Health Research

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

Dr Bhavi Ravindran BMedSci (Hons), GAICD
Medical Intern, Hunter New England Health

Professor Stephen Trumble MBBS, MD, Dip.RACOG, FRACGP
Head, Department of Medical Education, Melbourne Medical School, Faculty of Medicine, Dentistry and Health Sciences, University of Melbourne

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

Ms Brooke Pearson
Accreditation Officer, Medical School Assessments, Australian Medical Council

Ms Katie Khan
Program Administrator, Medical School Assessments, Australian Medical Council

Appendix Two Groups met by the 2019 Assessment Team

Meeting	**Attendees**
Monday 21 October 2019	
University of Western Australia	
Senior Medical School Staff	Dean MD Program Director
Executive Dean	Executive Dean
Faculty Executives	Executive Dean Head, Service Delivery Centre Dean Head, Global and Population Health Associate Dean Learning & Teaching
Medical Program Committee	MD Program Director (Chair) Head of School Associate Dean Learning & Teaching IMP3 Unit coordinator & Division of Internal Medicine Representative IMP2 Unit coordinator & Division of Paediatrics Representative IMP1 Unit coordinator & Division of Surgery Representative MD Year 1 Unit coordinator & Division of General Practice Representative MD Year 1 Unit coordinator & Division of Pathology Representative Division of Obstetrics & Gynaecology Representative Division of Emergency Medicine Representative Division of Psychiatry Representative Chair, Scholarly Activity Committee Chair, LEAPS & Professional Development and Mentorship Program Faculty of Science Representative, Physiology CAMDH Representative Dean, Post Graduate Course Work WAMSS Education Officer Med Ed Project Manager
Leadership, Educator, Advocacy, Professionalism, Scholar (LEAPS) Committee	Chair & Professional Theme Lead Leader Theme Lead Educator Theme Lead Scholar Theme Lead Consumer Advocate

Meeting	Attendees
	Vice President Internal, WAMSS Executive Officer
Observe teaching	GP Teachers
MD Year 1 Committee / Preclinical Working Group	MD Program Director Associate Dean Learning & Teaching Medical Education Project Manager Executive Officer *Representatives from:* Physiology Clinical Skills Anatomical Pathology Biochemistry Communication Skills Pharmacology Medical Education Pharmacology Population Health Health Humanities
Student Support & Sub Deans	Associate Dean, Student Affairs Manager, Student Services & Engagement Professional Development and Mentorship Program MDY1 Sub Dean MDY2 Sub Dean MDY3 Sub Dean MDY4 Sub Dean
Integrated Medical Placement 1 (IMP1) Committee	Chair, IMP1 Unit Coordinator Year 2 Sub Dean Discipline Coordinator, General Practice Discipline Coordinators, Geriatric Medicine Discipline Coordinator, Internal Medicine Discipline Coordinator, Rheumatology Discipline Coordinator, Clinical Preparation Director MD Program WAMSS Student Representatives Executive Officer
University Education Leadership	Deputy Vice Chancellor Education Pro Vice Chancellor Education Dean, Post Graduate Course Work
Faculty & School L&T Chairs	Chair, School Learning and teaching Committee Chair, Faculty Learning and teaching Committee

Meeting	Attendees
	Dean, Post Graduate Course Work
Tuesday 22 October 2019	
University of Western Australia	
Western Australian Medical Students Society (WAMSS)	President Vice President Internal Treasurer Secretary Education Chair First Year Representatives Second Year Representatives Third Year Representatives Fourth Year Representatives
Vice Chancellor	Vice Chancellor
Finance, Budget and Resources	Dean MD Program Director Head, Service Delivery Centre Health and Medical Sciences, Finance Manager Associate Director, Finance Health and Medical Sciences, HR Manager Hospital Liaison Officer
Curtin Medical School Teleconference	Dean, Curtin Medical School
Centre for Aboriginal Medical and Dental Health (CAMDH)	CAMDH Representatives
Scholarly Activities Committee	Overall Scholarly Activity Coordinator Health Professions Education Unit Coordinator Master of Aboriginal Health Unit Coordinator Administrator Scholarly Activity (overarching) and Service Learning Administrator Urban Research
Integrated Medical Placement 2 (IMP2) Committee	Chair, IMP2 Unit Coordinator, Paediatrics MDY3 Sub Dean, Discipline Coordinator, Obstetrics & Gynaecology Discipline Coordinator, General Practice Discipline Coordinator, Internal Medicine Discipline Coordinator, Ophthalmology CAMDH Representative Year 4 Coordinator WAMSS Student Representative Executive Officer
WA Health	Medical advisor and Chair of the Post-graduate Medical Council of WA

Meeting	Attendees
Assessment and Evaluation	MD Program Director Preclinical Representative Clinical Representative Medical Education Academic
Final Year Committee	Chair, IMP3 Coordinator, Internal Medicine Discipline Coordinator, Emergency Medicine CAMDH Representative Final Year Committee Administrative Officer OSCE Administrative Coordinator MD Program Director Discipline Coordinator, General Surgery WAMSS Student Representative
Medical School Executives and Heads of Divisions	Head of Division, Emergency Medicine Head of Division, Paediatrics CAMDH Representative Chair, Research Committee
Wednesday 23 October 2019	
Rural Clinical School, Albany Health Campus	
Overview of Rural Clinical School	Deputy Head of School, RCSWA Lead Medical Coordinator, RCSWA Albany
Tour of Albany Health Campus	Emergency Consultant Year 4 Student
Governance	Medical Director, Albany Health Campus
Junior Medical Officer supervision	Medical Education Officer, Albany Health Campus
Senior Clinicians	Adjunct Lecturer, RCSWA, Obstetrician and Gynaecologist, Albany Health Campus Head of Psychiatry, Albany Health Campus Senior Medical Practitioner, Albany Health Campus Senior Medical Practitioner, Albany Health Campus
Lunch with Rural Clinical School WA (RCSWA) students	RCSWA Albany Student Representatives
Rural Clinical School Discipline Coaches	Psychiatry Coach Research Coach Ophthalmology Coach Paediatrics Coach
Rural Clinical School Albany Staff	Medical Coordinators, General Practice Lead Medical Coordinator, General Practice Administration Officer

Meeting	Attendees
Rural Clinical School Narrogin Staff and Students	RCS Narrogin Medical Coordinators, General Practice Narrogin RCS students
Students	Student Representative, Geraldton Student Representative, Albany
Pioneer Health Practice	Principal Manager RCS Albany Medical Coordinator, GP/ED Intern, ex-UWA student
QEII Medical Centre	
Hospital Executive	Director of Clinical Services NMHS SCGH PGME
UWA Teaching Staff	Dean Medicine Emergency Medicine
Associates, Clinical Teachers and Adjuncts	Clinical Lead for SCGH EMED Education registrar Medicine
Students	Students
Joondalup Health Campus Adjuncts and Associate	Medicine clinical teacher Psychiatry
Lunch with GPs	General Practitioners
Perth Children's Hospital	
Hospital Executive	Acting Head of Medical Services PCH Director, Child and Adolescent Health Research Network, Child and Adolescent Health Service Director of Operations, PCH Director of Clinical Services, NMHS Mental Health, Public Health and Dental Services
Students	Students
Associates, Clinical Teachers and Adjuncts	Obstetrics & Gynaecology Paediatrics
UWA Teaching Staff	Obstetrics & Gynaecology Paediatrics
St John of God Subiaco Hospital	
Hospital Executive	CEO SJOG Subiaco Director Med Ed Subiaco Director Med Services Midland Representative for CEO SJOG Murdoch

Meeting	Attendees
Teaching Staff and Associates	Consultants RMO (UWA Graduate)
Students	Year 4 Students
Fiona Stanley Hospital	
Hospital Executive	Executive Director, Fiona Stanley Hospital Group Director of Clinical Services, Director of Medical Education Head of Clinical Service Immunology/Chief Pathologist PathWest Head of Clinical Microbiology
UWA Teaching Staff	Surgery Teachers Medicine Teachers
Associates, Clinical Teachers and Adjuncts	Director of Burns Service of WA/Director of Burn Injury Research Unit Clinical Lead, Psychiatry Clinical Nurse, Gastroenterology/IBD *Representatives from:* Breast Surgery Anaesthesia and Pain General Medicine Renal Gastroenterology
Students	Year 2 Student Year 3 Student
Royal Perth Hospital	
Students	Year 2 Student Year 4 Student
Hospital Executive	Director Post Graduate Medical Education, Armadale Hospital Director Post Graduate Medical Education, Royal Perth Hospital Deputy Director Clinical Services Royal Perth Hospital Student Experience Coordinator, PGME, Royal Perth Hospital
Associates, Clinical Teachers and Adjuncts	*Representatives from:* Vascular Gastro & Haematology General Surgery Rheumatology Geriatric Medicine

Meeting	Attendees
	Acute Medicine Unit Internal Medicine Unit
UWA Teaching Staff	Internal Medicine Geriatrics
Thursday 24 October 2019	
University of Western Australia	
Library Tour	Librarian
Selection Subcommittee	MD Program Director DMD Program Coordinator Academic Lead, Selection CAMDH Representative Manager, Admissions
Community Engagement	Dean Health and Medical Sciences Marketing Manager Health and Medical Sciences Development Officer
Service Delivery Team Support	Head, SDC Academic Services Manager Senior Academic Services Officer Planning Manager/Project Manager Acting Planning Manager Hospital Liaison Officer Admissions Manager Learning Designer AS Team Leaders
Curriculum Map, ePortfolio and Learning Management System Demonstration	MD Director Education Support Officer Education Technologist
Friday 25 October 2019	
AMC Team prepares preliminary statement of findings	AMC Team
Team presents preliminary statement of findings	UWA Staff