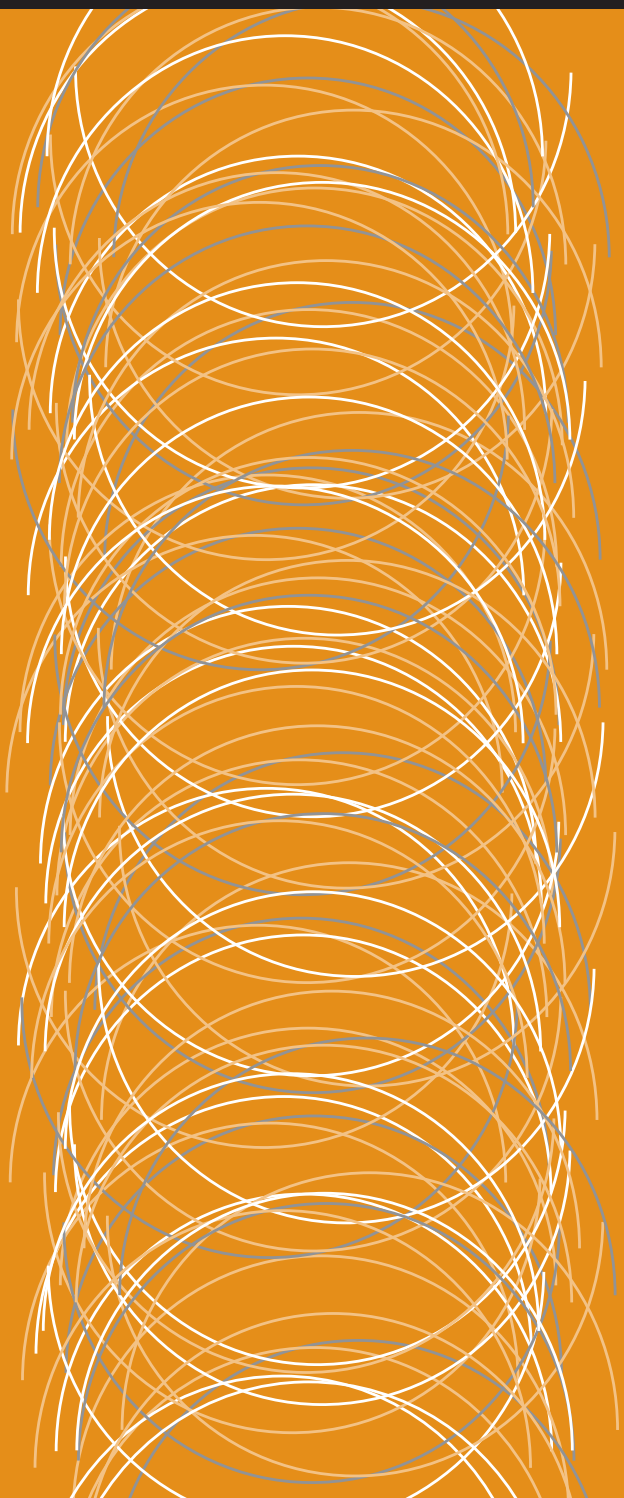
Australian Medical Council Limited

Accreditation of the University of Melbourne, Melbourne Medical School Medical program

AMC



Medical School Accreditation Committee
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Acknowledgement of Country

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

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

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

Executive summary 2020

Accreditation process

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

The accreditation of the University of Melbourne, Melbourne Medical School program expires on 31 March 2021.

The Melbourne Medical School provided responses to the accreditation standards, as well as plans for future changes to its program in their submission for this reaccreditation assessment. Changes include those to the current program in response to evaluation and feedback, and a pedagogically driven redesign of the Program for commencement in Year 2 in 2022.

The AMC reaccreditation assessment was conducted by the Team which reviewed the School's submission and the University of Melbourne Medical Students' Society (UMMSS) report. The AMC had planned a Team visit to the main campus in Parkville and associated clinical teaching sites in the week of 3 August 2020 but, because of the timing of the reaccreditation assessment and the very unusual circumstances of the COVID-19 pandemic, the assessment was conducted remotely, via videoconference.

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's finding is that it is reasonably satisfied that the medical program of the University of Melbourne, Melbourne Medical School meets the accreditation standards.

At their 10 December 2020 meeting AMC Directors resolved:

(i) that the four-year Doctor of Medicine (MD) of the University of Melbourne, Melbourne Medical School is granted accreditation for six years to **31 March 2027**, subject to the following conditions, and AMC monitoring requirements including satisfactory progress reports; and a follow-up assessment in 2021.

By 2021

1	Implement strategies to resolve the shortfall in Aboriginal and Torres Strait Islander leadership that arise from the vacant Associate Dean (Indigenous) position and the temporary absence of the Pro Vice-Chancellor (Indigenous), including membership needs of the MD Selection Committee. (Standards 1.1, 1.4, 2.1 and 7.2)
2	Implement strategies to increase resourcing of the First Nations Health unit to meet current and future program needs in recognition of its role in engagement with communities, curriculum development and delivery, student support and the interface with culturally safe care in the clinical phase of the program. (Standards 1.4 1.8, 3.5, 7.3 and 8.3)
3	In consideration of the challenges stemming from the COVID-19 pandemic, provide evidence of the financial resources to ensure the functioning and sustainability of the Program. (Standard 1.5)
4	Update all formal agreements with partner agencies. (Standard 1.6)
5	Develop non-transactional, authentic relationships with the University's local Aboriginal and Torres Strait Islander community and other underserved communities in order to ensure that the teaching, service and research activities of the Program are related to community need. (Standards 1.1 and 2.1)
8	Provide evidence of a sustainable formal approach or framework for interprofessional education. (Standard 4.7)
9	Provide curriculum mapping documentation showing alignment of the new course outcomes to assessments across all four years of the Program. (Standard 5.1)
11	A visit to the sites of learning to confirm the state of physical facilities associated with the program is to occur when circumstances allow. (Standard 8.1)
12	Develop opportunities for students placed in a rural clinical program to access clinical experience in the metropolitan context. (Standard 8.3)

By 2022

6	Provide finalised plans for the implementation of Years 2 to 4. (Standard 3.3)
7	Provide finalised plans for the implementation of the Discovery and Diversion pathways. (Standard 3.6)
10	Implement robust and fit for purpose IT systems that are able to manage the complex individual learning pathways available to students. (Standards 5.1 and 8.2)

Key findings

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

The AMC uses the terminology of the National Law (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 1.1, 1.4, and 1.6 are substantially met

Conditions

2021

1 Implement strategies to resolve the shortfall in Aboriginal and Torres Strait Islander leadership that arise from the vacant Associate Dean (Indigenous) position and the temporary absence of the Pro Vice-Chancellor (Indigenous), including membership needs of the MD Selection Committee. (Standards 1.1, 1.4, 2.1 and 7.2)

2 Implement strategies to increase resourcing of the First Nations Health unit to meet current and future program needs in recognition of its role in engagement with communities, curriculum development and delivery, student support and the interface with culturally safe care in the clinical phase of the program. (Standards 1.4 1.8, 3.5, 7.3 and 8.3)

3 In consideration of the challenges stemming from the COVID-19 pandemic, provide evidence of the financial resources to ensure the functioning and sustainability of the Program. (Standard 1.5)

4 Update all formal agreements with partner agencies. (Standard 1.6)

Recommendations

A Establish reference groups to provide wider input and consultation into the decisions of the MD Governance Committee. (Standard 1.1)

B Formalise the First Nations Health unit as a learning unit in order to allow for the development of support mechanism for First Nations students. This could facilitate First Nations Health tutors being trained as learning advisors who would then build relationships with the First Nations students. (Standard 1.1)

Commendations

The level of collegial engagement amongst the members of the large MD Operations Committee is commendable. (Standard 1.1)

The School is to be commended for its review and change of governance that has led to a new structure designed to separate strategic from operational decisions and minimise the influence of self-interest on strategic direction. (Standard 1.1)

The commitment of the leadership team at both school and department level is commendable. (Standard 1.2)

The governance structure of the Program that, through the Department of Medical Education (DME), elevates medical education to a scholarly discipline of equivalence to traditional disciplines is commendable. (Standard 1.3)

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

Conditions

2021

5 Develop non-transactional, authentic relationships with the University's local Aboriginal and Torres Strait Islander community and other underserved communities in order to ensure that the teaching, service and research activities of the Program are related to community need. (Standards 1.1 and 2.1)

Recommendations

C Consider investing in strategies and resources to support relationships that are critical to the success of the Program. (Standard 2.1)

D Continue to invest in structures and activities that promote comparable outcomes and approaches across sites, and explicitly inform students of these approaches. (Standard 2.2)

3. The medical curriculum	**Met**

Conditions

2022

6 Provide finalised plans for the implementation of Years 2 to 4. (Standard 3.3)

7 Provide finalised plans for the implementation of the Discovery and Diversion pathways. (Standard 3.6)

Commendations

The innovation and use of best practice evidence in the redesign of the MD curriculum is excellent. (Standard 3.3)

The collegiality, connection and medical education expertise demonstrated by all of the staff who were engaged in ensuring vertical and horizontal integration of the curriculum is commendable. (Standard 3.3)

The commitment and ingenuity of the current First Nations Health staff is impressive and the work they have done is excellent. (Standard 3.5)

4. Teaching and learning	**Met**

Standard 4.7 is substantially met

Conditions

2021

8 Provide evidence of a sustainable formal approach or framework for interprofessional education. (Standard 4.7)

Recommendations

E Clearly articulate how the Program prepares graduates for lifelong learning in the context of both independent learning and structured learning. (Standard 4.2)

Commendations

The simulation program is excellent. (Standard 4.3)

The School's flexible delivery of the program and the new approaches to teaching and learning that have arisen out of the adversity of a pandemic are commendable. (Standard 4.7)

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

Conditions

2021

9 Provide curriculum mapping documentation showing alignment of the new course outcomes to assessments across all four years of the Program. (Standard 5.1)

2022

10 Implement robust and fit for purpose IT systems that are able to manage the complex individual learning pathways available to students. (Standards 5.1 and 8.2)

Recommendations

F Evaluate the impact of non-graded assessment on student performance and achievement. (Standard 5.1)

G Continue to work with the University in adapting university level policies to reflect the needs of a contemporary medical program. (Standard 5.1)

H Reconceptualise attendance as an attribute associated with demonstrating achievement of professional practice competencies. (Standard 5.2)

I Implement a robust electronic platform for the management of assessment data to support evidence-based decisions concerning student progression. (Standard 5.4).

Commendations

The leadership provided by the Director of Assessment is commendable. (Standard 5.1)

The School is commended for its evidence-based strategic assessment program and for the prominence of a quality improvement approach to the review of assessment throughout. (Standards 5.1 and 5.4)

6. The curriculum – monitoring	**Met**

Recommendations

J Continue to support initiatives that strengthen the strategic framework for evaluation and promote a coordinated approach to requests for feedback from the student cohort. (Standard 6.1)

K Consider strengthening the staff and resources available for monitoring the Program. (Standard 6.1)

L Develop a formal plan for the integration of data from the numerous databases on which school enrolment, attendance, performance and feedback information is held. (Standard 6.1)

Commendations

The School is to be commended for its commitment to evaluation and feedback within the MD curriculum redesign at all levels. (Standard 6.1)

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

Recommendations

M Encourage partner universities to develop scholarships for entry-level Aboriginal and Torres Strait Islander students. (Standard 7.1)

N Ensure that the implications of the choice that students make regarding a rural clinical experience prior to entering the Program are explicit and accessible for students. (Standard 7.2)

O Clarify the scope of the Health and Wellbeing initiative for students within the continuum of support services available. (Standard 7.3)

8. Implementing the curriculum – learning environment	**Substantially met**

Standard 8.1 is substantially met

Conditions

2021

11 A visit to the sites of learning to confirm the state of physical facilities associated with the program is to occur when circumstances allow. (Standard 8.1)

12 Develop opportunities for students placed in a rural clinical program to access clinical experience in the metropolitan context. (Standard 8.3)

Recommendations

P Consider making elements of the Excellence in Clinical Teaching (EXCITE) program more accessible for staff engaged with student teaching, learning and assessment. (Standard 8.4)

Commendations

The positive and proactive changes that the School has implemented to address the impact of COVID-19 on the clinical environment, and their scholarly activities in this area is commendable. (Standard 8.3)

The range of resources and professional development opportunities that the School has developed with the EXCITE program and the Academy of Clinical Teachers are commendable. (Standard 8.4)

Introduction

The AMC accreditation process

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

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

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

The AMC's Medical School Accreditation Committee oversees the AMC process of assessment and accreditation of primary medical education programs and their providers, and reports to AMC Directors. The Committee includes members nominated by the Australian Medical Students' Association, the Confederation of Postgraduate Medical Education Councils, the Committee of Presidents of Medical Colleges, the Medical Council of New Zealand, the Medical Board of Australia, and the Medical Deans of Australia and New Zealand. The Committee also includes a member of the Council, a member with background in and knowledge of health consumer issues, a Māori person and an Australian Aboriginal or Torres Strait Islander person.

The AMC appoints an accreditation assessment team to complete a reaccreditation assessment. The medical education provider's accreditation submission forms the basis of the assessment. The medical student society is also invited to make a submission. Following a review of the submissions, the team conducts a visit to the medical education provider and its clinical teaching sites. 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, such as a requirement for follow-up assessments.

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

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

The University, the Faculty and the School

The University of Melbourne is a comprehensive university organised into eight faculties:

- Architecture, Building and Planning
- Arts
- Business and Economics
- Engineering and Information Technology
- Fine Arts and Music
- Medicine, Dentistry and Health Sciences
- Science
- Veterinary and Agricultural Sciences.

And two university schools:

- Melbourne Graduate School of Education
- Melbourne Law School.

In 2018, the University of Melbourne had in total, 8,983 full-time equivalent (FTE) staff and an equivalent full-time student load of 52,719 students, of which 42% were international students from over 140 nations.

The Faculty of Medicine, Dentistry and Health Sciences (FMDHS), which includes the Melbourne Medical School, is led by the Dean of the Faculty. The Faculty taught a total of 9,085 students in 2018.

The Faculty is composed of six Schools:

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

The Dean delegates responsibility for the medical school to the Head of the School who has responsibility for all graduate programs in the School, including the Melbourne Doctor of Medicine (MD) program.

The School is the oldest medical school in Australia, and the first to implement a graduate MD degree.

The MD program is the largest course in the School with the main campus located in Parkville, Melbourne. The program features clinical exposure through the following six metropolitan clinical schools:

- Royal Melbourne Clinical School
- St Vincent's Clinical School
- Epworth Clinical School
- Austin Clinical School

- Northern Clinical School
- Western Clinical School.

In addition, students have clinical exposure through the Rural Clinical School situated in the School's Department of Rural Health with its main sites in:

- Shepparton
- Bendigo
- Ballarat
- Wangaratta.

The student intake for the years 2016 to 2020 ranged between 343 and 369 students. For 2020, the student intake was 352 students, which was comprised of 180 Commonwealth supported places, an additional 67 bonded rural places, 56 domestic fee-paying students and 49 international fee-paying students. The School is committed to maintain a total enrolment of approximately 1,400 students across all four years of the program.

Accreditation Background

The medical program was first assessed by the AMC in 1989 as a six-year undergraduate Bachelor of Medicine/Bachelor of Surgery/Bachelor of Medical Science (MBBS/BMedSci) program. In 1998, the School submitted advice that the medical program would introduce a new four-and-a-half year graduate-entry stream.

In 2006, the School advised the AMC that it intended to change its medical program to fit its academic degree structure, phasing out its undergraduate program and replacing it with a postgraduate degree. In 2009, following a consideration of the Stage 1 proposal for a material change to the medical course, the School was invited to submit detailed plans for assessment by an AMC Assessment Team. This program was the first in Australia to result in the award of Doctor of Medicine (MD) although this was a common qualification internationally.

An AMC Team visited the School and associated clinical teaching sites in 2010. The AMC Directors, at their November 2010 meeting, granted the MD program accreditation for six years until 2016, subject to an assessment in 2012 to review the implementation of the first two years of the course and detailed plans for Years 3 and 4, and the submission of satisfactory progress reports to the AMC. The Medical Board approved the MD program as providing a qualification for the purposes of registration in the medical profession.

In 2012, an AMC Team conducted a follow-up visit to the School. Accreditation of the Doctor of Medicine (MD) program of the University of Melbourne, Faculty of Medicine, Dentistry and Health Sciences was confirmed until 31 December 2016 subject to satisfactory progress reports.

In 2016, the School submitted its comprehensive report for extension of accreditation. The report was accepted by the AMC Directors, the program was found to meet the accreditation standards, and an extension on accreditation was granted to the School until 31 March 2021.

Progress reports received in 2017, 2018 and 2019, were all accepted and the program was found to continue to meet the accreditation standards.

This report

This report details the findings of the 2020 reaccreditation assessment of the Melbourne Medical School medical program. The assessment examines the detail of the currently accredited program, incorporating iterative revisions, as well as the plans for a larger program redesign, expected to commence from 2022.

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

The members of the 2020 AMC team are listed at **Appendix One**.

The groups met by the AMC team in 2020 via videoconference are at **Appendix Two**.

The teaching sessions observed by the AMC team in 2020 via videoconference are at **Appendix Three.**

Appreciation

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

1 The context of the medical program

1.1 Governance

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

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

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

The University of Melbourne's four-year, graduate-entry Doctor of Medicine (MD) Program is a well-resourced, high quality medical program that produces graduates who are competent to practise. The Program is large and has traditionally delivered a conventional urban based pathway for medical training. A number of positive changes are either underway or signalled for the future, intended to increase the diversity of the student cohort, remove barriers to participation for less advantaged students, increase opportunities for rural training and offer a more flexible approach to learning opportunities.

These changes have been driven by a capable and committed leadership team that resides at both school and department level and clearly has the support of all staff. The level of cooperation and collegiality across the School was evident across all areas of the Program and included both academic and professional staff.

The School is to be commended for its review and change of governance that has led to a new structure designed to separate strategic from operational decisions and minimise the influence of self-interest on strategic direction. The ambitious redesign of the MD curriculum will be a test of the effectiveness of this new structure.

The terms of reference for each of the key MD committees are clear and there was evidence from staff, that the functions of each of these committees as well as the overall governance model were understood by the wider academic and professional staff involved in delivering the Program at the metropolitan sites, but perhaps less well understood in more remote locations.

The Team was delighted to learn that the School is progressively widening its scope to provide more opportunities for students to learn in a rural immersion environment: a move clearly intended to diversify its graduates and to contribute to Australia's pressing need for a rural medical workforce.

The representation on each of the MD committees is appropriate and it was pleasing to learn that the MD Governance Committee, which has the responsibility for strategic decisions regarding the Program, and is overseeing the design and implementation of the MD Program revisions. Representation in this group includes two student representatives, a community representative and the Associate Dean (Indigenous). However, the latter two key positions remain vacant and it is important that priority be given to filling them both as soon as possible. The Associate Dean (Indigenous) position is particularly important as this role offers a valuable perspective on many aspects of the Program, including, among other things, the MD Selection Committee's selection of students.

The School and Program would also benefit from strengthening engagement with its communities. Effective examples of this are seen in the community relationships of the Rural Clinical School and the developing relationships with the local Aboriginal community, and these could be applied as a model for the metropolitan program.

The level of collegial engagement among the members of the large MD Operations Committee was impressive, particularly with respect to promulgating the plans for the MD curriculum redesign. There was a strong sense of commitment to the new MD curriculum redesign and a desire to increase flexibility of learning for students.

The First Nations Health team, while outstanding, is small for both the size of the Program and the importance and scale of its task. Much of the responsibility for addressing First Nations Health is given to a small team and particular individuals in that team shoulder the responsibility for the success of the entire program. The First Nations Health team also have multiple responsibilities in developing and running the curriculum, providing pastoral support for students, as well as leading faculty development in cultural sensitivity and safety. Moreover, the team appears to function more as a service unit rather than a standalone unit with responsibility for teaching, research, and engagement. Formalising First Nations Health as a learning unit would allow for development of declared support mechanism for First Nations students. For example, First Nations Health tutors (some of whom are current PhD students) could be trained to be learning advisors and build relationships with the First Nations students in the Program. The Team was also concerned about the high risk of failure should the School lose even one of the current team members. It is important that attention is paid to this area as a priority. As such, the Faculty's commitment to a stronger First Nations Health program would be demonstrated by urgently attending to the recruitment of an Associate Dean (Indigenous).

As part of the new governance structure, it is intended that multiple reference groups be established to provide wider input and consultation into the decisions of the MD Governance Committee. These consultations are yet to commence and it will be beneficial for the reference groups to be established as soon as possible.

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 Program is embedded in the larger Faculty, but has a sufficient degree of academic and financial autonomy to define its own path, and to engage in continuous improvement and innovation to improve the quality of the Program. This degree of autonomy was acknowledged and supported by the Vice-Chancellor, Provost and Dean of the Faculty, and the recent move to pass-fail from the normal graded assessment was given as a good example of where the Program was able to steer a course that differs slightly from the usual university regulations.

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.

Strategic decision-making within the Program falls to the MD Governance Committee, and the responsibility for delivery of the Program rests exclusively on the large DME that sits alongside nine traditional medical discipline-based departments within the School. The DME provides a simple home and structure for line management and operation of the Program. Other than the Rural Clinical School, which is its own department, each clinical school is represented in the Department. The Rural Clinical School has a direct and effective relationship with the DME that involves it in all aspects of the work of the DME. While this model is unusual, its establishment signals the University's desire to elevate medical education to a scholarly discipline of equivalence to traditional disciplines. This is commended.

1.4 Educational expertise

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

The Team was impressed by the breadth and depth of educational expertise within the DME. One point of concern, however, is the sustainability of expertise that resides in the First Nations Health team. It is acknowledged that the University recently lost two key leaders in Indigenous Health, although one is expected to soon return from sabbatical. Given this situation, it is important that attention is paid to this area as a priority. It is also important to pay attention to succession planning for the key team members. Succession planning, growing people into roles, continuity of service provision and the maintenance of corporate memory are all vital to a strong medical school.

1.5 Educational budget and resource allocation

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

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

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

The Program is currently financially sound with secure levels of income and very substantial resources that are provided through an appropriately transparent budget model negotiated through Faculty. All revenues for teaching and research are delivered directly to schools and departments, which then contribute back to the University. The size of this contribution in comparison to other faculties was a clear indication of the status the Program enjoys within the University, and an acknowledgment of the higher costs of delivering a medical program against traditional university courses. This was both confirmed and supported by the Vice-Chancellor and Dean of Faculty. In addition, the School is fortunate to have a strong and well-established philanthropic endowment fund that it uses relatively unhindered, to support new initiatives.

The university sector, including medicine, faces considerable challenges stemming from the COVID-19 pandemic, and careful planning, adaptation, and monitoring of the financial impacts on the School will be required to ensure the functioning and sustainability 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 Program cannot operate without the support of the many external partners. Several health service partners indicated that they enjoyed a collegial and mutually beneficial relationship with the School, but that this was mainly secured by informal agreements. Many of the formal partner agreements have either lapsed or are out of date, and thus need to be renegotiated as soon as is practicable. If this is not done, it could place the Program and the University at risk, should a partner suddenly decide to deviate from an agreement. The Team acknowledges the scale of this issue but nonetheless, the establishment of a plan to update these partner agreements is important.

Members of the School know that the building of relationships with community is an involved process and one that requires input and ownership at all levels, especially that of the executive. The School also knows that reciprocity, recognition, time and commitment are required from staff to do justice to these relationships. Staff also require appropriate workload recognition for their cultural input into building and maintaining these relationships.

1.7 Research and scholarship

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

Research and scholarship of the Program are considered to be exceptionally strong. The ethos of research-driven medicine permeates throughout the Program, from the highest levels of leadership down to the students who are enthusiastic about their research component. The Program is fortunate to be in the heart of the internationally recognised Parkville medical precinct and the Program takes great advantage of this unique position. The Team was pleased to note that a research-led medicine ethos is also a strong part of the Program located at more distant sites away from the metropolitan hospitals and research institutes.

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 the primary provider, the DME has sufficient high quality academic and professional staff to deliver the Program. It is very well resourced and has an appropriate balance of academic to professional staff, which is determined largely at the school level with support from Faculty. There is some concern about the inability of the First Nations Health unit to recruit and train more Aboriginal and Torres Strait Islander staff.

The mechanisms for recruitment and training of patients and community members who are involved in teaching activities are appropriate.

The knowledge and commitment of the School's professional staff to the Program was impressive. They conveyed a sense of recognition and support from the School and Faculty for their essential roles in managing students and delivering the necessary resources across multiple sites.

There are suitable indemnification arrangements that protect both staff and students across the Program and at all its locations.

1.9 Staff appointment, promotion & development

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

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

The DME as the primary unit responsible for the delivery of the Program has sufficient resources and autonomy to make appointments as required.

Notwithstanding the impact of staff recruitment that has been brought about by the COVID-19 pandemic, the Department utilises well-established and embedded university processes for academic performance appraisal and promotion. Discussions with staff indicated that these mechanisms of performance appraisal, development and progression are fair.

One of the challenges for the DME will be to ensure staff who are responsible for delivering a medical education, also have time to engage in activities that foster advancement and promotion under the University's Academic Performance Framework. The Team was reassured that the DME leadership strongly encourages and supports its staff to engage in other academic pursuits such as medical education research. The team were reassured that staff were not disadvantaged by the Academic Performance Framework, although there was an acknowledgement that academic promotion can be harder to achieve through work in the DME, than is the case in other Departments.

It was pleasing to hear that 30% of teaching revenue for the Department comes from postgraduate programs.

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 is clear about its aspirations for the current MD curriculum and for the MD redesign that has a new emphasis on promoting diverse, individual student learning experiences via a strong pedagogically driven medical program. All students will be required to achieve the program outcomes prior to graduation but they may achieve these in different settings and have clearer opportunities to move out of the program for periods of time to explore broader interests in healthcare.

The School states a commitment to working with the communities it serves through teaching and learning, research, clinical care and advocacy, in order to improve health and advance health care. The School seeks to produce graduates who are excellent clinicians and researchers and the program redesign aims to reinforce this focus.

There are some concerns about how the Program addresses Aboriginal and Torres Strait Islander peoples' health. Much of the responsibility lands at the feet of a very small team of people, who are tasked with a very broad remit. Resolving the long-term absence of the Pro Vice-Chancellor (Indigenous) and the vacant position of the Associate Dean (Indigenous) will be seen as significant movement towards demonstrating the School's commitment to growing Aboriginal and Torres Strait Islander health professionals for the future. Further, a plan to enable the development and attainment of Aboriginal and Torres Strait Islander staff over the next few years will ensure any sudden staff movements will not disadvantage or imperil the medicine programs.

There are recognised community and other external stakeholders that are a part of the Program and contribute to its success. There are some significant gaps, however, and the School would benefit from renewed efforts in fostering relationships with the Aboriginal and Torres Strait Islander community and other underserviced communities. Some recent good work has occurred at the school level under the direction of the Director of First Nations Health, but the University would benefit significantly from further work in establishing non-transactional and authentic relationships with their local community. These relationships need to be built and consolidated over time. Consideration should be given to the deployment of relationship managers or similar to support relationships critical to the success of the Program.

The School is encouraged to continue to explore how it relates its high quality academic program to the needs of the communities it serves.

2.2 Medical program outcomes

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

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

2 Clinical Practice: the medical graduate as practitioner.

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

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

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

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

2.2.3 The medical program achieves comparable outcomes through comparable educational experiences and equivalent methods of assessment across all instructional sites within a given discipline.

Graduate outcome statements are utilised in the organisation of the program and appear to be consistent with those of the universities that are in partnership with the School. While the School embarks on its plan to offer broader and deeper individual learning pathways, care must be taken to ensure that the core curriculum is maintained, and that as the Program evolves, the program outcomes will be updated to continue to reflect the AMC graduate outcome statements.

Learning outcomes for Year 1 have been revised in response to evaluation and feedback, to provide a better foundation for integration with later years of the Program. The School is prioritising the revision of learning outcomes for all years of the Program redesign, and is mapping these to teaching and learning activities, to assessment and to the AMC graduate outcome statements.

Given its aspirations, ensuring consistency in both experience and outcomes across clinical sites is a challenge for a dispersed program of this nature. Student perceptions are that access to opportunistic learning varies and is dependent on location and rotation. Students also hold a perception of inconsistency of assessment, marking and feedback across sites. The School is aware of this and is encouraged to continue to pursue work in these areas, and importantly, to inform students of strategies that promote comparable outcomes and approaches across sites.

3 The medical curriculum

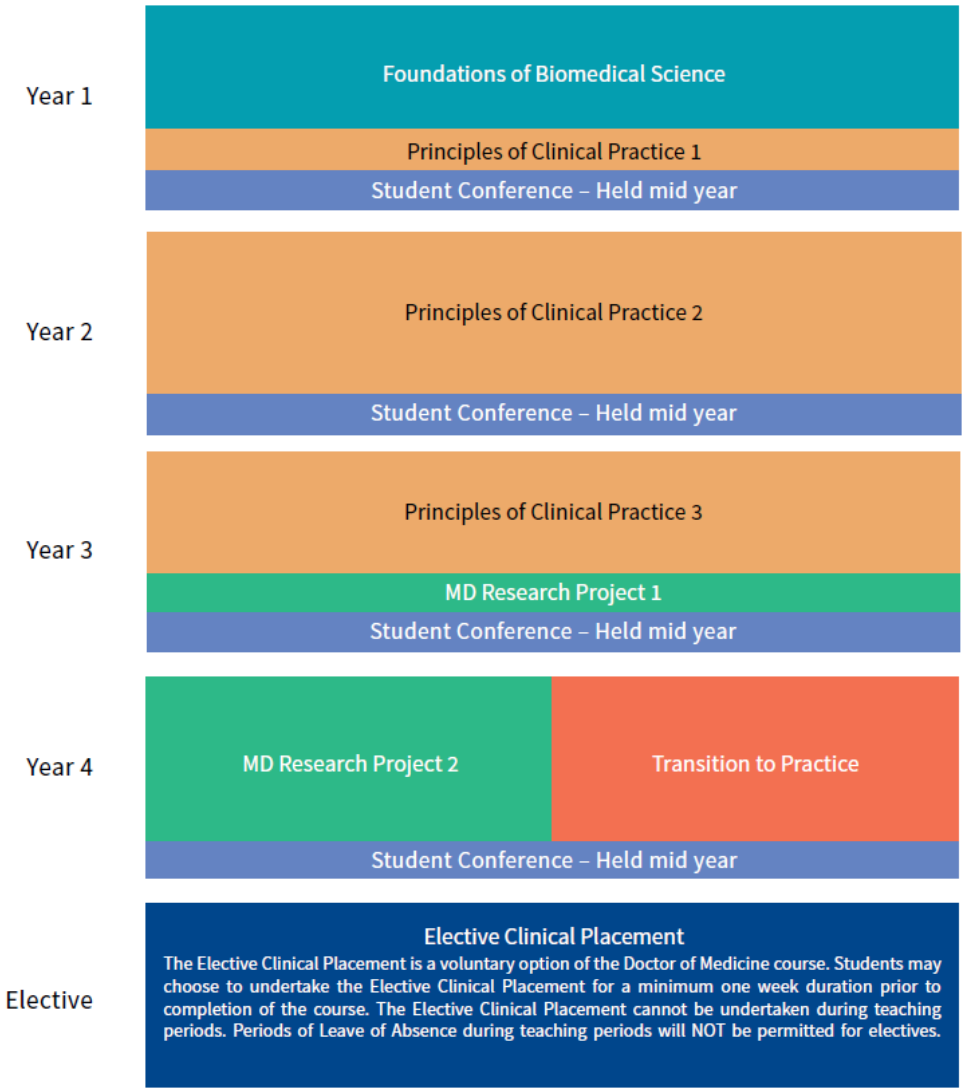
3.1 Duration of the medical program

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

The Program is a four-year graduate program with ample time available for students to achieve the stated program outcomes and to become competent, safe interns. Years 1 to 3 comprise two eighteen-week teaching periods plus a requirement to participate in the student conference in the week adjacent to the inter-semester break. Year 4 comprises a twenty-one week research period and requirement to participate in the student conference, followed after the inter-semester break by a fifteen-week teaching period, including preparation for practice and a twelve-week trainee intern placement.

In 2020, the first stage of the redesign of the MD Program was implemented for Year 1. The main features of this has been a refocusing of Year 1 to review and rationalise the many minor changes that have occurred over time in order to give greater prominence to key concepts and enable greater flexibility and opportunities for a more individualised student experience. A focus on students being able to achieve the core learning outcomes, in later years of the program is maintained.

Figure 1 Overview of current Doctor of Medicine structure



There are no plans to change the length of the Program in the redesign that is currently underway.

3.2 The content of the curriculum

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

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

3.2.2 Clinical Practice: The medical graduate as practitioner.

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

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

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

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

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

The curriculum content is organised to enable students to reach the AMC graduate outcome domains with four key roles of a Melbourne MD Graduate clearly articulated as:

- Clinician researcher
- Medical practitioner
- Professional and leader
- Health advocate.

These roles map to the AMC domains of Science and Scholarship, Clinical Practice, Professionalism and Leadership, and Health and Society, respectively.

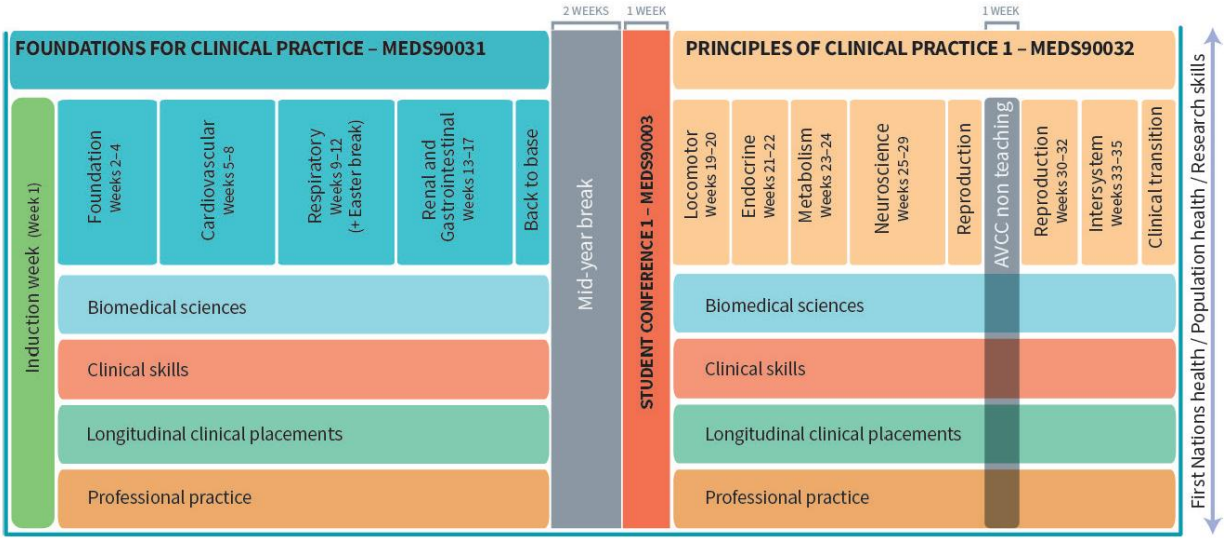
Students currently in Years 2, 3 and 4 of the Program will attain the 67 defined graduate attributes by completing the Program. Specific subject learning outcomes have been developed by each of the year-level working groups and these have been mapped to graduate attributes across the years and to the new course learning outcomes introduced in 2020 for the Year 1 cohort.

Three vertical themes: Biomedical Knowledge, Professional Practice and Clinical Skills have been established to broadly match three of the domains of the AMC graduate outcomes. Research skills are embedded in the clinical subjects and are predominantly addressed in the research-specific subjects of the MD Research Project MDRP 1 (Year 3) and MDRP 2 (Year 4). The fourth Health and Society domain is integrated across the three themes, and includes First Nations Health and Population Health.

Significant changes were introduced in Year 1 of the Program in 2020 refining the original MD1 structure. The changes were based on refining the existing program based on student and other stakeholder feedback and on best pedagogical practice. An example of one such change was the introduction of longitudinal placement in general practice into Year 1 to assist students in linking their clinical science learning to clinical practice reality. The pandemic has adversely influenced

this aspect of change but there is a great deal of support for this change to be enacted fully when restrictions are lifted.

Figure 2 Revised structure of Year 1



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 innovation and thorough grounding in best educational practice are evident in the design of the current one-plus-three model, and are particularly excellent in the aspirations for the MD curriculum redesign.

The stakeholder engagement undertaken in 2016, the evaluation of the decade-old Program, and the scholarly approach to the curriculum design are noted. The thoughtful and educationally driven approach to redesign was especially evident in planning changes to Year 1 this year, and to subsequent years from 2022. The redesign of learning activities and assessment tasks to encourage deeper learning, and a shift from didactic to more active engagement of students in interaction is one example of the thoughtful changes to be implemented.

There is strong evidence of horizontal and vertical integration supported by close collaboration between three theme leads (for Biomedical Knowledge, Clinical Skills and Professional Practice) leading vertical integration across the whole course, and the subject and year coordinators working in the horizontal plane. The collegiality, connection and medical education expertise demonstrated by the staff who were engaged in this activity are impressive. This augurs well for the ongoing MD curriculum redesign and the future of the Program.

The 'Discovery' and 'Diversion' pathways that are a feature of the MD redesign are an interesting innovation. It is intended that students will have the opportunity to undertake an individual learning experience by either exploring an area of interest in depth through the Discovery pathway (while achieving core learning outcomes in this setting), or to explore interests beyond the standard MD program under the Diversion pathway. One of the main drivers of the course redesign is to develop a broader range of career pathways, some of which include the option to divert from a focus on clinical practise if the student feels that they are more suited to other contributions to healthcare. Students who feel that a clinically focused career is not for them will be able to exit the MD program via this pathway with skills and a qualification. Other students might use the pathway

to temporarily explore areas of interest, then return to the MD to resume the Program, having achieved relevant learning outcomes, for example, in research.

The governance structure, collegial relationships and regular meetings between key academics and professional staff facilitate integration and appropriate articulation within the whole Program.

The student conference, a highly innovative inclusion at the instigation of the Program ten years ago, has developed as a major annual student-led event involving all students. Responsibility for program planning, organising logistics and budgeting (with Faculty oversight) is taken entirely by students, and the conference remains a highlight of the Program offering leadership and networking opportunities across all years. The need to rapidly convert the 2020 conference to an entirely online event at relatively short notice demonstrated the capability of students to be flexible, innovative and professional.

Planning is underway to progress the rural end-to-end medical program in collaboration with La Trobe University. Starting in 2022, this will provide half of the Year 1 entrants to the Program, based at Shepparton, from its Bachelor of Biomedical Science degree.

The educational expertise among staff, particularly the leadership team in the DME is obvious in the plans for the MD curriculum redesign, and the ambition to further improve the Program in the ways outlined in the submission is lauded. The plans for Years 2 to 4 are yet to be refined and implemented.

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.

Course and program learning outcomes have been developed and are available to staff and students. Course-level objectives are communicated via the University Handbook.

A course guide and individual subject guides, including learning objectives, are available electronically through the customised MD curriculum database, MD Connect. Term-specific objectives are also available through MD Connect with guides stating the learning objectives for each year of the course.

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).

Curriculum coverage of Indigenous health is an area that the School acknowledges requires strengthening.

The Team recognised that there has been a great deal of consideration, planning and work done by the First Nations Health team towards embedding First Nations Health into the Program. So far this work has been focused mainly on the early years of the curriculum. First Nations Health is now a vertical theme running through MD1. An example of a successful new learning activity is the visit to the Bunjilaka exhibition at Melbourne Museum, which enables students to be immersed in local Indigenous knowledge away from their clinical schools. While the small team of two Indigenous and one non-Indigenous staff have clearly punched above their weight in implementing new curriculum content, staff turnover and the lack of consistent senior Indigenous support in the University and the School is a challenge. It causes uncertainty about the strategic direction in the First Nations Health space and presents a risk to progress and sustainability in the MD curriculum

and teaching. Further, there are few staff that report to be themselves 'competent' in the delivery of First Nations Health content, and would rather rely on the few Indigenous staff or their allies to deliver this important component of the Program.

Clearly, there is a great deal more to be done to provide adequate learning opportunities during the clinical years of the Program where students reported a lack of opportunity to learn practical skills in the provision of culturally sensitive care to First Nations People. Students reported that the Shepparton Clinical School has introduced helpful teaching such as meeting with the Aboriginal Liaison Officer, and sharing of these ideas across schools may be beneficial. This should be replicated across all areas of the curriculum.

The commitment and ingenuity of the current First Nations Health team is impressive and the work they have done is excellent. There is, however, risk posed by the current reliance on such a small team to achieve the breadth of work required to provide a sustainable First Nations Health curriculum in a culturally safe and competent environment.

3.6 Opportunities for choice to promote breadth and diversity

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

The opportunities for choice in the current Program are largely related to the research project where students can choose the topic of their research activity in the MDRP1 and MDRP2 courses. There is also an opportunity to choose a four-week vocational selective rotation within the Transition to Practice element of the course in Year 4. Students also may take up an optional clinical elective for a minimum of one week at any time after MD1.

The Team was interested to hear of the plans for introducing more flexibility into the Program through the Discovery and Diversion pathways to be embedded in the MD curriculum redesign. It will be interesting to see how these plans mature into introducing more opportunity for choice as well as the opportunity to have increased breadth and diversity of experience across the curriculum.

4 Learning and teaching

4.1 Learning and teaching methods

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

The School provides a learning environment for students that is diverse and supported across the preclinical and clinical sites.

In Year 1, learning is situated primarily at the School's central campus in Parkville. Case supported learning (CSL) is utilised to introduce core biomedical content, while at the same time developing communication and teamwork skills. CSL sessions draw on a student led approach to learning, supported by a facilitator. Clinical skills tutorials are utilised to develop communication skills, medical interviewing frameworks, physical examination skills, and introductory clinical and diagnostic reasoning, while Professional Practice tutorials introduce and explore issues related to professional identity, and issues related to being a doctor. These sessions are facilitated by a medically trained tutor.

A wide range of teaching and learning methods are employed, including lectures, small group learning, role plays and the use of simulated patients in sessions to build communication and physical examination skills competence. There has been deliberate effort to cater to diverse learning styles and enhance engagement through the testing of more innovative methods which might be scaled up prior to the 2022 commencement. Clinical visits, longitudinal Year 1 clinical interprofessional placements, a learning portfolio and peer teaching are all pedagogically sound innovations which are either underway from this year, or have been delayed by the pandemic and are due to start when possible. The Team encourages these developments and looks forward to reviewing progress.

From Year 2, learning moves to the clinical areas. Following the completion of a nine-week introductory block, Year 2 students rotate through placements in Medicine, Surgery and Ambulatory care. A Clinical Skills Coach facilitates the development of clinical skills during bedside teaching, and provides feedback on the students' developing clinical skills. The breadth of clinical experiences in hospitals and in the community effectively prepares students for their transition to practice.

Clinical Placements continue throughout Year 3 when students also have time to plan the research project they will undertake in semester 1 of Year 4 prior to the transition to Internship semester. Engaging all students in the various elements of planning and running the annual Student Research Conference provides a variety of learning, leadership and presentation opportunities and experiences. Plans for modification to Years 3 and 4 as part of the MD curriculum redesign are underway. This will include strategies to enable students to maintain their clinical skills while immersed in the research component of the course. Under the redesign, it is intended that students will be able to undertake a vertically integrated research pathway, rather than having to complete a research project in one semester of Year 4.

The move to online learning in response to COVID-19, has facilitated new opportunities for the Program which the DME and Clinical Schools will review for future potential incorporation. For example, interprofessional learning has been enhanced through opportunities for student involvement in a virtual clinical environment with teams of students from a variety of health related professions.

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.

Reflective practice is integral to the Program and is identified by students and staff as central for developing skills in lifelong learning. Explicitly stating the requirement to be able to demonstrate self-awareness through analytic reflection on their practice, recognition of their limits, and continual improvement of their knowledge and skills to enhance their performance as one of the newly developed course learning outcomes is valuable. A number of potential strategies to help students to achieve this throughout the course are articulated in the submission but it is not clearly evident how these aspirations will be realised within the Program. A clear articulation of how the Program prepares graduates for lifelong learning in the context of both independent learning and structured learning across the entire Program may be beneficial.

The realisation of pathways for students to explore areas of interest in either more depth, or more breadth, is an excellent innovation planned for the new Program. As the Program develops its Discovery and Diversion streams, a robust electronic system to support individualised learning will be necessary to track these individualised learning pathways.

4.3 Clinical skill development

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

The Program's structured program for clinical skills development beginning in Year 1 is well-established. An early focus on graduated clinical exposure helps to contextualise the skills and reinforce the importance of repeated practice to students. The well-established sensitive physical examinations program (SPEP) in Year 2 also contributes to students learning to take a patient-centred approach to medicine. The simulation program is to be commended as an example of best practice and is a credit to the School.

The School utilises a range of simulation activities, including sessions where students closely observe an expert demonstration of clinical scenarios, practised interviews, as well as through the use of manikins in specific scenarios in the clinical skills simulation laboratory. The quality of the practical sessions and the level of student engagement is generally high. Student feedback to the Team indicated that students appreciate the abundant opportunities available. The School is aware of feedback about some variability in the quality of clinical coaches in the early years and the Team encourages the effort underway to assist clinical teaching staff in development of their teaching 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.

During first year there is relatively little involvement with patients with the focus being on observation in clinical settings for one day a week, learning how the health system works and about the various health professional roles in the healthcare team. When students commence the clinically focused learning based at the clinical schools in Year 2, they spend the first eight-week foundation block gaining a grounding in communication, history-taking and physical examination. They then move on to carefully scaffolded clinical rotations where they gain increasing capability

under close supervision. During Years 2 and 3 students moved through all of the core clinical rotations gaining increasing competence and confidence in their clinical skills and clinical exposure under supervision. Between the clinical placement rotations there are a series of intercession weeks focusing on student reflection. The degree of involvement with patients increases progressively throughout the course and culminates in students undertaking a two 4-week Trainee Internship terms, and a Vocational Selective. The trainee internship period involves the student shadowing an intern and undertaking any activities usually undertaken by an intern, that fall within the scope of final year medical student practice.

4.5 Role modelling

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

The School is aware of the importance of positive role models in helping shape students into the doctors that they want to be, and that society needs. Throughout the Program, students have access to skilled bioscientists, and expert medical practitioners in a range of fields, from both within the University, and in clinical practice. The influence of role-modelling is particularly evident from Year 2 onward when students spend much more time in clinical settings.

The MD research project in Year 4 provides students with an opportunity to work closely with a research supervisor whom they have met and chosen to work with. In practice this means that students choose a supervisor who exhibits qualities that the students find desirable and from whom they seek to learn.

The use of near-peer role models in the Trainee Internship rotation is an example of thoughtful design that incorporates effective role modelling. Students are encouraged to seek a range of role models that are accessible, including role models from other health disciplines, such as nursing and allied health services.

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 has demonstrated a strong commitment to developing clinical scientists. While there is also a strong focus on professionalism in clinical practice, there remain opportunities to develop how students witness the demonstration of cultural sensitivity in the clinical learning environment.

The newly articulated 12 Course Learning Outcomes include attributes related to patient centeredness and there are a number of learning activities, which encourage a patient centred approach. One example is the Patient Partner Program where students follow the journey of a person in the community as they interact with the health system over the duration of a year. Students must see the person at least four times over the year. This provides an opportunity for students to think about person centred care in the context of an individual's life, and that of their significant others. Students are appreciative of these opportunities offered across all clinical sites particularly in Year 2 but there is scope within the program to further embed the practice of patient centred care and collaborative engagement with patients and communities throughout the curriculum.

4.7 Interprofessional learning

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

The School recognises the importance of interprofessional learning and has established an Interprofessional Practice Committee, and a framework to strengthen this aspect of the curriculum. So far, activity in this area has mainly been in Year 1. An example of an innovation in interprofessional practice was the 'Ways of Knowing' day, run for the first time this year. This day attracted 680 students from a variety of health professional education courses to come together to work with and learn from each other. This is planned for expansion next year. Training in interprofessional education for staff across the Faculty is planned with 15 School of Medicine staff already signed up. Some clinical sites were identified as having structured approaches to interprofessional education and learning during placements, while others depended on mostly opportunistic opportunities.

The formal approach to interprofessional education should be prioritised in the ongoing development of the Program.

It was noted that the clinical nurse educators provided a very strong contribution to the learning and connectedness of students in the clinical environment.

The Team noted the changes forced on the School by the pandemic and commends them on the flexibility of delivery and for grasping the opportunities to develop new approaches to teaching and learning.

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 is commended for its evidence-based approach to guiding the assessment strategy across the Program. The School's assessment team managed by exemplary leadership from the Director of Assessment, and close connections across all facets of the curriculum, has been instrumental in achieving a robust program of assessment across the Program.

The School's principles of objectivity, fairness and transparency are reflected in the program of assessment that aligns closely with the Program learning outcomes. The Director of Assessment, in close collaboration with theme and year leads, takes a highly inclusive approach to written and clinical assessment. The oversight of assessment practices in the School is systematically managed through effective governance policies, primarily the Written Assessment Review Panels (WARP) and Clinical Assessment Review Panels (CARP). This, coupled with subject level evaluation reports facilitates ongoing review of all aspects of assessment with a fully representative group of stakeholders responsible for the Program. The Director of Assessment has wide support from the MD Course Director, subject coordinators, theme leaders and Deans of the Clinical Schools. Assessment information, weightings where relevant, and hurdle requirements are clearly documented in each subject's handbook, and is accessible to all staff and students on the University webpages.

The leadership of the Director of Assessment, who is held in high regard widely across the School and Faculty, is commendable. This was evidenced through the University awarding significant funding for the project 'Written assessment – from hurdling roadblocks to mastery'. This project spans several innovations in assessment and provides ample fertile ground for the MD curriculum redesign, which, from an assessment perspective, aims to develop a culture of continuous assessment with enhancements to feedback. The School's future direction towards a programmatic approach with a focus on mastery and assessment for learning is compatible with best practice assessment design.

The move to an ungraded MD1 in 2020 has been well received by the student cohort, noting that this values collaboration and teamwork over competition for grades. During the Team's visit, the Director of Assessment received notification that approval had been gained for a temporary change to an ungraded pass/fail for Years 2 and 3. This enables the Program to vary from the University's established approach, whereby around 50% of a course could be ungraded (Year 1 and the final semester of Year 4 were already ungraded). It is a welcome observation that the Program has the agency to seek modifications to conventional University methodologies. If this is a permanent change, it will be important to evaluate impact on student performance and achievement.

There are however, aspects of the University policy that currently pose unnecessary constraints on assessment in the Program. One relates to the requirement that for clinical assessment students need to be assessed by a medical practitioner of three years' experience. The School is encouraged to continue its work with the University in considering how university level policies can be adapted

to reflect the needs of a contemporary medical program that reflects current approaches to learning, and values team-based, interprofessional perspectives on student assessment.

Careful consideration has been made to balance formative and summative assessment. The introduction of progress testing coupled with early identification of at risk students, and the support provided to students in the development of clinical skills at each clinical school are likely contributors to the high rates of progression across the Program.

The MD curriculum redesign aims to offer individualised pathways and this has important implications for assessment. The current vision is to adopt a strategy with learning mentors working with students to make individualised plans to monitor progression and achievement of the course outcomes. To achieve this goal, it will be essential to have robust and fit for purpose IT systems in place (including an electronic learning portfolio). This programmatic approach requires reliable real-time capture of assessment data to enable optimal support of student learning longitudinally across the whole four years of the Program.

In addition, as the MD curriculum redesign process continues, it will be necessary for the School to provide further updates regarding assessment design as they move away from the current hurdle based approach towards their vision of achievement of mastery. This includes provision of curriculum mapping documentation showing alignment of the new 12 course outcomes to assessments across all four years of the Program.

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 submission provided a comprehensive overview of a variety of fit for purpose assessment methods that have been adopted across the Program. The submission demonstrated how the different methods of assessment gradually increase their focus from assessing knowledge-based outcomes to clinically-based outcomes, taking into account the high weighting of the research component in the final year of the Program. The relationship between assessment methods and their relevance to Miller's pyramid (knows, knows how, shows how and does) provides a useful framework when considering the primary purpose of any one assessment method. Knowledge-based assessments adopted by the Program include multiple choice questionnaire (MCQ), short answer questionnaire (SAQ), assignment based tasks such as the Rural Health Project and other short assignments for the portfolio. Clinical assessment tasks include OSCEs, mini-CEX, Standardised Case Based Discussions, procedural skills, multisource feedback and logbook tasks for specialty rotations.

A number of innovative assessment methods have been incorporated, including Cumulative Achievement Testing (CAT), which is a novel approach to testing core knowledge and encouraging retention in the early years of the Program. The CAT is structured so that over the course of the first year, the number of items assessed and length of the examination increases, as more content is covered. This approach supports longer-term retention of knowledge-based concepts. The adoption of Situational Judgement Testing (SJT) also represents another innovation related to the assessment of professionalism. The SJT along with a well-constructed professional behaviour

process (outlined in Standard 7.4.2) demonstrates another example of how assessment design is carefully constructed and integrated across the Program.

The School demonstrates ongoing consideration of the methods of assessment and the optimal timing for the assessment task. For example, the Program is currently considering the introduction of the locally adapted British Prescribing Skills Assessment in the final year and has varied the timing of the applied knowledge test in Year 4 to offer opportunities for remediation prior to completing the course, thereby assisting students to focus on intern readiness tasks in the latter part of the Program.

The Program has developed a cascading set of blueprints from program level to subject level to individual task level, which is overseen by the Director of Assessment and the governance groups (WARP and CARP). The approach to blueprinting high stakes assessment tasks fosters engagement between content experts and other stakeholders to ensure alignment with learning outcomes at each stage of the Program. Different approaches to blueprinting depending on the type of assessment task were provided in the submission.

A robust application of standard setting methods and determination of setting the cut score have been adopted by the School, informed by evidence from their research and evaluation activities. For example, the development of the SJT method of assessment and an approach to setting the passing standard using adapted Angoff methods has been published in the highly respected, peer-reviewed medical educational journal, Academic Medicine. As well as achieving the cut score, students are also required to pass a series of hurdles in each subject. These hurdles include written assessment, clinical assessment, professionalism and attendance hurdles. This has been recently introduced across all years to ensure that students are not able to compensate substandard performance in one domain such as clinical assessment with better performance in written assessment tasks.

As the Program moves towards a programmatic approach to assessment, the nature of hurdles, for example, those related to attendance, will need to be re-evaluated. Feedback from students indicated that they did not necessarily support the processes used to manage the attendance hurdle. Students expressed the opinion that this felt paternalistic, noting that processes to gain approval for absences were overly complex. An example of needing to complete extensive forms to take leave to present a paper at a related conference was one instance reported by the student group. It may be worthwhile considering alternative methods to reconceptualise attendance as an attribute associated with demonstrating evidence of achievement of professional practice competencies.

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 Program has a comprehensive strategy to identify underperforming students. The longitudinal attachment to a single clinical school fosters close relationships between students, clinical educators and clinical staff, and provides opportunities to identify and remediate weakness in clinical skills. This, coupled with low stakes continuous clinical assessments in Years 2 and 3, assists

timely remediation prior to the more high stakes clinical examinations at the end of the year. The inclusion of formative progress testing in Years 2 to 4, which includes post-test feedback reports, provides opportunities for students to identify their strengths and areas needing improvement while also indicating the expected exit standard to be achieved by the end of the Program. As noted previously, the adoption of the CAT in Year 1 also provides opportunities for students to gain an early indication of their progress in the first semester of the Program. The move to implement the MD4 Applied Knowledge Test early in the final semester of the Program also provides a final opportunity to identify students who are not at the required exit level, and offers an opportunity for them to remediate prior to finishing their final year.

The initiatives to provide rich automated feedback have been recognised by a Faculty innovation award in 2017. Students receive feedback reports from key assessment tasks (progress tests, OSCEs, SJTs). These reports provide comparisons to the whole cohort, data to illustrate longitudinal performance and individualised information enabling students to identify content areas (by system, discipline, and question focus) where they are performing well, and those that may represent misconceptions in their understanding.

Despite this, there were reports from students that some assessment tasks were perceived as 'tick box exercises' and there was variability in the feedback received across the clinical sites, indicating that feedback was sub-optimal in detail or delayed, limiting its usefulness to the individual. These perceptions are currently being addressed by the School in their research on student feedback. The School is exploring variations in student responses to feedback, and their development of resources to explain approaches to assessment and development of feedback literacy. Refinements made to these initiatives in MD1 are likely to also address student comments regarding the clarity of expectations with their ePortfolio assessment tasks. The current automated feedback innovations and strategies to enhance students' understanding about feedback will provide a strong foundation for future enhancements across all years of the Program.

There are excellent processes in place providing detailed reports on cohort performance in each subject. This information is used to plan modifications to assessment and teaching.

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.

There is a clear quality improvement process across the assessment lifecycle: from choosing the type of assessment, developing the assessment task and criteria for judging the expected standard, implementing the assessment (including the training of examiners to aid consistency across clinical sites), with ongoing analysis of assessment outcomes to guide future refinements. An example of the rigorous quality improvement approach to assessment was the revision of assessment hurdles to support appropriate progression. The report outlined the evolution associated with the adoption of hurdles in Years 2 and 3. The analysis of cohort data has led to a plan to modify how the combination of written and clinical assessment hurdles will be applied in 2021. This is to ensure that students are ready to move from the more general disciplines to specialty disciplines, and to overcome the risk of compensatory effects when students focus on and excel in one form of assessment (e.g. knowledge-based learning) to the detriment of other forms of assessment (e.g. patient-based learning).

In addition to internal quality improvement processes, the assessment team also engages in external benchmarking through the use of standardised items from AMSAC, MDANZ and AMC as appropriate for different years of the Program (for example, the AMC item database for the Year 4 final Applied Knowledge Test). Likewise, the School utilises the National Board of Medical Examiners' items for the progress tests after adapting them to the Australian context.

It was noted that the collation of assessment data was primarily managed through shared spreadsheets, which may present some limitations particularly when the desired future direction for the Program is to allow individualised learning pathways. It appears that the systems relied upon for generation of feedback were developed in-house and are not necessarily sustainable, particularly when the Program adopts a programmatic approach which is highly dependent on students having an ability to monitor their progress in real-time. With MD1 adopting a portfolio style approach to the capture of evidence for assessment decisions, it will be very important for the School to have access to a robust electronic learning platform. This will be required to manage large datasets across all aspects of assessment: from mapping of assessment components to competency domains, collation of both qualitative and quantitative data longitudinally, and representation of assessment data into dashboards for learners and teachers to proactively make evidence-based decisions about progression.

Ensuring consistency across sites is an issue that all medical programs grapple with. The Team was impressed with the suite of online assessor modules that were available to assist with the training of examiners and aid in cross-site calibration. The Team was provided with access to the training module for Standardised Case Based Discussions, which provided a comprehensive staged induction to the assessment of this new form of oral assessment. These freely available online modules coupled with the EXCITE clinical supervisor suite of professional development options demonstrate the Program's commitment to excellence in clinical teaching and assessment.

6 The curriculum – monitoring

6.1 Monitoring

6.1.1 The medical education provider regularly monitors and reviews its medical program including curriculum content, quality of teaching and supervision, assessment and student progress decisions. It manages quickly and effectively concerns about, or risks to, the quality of any aspect of medical program.

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

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

There is evidence of a comprehensive approach to monitoring and reviewing the Program overseen by the Director of Evaluation and Quality. A range of qualitative and quantitative measures are applied and the feedback from these activities can be found on MD Connect.

Qualitative data is collected in formal (monthly meetings with student leadership) and informal (Head of School lunches) gatherings, and there are opportunities for students and teaching staff to provide feedback via regular surveys delivered in various formats and timings.

The data on student performance considers student characteristics and Clinical School allocation to track individual and cohort performance across successive courses, years and clinical schools. Student issues are responded to and appropriately in a timely way.

End of subject surveys are conducted by the School in parallel with University based Subject Experience Surveys (SES). The latter have a poor response rate (reportedly <24%). There is evidence of survey fatigue amongst the students. Importantly, the Director of Evaluation and Quality and the small unit of two 0.7 FTEs, do not have full oversight of all the surveys that are requested of the medical student cohort. Students are also approached by other external parties, most often through the DME office. To mitigate this, the Director of Evaluation and Quality is actively seeking to better protect the student cohort from requests that occur outside the School's strategic evaluation framework.

The central function of monitoring the program lies with a small, and possibly, under-resourced team. A formal plan for data integration of the numerous databases on which school enrolment, attendance, performance and feedback information are held, would be of benefit to the Program.

The School is engaged with an Australian collaboration examining the relationship between selection measures, student characteristics and student achievement. The School actively engages in benchmarking with other external providers for its early and final program years, and for its recent graduates in intern years.

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.

Outcome evaluation is a clear area of strength. The School undertakes internal quantitative data analysis and has measured both the individual and cohort performance across courses, years of study and clinical school, and grouped by gender, domestic, international and enrolment category. The School is to be commended for its commitment to evaluation and feedback within the MD curriculum redesign at all levels.

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 annual course evaluation reports are comprehensively conducted and widely disseminated.

The Director of Evaluation and Quality provides information relating to the overall student cohort and the cohort subgroups back to the MD Selection Committee via the MD Operations Committee and the MD Governance Committee. There may be benefits in embedding the approach of this pilot project directly into the MD Selection Committee assessment processes.

The Team noted that most of the outcome data is cohort based rather than individually targeted.

7 Implementing the curriculum – students

7.1 Student intake

7.1.1 The medical education provider has defined the size of the student intake in relation to its capacity to adequately resource the medical program at all stages.

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

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

The School has continued to provide high quality teaching to its students despite the challenges of the COVID-19 environment. They have demonstrated high quality support, resources and integration between the central faculty of the Program and its many clinical schools during this difficult time.

The allocation of students to a clinical zone initially, followed by a clinical school location soon after commencement of their program, enables students to develop longitudinal connections and a sense of belonging to the clinical sites, clinical staff and members of their peer group.

The Program has clearly defined its student cohort and aims to increase diversity of the current cohort and that of future medical graduates with the intent to better serve the community. The Program provides specific pathways for Aboriginal and Torres Strait Islander and rural origin prospective students. The Program is currently achieving its targets for alternative entry pathways and the recent increase in Indigenous students is a welcome trend.

The absence of scholarships to entry-level Aboriginal and Torres Strait Islander students at partner universities to facilitate transition to medicine was noted. This is an area for development that would benefit the Program.

There are concerns that some Aboriginal and Torres Strait Islander students feel uncomfortable in identifying their Indigenous status. Students reported feeling unsafe in certain contexts (for example, being alone, not wanting to justify skin colour) and in particular, when being handed the unwanted responsibility of speaking for all Aboriginal and Torres Strait Islander people on First Nations Health topics. The Program includes a small, dedicated First Nations Health unit with oversight of both the Indigenous curriculum delivery and student support. The Team recognises the value of this unit but is concerned that it is significantly under-resourced with the under-resourced capability a long-term threat to the viability to the Program as a whole.

7.2 Admission policy and selection

7.2.1 The medical education provider has clear selection policy and processes that can be implemented and sustained in practice, that are consistently applied and that prevent discrimination and bias, other than explicit affirmative action.

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

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

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

The Program has clear, transparent objectives and evaluated admissions procedures. There is appropriate oversight of the MD Selection Committee by the central MD Governance Committee. It is noted that the Associate Dean (Indigenous) is a member of the MD Selection Committee, although this role is currently unfilled. The absence of a community representative on this Committee is also of concern, as this perspective would be of benefit to the Program. The consequences of not filling these positions – as a matter of urgency – seems to be under-appreciated by the School.

The new Murray Darling Medical School Network, the end-to-end medical training initiative, in collaboration with the Bachelor of Biomedical Science program at La Trobe University, is an excellent initiative, and provides an opportunity for rural based students to achieve access to a medical qualification. Integration between the La Trobe program and the MD Program is well thought out and underpinned by excellent communication.

The Program has well-established and tested policies for admission of students with disabilities and serological infectious diseases. Where necessary to support student participation, the Program is supported in adapting the University policies to ensure that affected students are provided with a safe student experience and a realistic opportunity to complete their course. The Program also considers the safety of the wider student cohort in these decisions. Options for scholarships across all admissions pathways would be a welcome addition to ensure wider access pathways to the medical degree.

The Program has well-developed alternative pathways for admission. Information about these and the standard pathways is publicly available. There may be benefits in improving the clarity of the process related to clinical zone selection prior to admission, particularly in relation to the rural zone and the extended rural cohort pathway, so that students are immediately aware of the implications of selecting this preference.

7.3 Student support

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

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

- *students with disabilities and students with infectious diseases, including blood-borne viruses*
- *students with mental health needs*
- *students at risk of not completing the medical program.*

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

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

The Program provides a wide range of student support services both centrally and locally at the clinical school levels. The Team was impressed with the apparent close connection that students

have with their respective clinical school staff and their readiness to consult locally. These staff are well supported by the central Faculty with explicit reporting and feedback mechanisms. The Team noted that the specific subject of individual bullying and harassment did not arise spontaneously in discussions with students or staff. Although rare in occurrence, students demonstrated comfort in reporting inappropriate behaviour.

The Program provides three Health and Wellbeing Practitioners (HWP), two of whom are part-time appointments. HWPs are positioned to provide short-to-medium term support to students. One practitioner is allocated to metropolitan clinical schools and two to the rural clinical schools. Waiting times for the Health and Wellbeing service are reported by students to be long. In the COVID-19 environment, with telehealth consultations replacing locality based in-person HWP support, students report that they may now access any HWP, regardless of their clinical school allocation, which is seen to be helpful.

It is apparent that support for student wellbeing is the primary intention of this excellent initiative. The inclusion of 'Health' in the unit's title might be construed as a principal concern for clinical health, for which students should understand that other University and community facilities should be approached. The Team felt that the design of the Health and Wellbeing service might be a concern in terms of expectations, resourcing and sustainability. There may be benefits in clarifying the scope of the Health and Wellbeing initiative for students within the continuum of support services available.

Outside the service provided by the HWP, the design and provision of student support is student driven, and seemingly effective. It rests heavily on the students' good relationships with, and culture of, the clinical schools.

The increase in the Aboriginal and Torres Strait Islander student enrolment from two in 2017 to 15 in 2020 is commendable. It appears, however, that support for the cohort of Aboriginal and Torres Strait Islander students is less than that which may be required. While there are many external and University based Indigenous organisations, the main support for this cohort lies with the School's First Nations Health team which both teaches and provides support. Without question, this team does excellent work, but the breadth of their responsibilities and the limited resources available make their task challenging. Relying on the goodwill of so few, and the workload expectations of this team, is a challenge and needs to be addressed.

The Team notes the detailed and extensive identification and support of students at risk of not completing the Program. It commends the specific initiative to analyse the 'failure to fail' effect. The historic and current student course completion rate is impressive, with the attrition rate being generally very low. The School understands that this may mask a 'failure to fail' process and is vigilant in identifying where action needs to be taken to protect students and the community from inappropriate academic progression.

There is a wide range of learning support provided for students with special needs. Support is available at many levels and locations with defined reporting pathways and feedback mechanisms. Longitudinal academic support is a feature of the planned Program redesign. The Team is concerned that the First Nations Health unit is logistically small and potentially under-resourced. It appears to carry both the educational load and the special needs support role for Indigenous students.

The Program adheres to the functional separation of student support from academic progression decision making. Requirements for academic progression are clearly defined and specific feedback is provided.

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 Program has a Core Participation statement that outlines the cognitive and physical requirements to complete the program. The University provides a Student Equity and Disability Service (SEDS) in which students are encouraged to self-refer regarding disability either present on entry to, or arising during, the Program. There is evidence that the Program supports students with disability such as diplegia and severe hearing impairment, through additional course aids and curriculum modification to help them achieve learning outcomes.

The Program has a well-defined and transparent process for addressing students whose professional behaviour raises concerns about their fitness to practise medicine or their ability to interact with patients or colleagues. A Fitness to Practise Committee is established to which Professional Behaviour Notifications may be referred. There is evidence of active investigation of unprofessional behaviour and a system of graduated proportionate responses. This occurs at clinical school level and at a faculty level. Where necessary, the Head of the DME and the MD Course Director have the authority to involve Ahpra.

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.

There is a wide range of active student participation in governance at both the levels of the central medical program and at the individual clinical sites. There are two University of Melbourne Medical Students' Society (UMMSS) students on each of the MD Governance Committee, the MD Operations Committee and the MD Course Redesign Committee. In addition to working with UMMSS, there is evidence of active participation by, and consultation with, students in the decision-making processes.

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.

There is evidence of adequate indemnification and insurance for students of the Program. The Program currently carries $20,000,000 insurance for each of: Clinical Trials - no fault compensation, Clinical Trials - Legal Liability, Medical Malpractice and Professional Indemnity.

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 nature of the virtual accreditation assessment, due to the impacts of COVID-19, has meant that the Team was unable to visit the physical facilities of the School. However, meetings held with all stakeholders of the Program, and the information and resources provided by the School regarding the facilities and various clinical schools provided a comprehensive view of the Program. Nonetheless, a visit to the site will need to occur when circumstances allow.

Despite operating over a broad geographical area and sharing clinical sites with other medical education providers, the School has worked hard to ensure students and staff have access to safe and well-maintained physical facilities. The Team noted the generally positive feedback from students and Faculty regarding the sites of the Program. This has been a consistent feature in previous reports since 2010.

The facilities at Shepparton were identified as being in need of renewal. The Team was provided with advanced plans for a new teaching and learning centre with student accommodation on this site. Based on feedback from the students, the renewal is timely given the comments concerning cramped student facilities and privacy issues due to the location of air vents.

The Team noted that the pandemic has provided an impetus for the School to review the use of its physical spaces. Faculty and students are to be commended for adapting quickly and pragmatically to the challenges associated with COVID-19 in their teaching and learning sites. These changes to learning environments are likely to continue in the longer term. As the Program decreases its reliance on large group teaching spaces for lectures and adopts flexible online learning, the Faculty will need to work closely with their partner sites to reconfigure the learning environments for this new world of learning.

8.2 Information resources and library services

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

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

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

The School has a wide range of information communication technology (ICT), software and reference databases.

MD Connect is the integrated curriculum delivery and administration system specifically designed to support the Program. It functions as a timetable, communication platform, curriculum search and repository, library access and electronic health record learning environment.

While MD Connect is particularly helpful in providing access to archived teaching material, more effective technological means of supporting curriculum mapping and e-portfolio functions are required to realise the aims of the new curriculum. The DME plans to use fit for purpose platforms for these key functions and the Team looks forward to reviewing progress as these are implemented.

The School is in the early stages of transitioning to the University's Enterprise Learning Management System (LMS), 'Canvas'. In the longer term, this LMS offers a more sustainable information and communication technology platform with the provision of centralised university support. Feedback from the first year students, who are the primary cohort accessing Canvas, was positive.

As the School promotes an individualised approach to student learning, it will be important to find ways to support and monitor how students progress along their personal learning journeys. This will be particularly important in order to realise the School's desire to promote depth and breadth of learning, through opportunities for students to undertake unique learning opportunities. Managing such individualised learning experiences will require the support of appropriate ICT infrastructure. The School's LMS and curriculum innovations merit ongoing evaluation in this regard; specifically in understanding the mechanisms to support the use of these systems by students and staff, how MD Connect links with the functionality provided by Canvas, and whether they are fit for purpose.

8.3 Clinical learning environment

8.3.1 The medical education provider ensures that the clinical learning environment offers students sufficient patient contact, and is appropriate to achieve the outcomes of the medical program and to prepare students for clinical practice.

8.3.2 The medical education provider has sufficient clinical teaching facilities to provide clinical experiences in a range of models of care and across metropolitan and rural health settings.

8.3.3 The medical education provider ensures the clinical learning environment provides students with experience in the provision of culturally competent health care to Aboriginal and Torres Strait Islander peoples and/or Māori.

8.3.4 The medical education provider actively engages with other health professional education providers whose activities may impact on the delivery of the curriculum to ensure its medical program has adequate clinical facilities and teaching capacity.

The model of clinical schools has been a long-standing feature of the Program. The clinical learning environment appears to provide sufficient opportunity for patient contact and the gaining of clinical experience to adequately prepare graduates for clinical practice. The Trainee Internship placement is particularly appropriate and effective in this regard. The positive and proactive changes that the School have implemented to address the impact of COVID-19 on the clinical environment, and their scholarly activities in this area is commendable.

The current structure of allocation to clinical schools means that students are rigidly locked into either metropolitan or rural clinical contexts. Historically, students based at the metropolitan schools appear to have had some access to rural clinical learning environments. In the current clinical school structure, it does not seem to be possible for students based at the rural schools to access clinical experience in the metropolitan context. The Program may benefit from the School exploring approaches where metropolitan and rural schools develop linkages to facilitate students accessing a broader range of models and aspects of Australian health care.

The School acknowledges that experience in the provision of culturally sensitive clinical care to Aboriginal and Torres Strait Islander peoples is an area for development in the Program. The School's candour in this area, and the efforts being made to improve this part of the course were noted. Students recognised the importance of this aspect of Australian medical education and were similarly motivated.

The School is encouraged to actively foster and develop relationships with the local Aboriginal communities and external Aboriginal and Torres Strait Islander health service agencies, and explicitly promote First Nations' health care in the course with an emphasis on the clinical phases.

There is under-resourcing, under-utilisation or insufficient availability of suitable placements in general practise and Aboriginal and Torres Strait Islander medical services. It is important that attention be paid to addressing the need for suitable placement opportunities in these environments.

The School has functional and collegiate relationships with other health professional and medical education providers, which includes the sharing of clinical teaching spaces.

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.

Despite the inherent variations in using a clinical schools model, the clinical supervision of students, the supports for staff and governance of clinical supervision are adequate.

The range of resources and professional development opportunities that the School has developed with the EXCITE program and the Academy of Clinical Teachers are commendable.

The EXCITE program offers domestic and international health professionals at any stage of their career options for completing either Graduate Certificate, Diploma or Masters in Clinical Education with fees ranging up to $41,000. The School also offers a clinical supervision course to those who will undertake student teaching and assessment. This course's online, flexi-time format is tailored to suit all clinicians who teach and/or supervise learners at any level. While this course is reasonably priced, there may be benefits in making aspects of this program more accessible for staff engaged with student teaching, learning and assessment.

Appendix One Membership of the 2020 AMC Assessment Team

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Ms Georgie Cornelius
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Appendix Two Groups met by the 2020 Assessment Team

Meeting	Attendees
Monday, 3 August 2020	
Melbourne Medical School	
Overview of Assessment Week	Head of School Department Head, Medical Education MD Course Director School Manager
Melbourne Medical School Executive Committee	Head of School (Chair) Deputy Head of School/Director of Research Department Head, General Practice Department Head, Medical Education Department Head, Medicine and Radiology Department Head, Rural Health James Stewart Chair of Medicine Chair of Psychiatry, Austin Health School Manager Executive Officer, Strategic Projects Deputy School Manager
The University of Notre Dame Australia, School of Medicine, Sydney	Acting Dean Associate Dean, Melbourne Clinical School
The University of Melbourne Medical Students' Society (UMMSS)	President Vice-President (External) Treasurer Community Wellbeing Officer
MD Governance Committee	Head of School (Chair) Chair of Anaesthesia, Austin Health Department Head, Anatomy And Neuroscience Department Head, Medical Education Department Head, Rural Health Director, Assessment Director, Evaluation and Quality Director, Graduate Programs MD Course Director UMMSS Vice President (External)

Meeting	Attendees
MD Operations Committee	MD Course Director (Chair) Director, Assessment Director, Evaluation and Quality Director, Medical Student Education Director, Medical Student Education (Outer Metro rep) Department Manager, Medical Education Team Leader, Academic Programs Theme Lead, Clinical Skills Theme Lead, Professional Practice Clinical Nurse Educators representative Coordinator, Student and Programs Coordinator, Applied Medical Science Subject Coordinator, MD1 Subject Coordinator, Principles of Clinical Practice (PCP) 2 Subject Coordinator, PCP3 Subject Coordinator, MD Student Conference and PCP3 Subject Coordinator, Transition To Practice (TTP)
Tuesday, 4 August 2020	
Melbourne Medical School	
Department of Medical Education	Department Head, Medical Education Department Manager, Medical Education Director, Assessment Director, Evaluation and Quality Director, First Nations Health Education MD Course Director Director, Postgraduate and Custom Programs Director, Research and Research Training Director, Work Integrated Learning Director, Medical Student Education, Royal Melbourne Hospital Clinical School Director, Medical Student Education, Western Hospital Clinical School

Meeting	Attendees
MD Course Redesign Committee	Department Head, Medical Education (Chair) Director, Assessment Director, Evaluation and Quality MD Course Director Director, Medical Student Education, Royal Melbourne Hospital Clinical School Director, Rural Clinical School Director, Work Integrated Learning Manager, Learning Technologies and Business Systems Team Leader, Academic Programs Coordinator, Applied Medical Science Senior Lecturer, Obstetrics and Gynaecology Subject Coordinator, MD1 UMMSS Vice-President (External) UMMSS representative
Monash University, Faculty of Medicine, Nursing and Health Sciences	Deputy Dean (MBBS)
Students	Students
Indigenous Health	Director, First Nations Health Education Lecturers, Medical Education in First Nations Health
Financial autonomy and sustainability	Director of Finance & Deputy Chief Operating Officer, Faculty of Medicine, Dentistry and Health Sciences Deputy Dean, Faculty of Medicine, Dentistry and Health Sciences Head of School School Manager
Clinical Teaching Skills	MD Course Director Director, Sensitive Examination Program Theme Lead, Clinical Skills Lead Tutor, Year 1 Clinical Skills Procedural Skills Teaching Specialist Deputy Director, Medical Student Education, Western Hospital Clinical School Subject Coordinator, Year 1 Subject Coordinator, PCP3

Meeting	Attendees
	Subject Coordinator, PCP3 and MDSC Subject Coordinator, TTP
Wednesday, 5 August 2020	
Royal Melbourne Hospital	
Clinical School Leadership	Director, Medical Student Education Deputy Director, Medical Student Education Assistant Director, Medical Student Education Clinical School Manager
Clinical Supervision	Ethical Practice (EP) Tutor, Clinical Lead, MD2 EP Tutor, Clinical Lead, MD4 Clinical Sub-Dean, EP Tutor, Clinical Lead, Ambulatory Care Clinical Lead, Emergency Department (ED) Clinical Skills Coach Subspecialty Coordinator
Students currently on placement	Students
Health service executives	Chief Executive Officer Chief Medical Officer
St Vincent's Hospital	
Clinical School Leadership	Director, Medical Student Education Deputy Director, Medical Student Education Clinical School Coordinator
Clinical Supervision	Clinical Nurse Educators Academic Lead, EP Tutor Simulation Lead MD Research Project Local Coordinator and ED Physician
Department Chairs	Chair of Medicine Chair of Surgery Director, Medical Student Education and Clinical Dean
Medical Education Team	Medical Education Officer
Students currently on placement	Students

Meeting	Attendees
Northern Health	
Clinical School Leadership	Director, Medical Student Education Deputy Director, Medical Education Clinical School Coordinator
Clinical Supervision	Tutors, Year 2 Clinical Skills Coach Tutors, Year 2 EP Tutor, Years 2, 3 & 4 Clinical Skills Coach, Simulation Teaching Year 3 & 4 Tutor, Year 3 Women's Health Clinical Nurse Educator Specialist, Maternal Foetal Medicine Lead, Paediatrics Assistant Director, Medical Education Deputy Director and Tutor, Year 2 Clinical Skills Coach
Health service executives	Chief Executive Officer Chief Medical Officer Director of Medicine Head of Paediatrics Director of Research Director of Surgery Director of Women's Health and Children's Health Deputy Director of Medical Education
Students currently on placement	Students
Rural Clinical Schools	
Clinical School Leadership	Director, Medical Student Education, Rural Clinical School & Head, Department of Rural Health Chair of Medicine, Rural Health Rural Clinical School Manager Deputy Director, Medical Student Education, Ballarat Deputy Director, Medical Student Education, Bendigo Deputy Director, Medical Student Education, Wangaratta

Meeting	Attendees
Clinical Supervision	Deputy Director, Medical Student Education, Wangaratta Extended Rural Cohort (ERC) Hub Educator, Shepparton Manager, Clinical Skills Laboratory, Shepparton
Health service executives	Chief Medical Officer, Ballarat Health Chief Executive Officer, Echuca Health Chief Medical Officer, Echuca Health Chief Medical Officer, Goulburn Valley Health, Shepparton Chief Executive Officer, Numurkah Health Executive Director Medical Services, Northeast Health, Wangaratta Operational Director Education and Research, Northeast Health, Wangaratta Director, Medical Training, Northeast Health, Wangaratta
Students currently on placement	Students
Melbourne Medical School	
General Practitioners	General Practitioner (GP), Murchison Medical Centre GP, Shepparton Medical Centre Medical Director and GP, Shepparton Medical Centre GP, Camberwell Road Medical Practice GP, Deepdene Surgery GP, Echuca Moama Family Medical Practice
Thursday, 6 August 2020	
Melbourne Medical School	
Local oversight and delivery of curriculum	MD Course Director Director, First Nations Health Education Theme Lead, Clinical Skills Theme Lead, Communication Theme Lead, Professional Practice and Lecturer in Work Integrated Learning Theme Lead, Research

Meeting	Attendees
	Professional Practice Lead, MD1 and Lecturer in Work Integrated Learning Subject Coordinator, MD Research Project
Deakin University, School of Medicine	Dean, Head of School Deputy Head of School
Program outcomes, purpose	Vice-Chancellor Provost Dean, Faculty of Medicine, Dentistry and Health Sciences & Assistant Vice-Chancellor (Health)
Assessment policy and process, standard setting and blueprinting	Director, Assessment Chair, Clinical Assessment Review Panel Senior Lecturer, Medical Education Lecturer, Medical Education
Monitoring and Evaluation	Director, Evaluation and Quality Research Fellow
Student Support	Health and Wellbeing Practitioner (Metro) Health and Wellbeing Practitioner (Rural) Co-chair Student Wellbeing Advisory Group and Subject Coordinator, PCP3 Subject Coordinator, PCP3 MD Course Director Deputy Director, Medical Student Education, Austin Clinical School Deputy Director, Medical Student Education, Royal Melbourne Hospital Clinical School
Admissions	Head, Department of Medical Education Head of School Director, Learning and Teaching Unit Director, Evaluation and Quality MD Course Director Director, Medical Student Education, Austin Hospital Clinical School Selection Lead Coordinator, Selection and Recruitment Academic Programs Manager School Manager

Meeting	Attendees
Indigenous students	Students
Friday, 7 August 2020	
Melbourne Medical School	
La Trobe University's Pathway Program	Head, Department of Pharmacy and Biomedical Sciences Head of Biomedical Sciences and Senior Lecturer, Department of Pharmacy and Biomedical Sciences Senior Project Coordinator, Biomedical Science (Medical) Program
Professionalism	MD Course Director Theme Lead, Professionalism Head, Department of Medical Education Academic Director, Interprofessional Education Deputy Director, Medical Student Education, Austin Clinical School Deputy Director, Medical Student Education, Western Clinical School and Subject Coordinator, PCP
Professional Staff	Manager, Department of Medical Education Manager, Learning Technologies and Business Systems Project Manager, Academic Programs Team Leader, Academic Programs Students and Programs Coordinator (PCP 2 & 3) Students and Programs Coordinator (MD Research Project and TTP) Coordinator, Northern Clinical School Clinical School Officer, MD2, Rural Clinical School, Shepparton Clinical School Officer, MD2, St Vincent's Hospital Clinical School Clinical Programs Coordinator, Paediatrics Clinical Programs Coordinator, Women's Health

Meeting	Attendees
Department of General Practice	Head, Department of General Practice MD Academic Coordinator, General Practice Manager, Teaching and Learning, Department of General Practice

Appendix Three Teaching sessions attended by the 2020 Assessment Team

Date	Teaching session
Monday, 3 August 2020	Case Supported Learning Tutorial, Year 1
	Simulation, Year 2
Tuesday, 4 August 2020	Clinical Skills Tutorial, Year 1
Wednesday, 5 August 2020	Practical Skills Tutorial, Year 4
Thursday, 6 August 2020	Simulation, Year 2
Friday, 7 August 2020	Case Supported Learning Tutorial, Year 1
	Lecture: Case Studies in Health Services Research: Evaluating Low Quality Care, Year 3