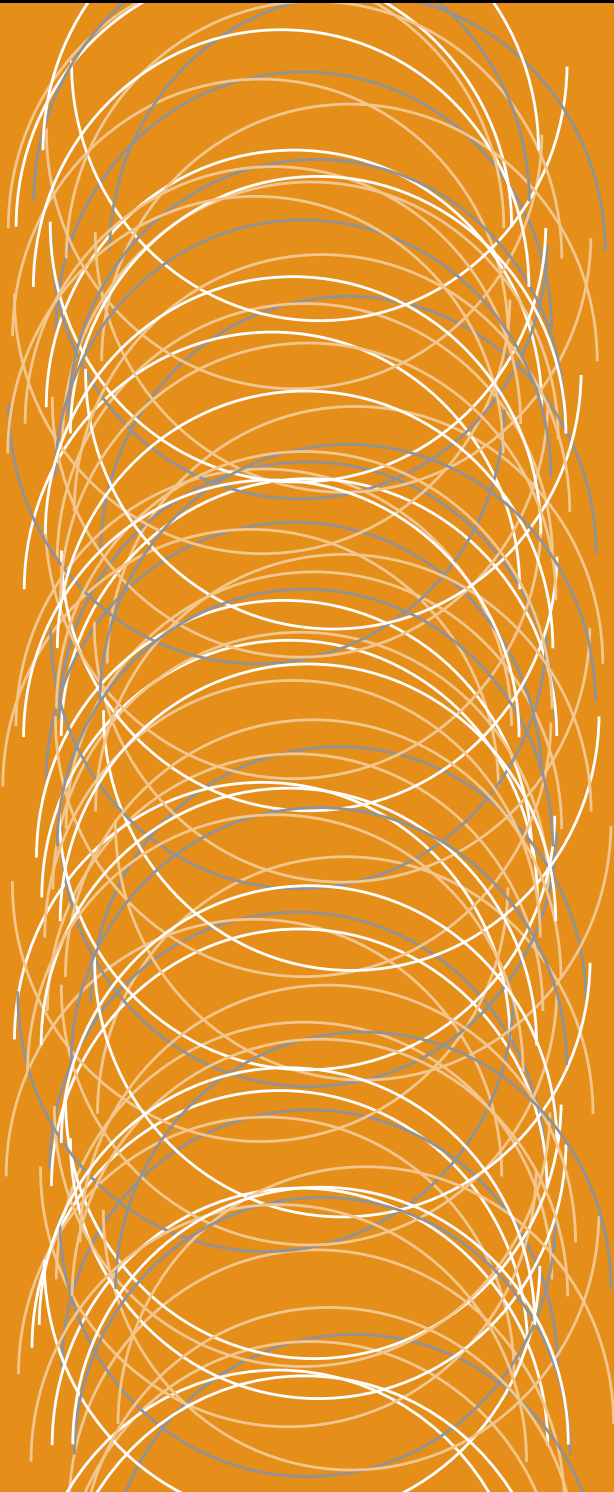


Australian Medical Council Limited

Accreditation of
Australian National University
College of Health and Medicine
School of Medicine and Psychology medical program

AMC



Medical School Accreditation Committee
December 2023

February 2024

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Acknowledgement of Country

The AMC acknowledges the Aboriginal and Torres Strait Islander peoples as the original Australians, and the Māori as the original people of Aotearoa New Zealand.

We acknowledge and pay our respects to the Traditional Custodians of all the lands on which we live and work, and their ongoing connection to the land, water and sky. The Australian Medical Council offices are on the land of the Ngunnawal and Ngambri Peoples. The Acton campus of the Australian National University is located on the land of the Ngunnawal and Ngambri people, and the School of Medicine and Psychology operates across many lands across NSW and the NT.

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

Executive summary

Accreditation process

According to the Australian Medical Council's (AMC) *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2022*, accredited medical education providers may seek reaccreditation when their period of accreditation expires. Accreditation is based on the medical program demonstrating that it satisfies the accreditation standards for primary medical education. The provider prepares a submission for reaccreditation. An AMC team assesses the submission and visits the provider and its clinical teaching sites.

Accreditation of the *Medicinae ac Chirurgiae Doctoranda (MChD)* medical program of the Australian National University, School of Medicine and Psychology (SMP) expires on 31 March 2024.

An AMC team completed the reaccreditation assessment. It reviewed the School's submission and the student report and visited the Australian National University and associated clinical teaching sites in the week of 31 July – 4 August 2023.

At the time of the assessment the Program had three conditions on its accreditation, which were set by AMC Directors following the Medical School Accreditation Committee's review of the changes reported by the Program during the COVID-19 pandemic:

- Demonstrate that the university provides adequate financial resources to ensure the medical program can achieve its purpose and objectives (Standard 1.5)
- Provide evidence that the Change Implementation Plan ensures adequate academic and professional staffing of the medical program (Standard 1.8)
- Provide evidence of the outcomes of monitoring and review of the Indigenous Health curriculum (Standard 6.2)

Progress against these conditions was reviewed within the accreditation assessment.

The medical program has many strengths, particularly the enthusiasm and commitment of staff, the expertise and engagement of clinical titleholders, impressive collegiality of staff and students, and the quality of graduates. The accreditation assessment took place following a period of significant challenge and during a time of great change in governance structure, personnel, partnerships and resources, yet the enthusiasm of academic and clinical staff for the program, and for supporting students and each other has been evident throughout the process. The professional staff have also shown dedication and innovation during this challenging time.

All stakeholders who spoke to the AMC team were excited about working together on the imminent curriculum review, which had been paused during the structural changes. Within the SMP there are exciting aspirations and clear potential for innovation and development of a unique medical program with a strong focus on mental health and wellbeing.

The University has also set a clear agenda to explore opportunities to increase the student cohort size and to increase the proportion of overseas students within the program which, if implemented, will bring a different experience and a different set of requirements for the medical program.

This accreditation assessment is based on the current program, which has benefited from continuous quality improvement in several areas since the last assessment. The current cohort size and demographic has seen a small increase in overall numbers and in overseas students, returning to a similar demographic to pre-COVID-19 cohorts.

Under the AMC accreditation procedures, the program is required to report on changes, including to curriculum and cohort size, that affect the way in which it continues to meet the accreditation standards. The Medical School Accreditation Committee will assess the impact of the changes and determine if additional accreditation assessment or monitoring activities are required to provide assurance that the program continues to meet the accreditation standards.

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

Decision on accreditation

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

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

Reaccreditation of established education providers and programs of study

In accordance with the Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2022, section 5.1, the accreditation options are:

- (i) Accreditation for a period of six years subject to satisfactory progress reports. Accreditation may also be subject to certain conditions being addressed within a specified period and to satisfactory progress reports (see section 4). In the year the accreditation ends, the education provider will submit a comprehensive report for extension of accreditation. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to a maximum of four years, before a new accreditation review.
- (ii) Accreditation for shorter periods of time. If significant deficiencies are identified or there is insufficient information to determine that the program satisfies the accreditation standards, the AMC may grant accreditation with conditions and for a period of less than six years. At the conclusion of this period, or sooner if the education provider requests, the AMC will conduct a follow-up review. The provider may request either:
 - a full accreditation assessment, with a view to granting accreditation for a further period of six years; or
 - a more limited review, concentrating on the areas where deficiencies were identified, with a view to extending the current accreditation to the maximum period (six years since the original accreditation assessment). Should the accreditation be extended to six years, in the year before the accreditation ends, the education provider will be required to submit a comprehensive report for extension of the accreditation. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to the maximum possible period, before a new accreditation assessment.
- (iii) Accreditation may be withdrawn where the education provider has not satisfied the AMC that the complete program is or can be implemented and delivered at a level consistent with the

accreditation standards. The AMC would take such action after detailed consideration of the impact on the healthcare system and on individuals of withdrawal of accreditation and of other avenues for correcting deficiencies.

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

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

AMC Directors at their 8 February 2024 meeting resolved that:

- (i) the medical program of the Australian National University, College of Health and Medicine, School of Medicine and Psychology substantially meets the accreditation standards,
- (ii) accreditation of the four year *Medicinae ac Chirurgiae Doctoranda* (MChD) program of the Australian National University, College of Health and Medicine, School of Medicine and Psychology be granted for four years, to 31 March 2028 and;
- (iii) accreditation of the program and provider is subject to the following conditions and the monitoring requirements of the AMC.

<i>To be satisfied by 2024</i>	
1.	Demonstrate that community groups and stakeholders are engaged in the curriculum review, represented in decision-making, and consulted on key issues, including the program's purpose, curriculum, outcomes and governance. (Standard 1.1.2 and 1.1.3/ 2024 standard 1.2.1) by 2024
2.	Confirm the arrangements for the curriculum review, including details of what has been communicated to relevant groups about leadership, overall governance, budgetary delegation, process, and timeline. (Standard 1.2 and 1.5/ 2024 standard 1.4.1, 1.4.2) by 2024
3.	Provide confirmation that there is sufficient income to sustain the medical program once the TRANSFORM funding is no longer available. (Standard 1.5 and 1.8/2024 standard 1.4.1 and 5.2) by 2024
4.	Provide evidence of formal agreements with GP placement providers or otherwise demonstrate the sustainability of the general practice placement provision in ACT. (Standard 1.6.1/2024 standard 1.2.2) by 2024
5.	Demonstrate that the vacant academic positions (including roles in partnership with CHS) are being recruited with details of end dates of any fixed term appointments. (Standard 1.8.1/2024 standard 5.2.1) by 2024
6.	Provide urgent assurance of succession planning for the Professor of General Practice. (Standard 1.8.1/2024 standard 1.4.3) by 2024
8.	Confirm the autonomy/decision-making authority of the newly formed Indigenous Health Unit, define the involvement of the Tjabal Indigenous Education Centre in supporting curriculum review and development, and describe any discretionary budget to develop the curriculum in line with the new accreditation standards and the Program's existing vision. (Standard 3.5/2024 standard 1.4.4 and 2.3.7) by 2024

- | |
|--|
| 10. Confirm the plans for student cohort growth and demonstrate capacity to match (with detailed analysis required for growth exceeding 120 students per year). (Standard 7.1.1/2024 standard 4.1.1) by 2024 |
|--|

<i>To be satisfied by 2025</i>

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| 7. Demonstrate that there is an effective system in place for managing changes to the documentation of current learning outcomes and the management of learning materials on the LMS particularly in Phase 2. (Standard 3.4/2024 standard 1.4.6) by 2025 |
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| 9. Demonstrate that the program outcomes are being evaluated in the context of a clear framework that engages stakeholders in determining whether ANU graduates are meeting the needs of local communities. (Standard 6.2.2/2024 standard 6.2.2) by 2025 |
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- | |
|---|
| 11. Work with students and community groups to review strategies for recruiting, supporting and retaining Aboriginal and/or Torres Strait Islander students. (Standard 7.1.2 and 7.2.3/2024 standard 4.1.2) by 2025 |
|---|

<i>To be satisfied by 2026</i>

- | |
|--|
| 12. Demonstrate that students will have access to appropriate spaces for learning during and after completion of the redevelopments at Canberra Hospital and North Canberra Hospital. (Standard 8.1.1/2024 standard 5.1.3) by 2026 |
|--|

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
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Standards 1.2, 1.5, 1.6.1 and 1.8 are substantially met

Standards 1.1.2 and 1.1.3 are not met

Conditions

- 1 Demonstrate that community groups and stakeholders are engaged in the curriculum review, represented in decision-making, and consulted on key issues, including the program's purpose, curriculum, outcomes and governance. (Standard 1.1.2 and 1.1.3/2024 1.2.1) by 2024
- 2 Confirm the arrangements for the curriculum review, including details of what has been communicated to relevant groups about leadership, overall governance, budgetary delegation, process and timeline. (Standard 1.2 and 1.5/2024 1.4.1 and 1.4.2) by 2024
- 3 Provide confirmation that there is sufficient income to sustain the medical program once the TRANSFORM funding is no longer available. (Standard 1.5 and 1.8/2024 1.4.1 and 5.2) by 2024
- 4 Provide evidence of formal agreements with GP placement providers or otherwise demonstrate the sustainability of the general practice placement provision in ACT. (Standard 1.6.1/2024 1.2.2) by 2024
- 5 Demonstrate that the vacant academic positions (including roles in partnership with CHS) are being recruited with details of end dates of any fixed term appointments. (Standard 1.8.1/2024 5.2.1) by 2024
- 6 Provide urgent assurance of succession planning for the Professor of General Practice. (Standard 1.8.1/2024 1.4.3) by 2024

Recommendations

- A Review the workload of and support for the Associate Director Education (Medicine) role to ensure the devolved responsibilities of the School's Director are sustainably able to be carried out. (Standard 1.2.2/2024 1.4.2 and 1.4.3)
- B Monitor workload among Sydney Clinical School staff and consider whether there is a need for clinician educator roles. (Standard 1.8.1/ 2024 5.2.1)
- C Prioritise the planned work to improve the attractiveness of clinical academic titles. (Standard 1.9.1/2024 5.3.1)

Commendations

- The many talented staff who use their extensive educational expertise in the development and management of the medical program. (Standard 1.4/2024 1.4.4, 5.2.4)
- The strong relationship between the University and Southern New South Wales Local Health District, which aims to grow the rural medical workforce. (Standard 1.6.1/2024 1.2.2)

2. The outcomes of the medical program	Met
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Recommendations

- D Invest in broader consultation with community stakeholders to ensure the new curriculum reflects broad perspectives on the needs of the communities that ANU serves. (Standard 2.1.3/2024 1.2.1 and 1.2.2) by 2024 (through providing an update on how stakeholders are engaged in the curriculum review and in the governance of the program in the 2024 self-assessment.)

Commendations

- The commitment of the SMP to shaping a robust joint vision and purpose while maintaining the Program's strong independent identity. (Standard 2.1/2024 1.1, 1.1.2)
- The work on transition to practice, which demonstrated responsiveness to student and clinician feedback and has been very successful in ensuring that ANU graduates are competent and well regarded as interns in the local health service. (Standard 2.2/2024 2.1.1, 2.1.2 and 1.1.3)

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

Standards 3.4 and 3.5 are substantially met

Conditions

- 7 Demonstrate that there is an effective system in place for managing changes to the documentation of current learning outcomes and the management of learning materials on the LMS particularly in Phase 2. (Standard 3.4/2024 1.4.6) by 2025
- 8 Confirm the autonomy/decision-making authority of the newly formed Indigenous Health Unit, define the involvement of the Tjabal Indigenous Education Centre in supporting curriculum review and development, and describe any discretionary budget to develop the curriculum in line with the new accreditation standards and the Program's existing vision. (Standard 3.5/2024 1.4.4 and 2.3.7) by 2024

Commendations

- The work of the Indigenous Health Unit to introduce new curriculum content related to Indigenous health across the curriculum since 2019, and the 2022 updates that have been well received by students. (Standard 3.5/2024 2.2.2 and 2.2.3)

4. Teaching and learning	Met
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Recommendations

- E Increase the availability of learning opportunities with patients, including in community settings, in Phase 1 to ease the transition to Phase 2, and support for students to increase their independence earlier in clinical placements. (Standard 4.4/2024 2.3.5)
- F Develop a framework or mapping to articulate how interprofessional learning is embedded across the length of the program for students at each of the three clinical schools. (Standard 4.7/2024 2.3.3)
- G Review the reporting arrangements for the CHM IPE team to ensure that they are central to the program during the curriculum review process. (Standard 4.7/2024 2.3.3)

Commendations

- The clinical skills program at ANU is impressive in design and highly regarded by students. (Standard 4.3/2024 2.3.4)
- The role of longitudinal academic supervisor in Phase 2 provides an important safety net and opportunity for student development. (Standard 4.4/2024 2.3.5)

5. The curriculum - assessment of student learning	Met
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Recommendations

- H Develop a process for direct engagement of students in the assessment evaluation remit of the MChD Assessment and Academic Progress Subcommittee. (Standard 5.1.1/2024 1.3.4)
- I Ensure course evaluation captures student perceptions about gaps in teaching to Level 3 learning outcomes to ensure maintenance of constructive alignment with assessment. (Standard 5.1.1/2024 3.1.2)
- J Evaluate the Phase 2 clinical assessment requirements and their implementation, including the e-portfolio. (Standard 5.1.3/2024 3.1.4)
- K Review the high-level assessment blueprint, particularly with respect to including generalist and specialist approaches to clinical practice in urban, rural and remote contexts and aligning assessment to course purpose with respect to demonstrated knowledge of Aboriginal and/or Torres Strait Islander health and societies. (Standard 5.2.2/2024 3.1.3)
- L Review procedures for identifying and supporting underperforming students in Phase 1 and Phase 2 and work with the University to facilitate appropriate sharing of information to support students. (Standard 5.3.1/2024 3.2.2)
- M Develop faculty development resources for all clinical assessors about effective performance feedback to students. (Standard 5.3.2/2024 3.2.1)
- N Develop a process and procedure to formalise the dissemination of student cohort performance information to all assessors in the medical program, including affiliates and junior medical staff at clinical sites. (Standard 5.3.2/2024 3.2.1)

Commendations

- The comprehensive approach to assessment quality assurance that includes the total program of assessment. (Standard 5.4/2024 3.3)

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

Standard 6.2.2 is substantially met

Conditions

- 9 Demonstrate that the program outcomes are being evaluated in the context of a clear framework that engages stakeholders in determining whether ANU graduates are meeting the needs of local communities. (Standard 6.2.2/2024 6.2.2) by 2025

Recommendations

- O Consolidate evaluation responsibilities in a School or College-level academic role with appropriate resourcing. (Standard 6.1.1/2024 6.1.1)
- P Review the evaluation processes, including feedback pathways, with active involvement of student representatives and broader input from staff and external stakeholders. (Standard 6.3.1 and 6.3.2/2024 6.3.1 and 6.3.2)
- Q Prioritise the implementation of an Advisory Board to provide a mechanism for discussion with health services and community stakeholders about graduate outcomes and program evaluation. (Standard 6.3.1 and 6.3.2/2024 6.3.1 and 6.3.2)

7. Implementing the curriculum – students	Substantially Met
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Standards 7.1.1, 7.1.2 and 7.2.3 are substantially met

Conditions

- 10 Confirm the plans for student cohort growth and demonstrate capacity to match (with detailed analysis required for growth exceeding 120 students per year). (Standard 7.1.1/2024 4.1.1) by 2024
- 11 Work with students and community groups to review strategies for recruiting, supporting and retaining Aboriginal and/or Torres Strait Islander students. (Standard 7.1.2 and 7.2.3/2024 4.1.2) by 2025

Recommendations

- R Prioritise the appointment of additional support for international students. (Standard 7.3.1/2024 4.2.1)
- S Consider a more centralised and accessible structure for the provision of student support services within the Program, comprising more identifiable and independent staff, and explore options for increasing proactive support for students on rural placements. (Standard 7.3.1 and 7.3.2/2024 4.2.2, 4.2.3 and 4.1.4)

Commendations

- The Program’s leadership and continued work to support the inclusion of students with disabilities in the medical program. (Standard 7.2/2024 4.1)

Standard 8.1.1 is substantially met

Conditions

- 12 Demonstrate that students will have access to appropriate spaces for learning during and after completion of the redevelopments at Canberra Hospital and North Canberra Hospital. (Standard 8.1.1/2024 5.1.3) by 2026

Recommendations

- T Engage with local Aboriginal and/or Torres Strait Islander community groups and Aboriginal Community Controlled Health Services in NSW and ACT to address concerns about the lack of clinical context experience in providing culturally safe care. (Standard 8.3.3/2024 5.4.2)

Commendations

- The excellent facilities at the Sydney Clinical School and Rural Clinical School (Standard 8.1)
- The professionalism, skills, enthusiasm and leadership of the TELT team in providing innovative and relevant resources for students across both phases of the program. (Standard 8.2/2024 5.1)
- The contribution of the Academic Unit of General Practice, ACT and the Canberra Regional Medical Education Council in supporting clinical supervisor training and development opportunities that were valued highly by supervisors. (Standard 8.4/2024 5.5)

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 2022*. The granting of accreditation may be subject to conditions, such as a requirement for follow-up assessments.

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

After it has accredited a medical program, the AMC seeks regular 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 College and the School

The Australian National University (ANU) was founded in 1946. It is governed by a 15-member Council whose function, powers and membership are set under *The Australian National University Act 1991*. The Council oversees and controls the management of the University. Chaired by the Chancellor, decisions are made with the support of committees or through authorised delegations allocated to individuals in accordance with their role.

The Academic Board of ANU was re-established by Council in 2012 under the ANU Academic Board Statute and oversees the University's academic business.

ANU is a tertiary institution with a strong research focus. As of 2023, it employs over 4000 staff and provides a unique educational experience to its 10,252 undergraduate, and 7128 postgraduate international and domestic students.

The University is organised into seven Colleges:

- ANU College of Arts and Social Sciences
- ANU College of Law
- ANU College of Health and Medicine
- ANU College of Asia and the Pacific
- ANU College of Science
- ANU College of Engineering and Computer Science
- ANU College of Business and Economics

ANU Medical School (ANUMS) has undergone significant organisational restructuring since the AMC 2019 accreditation assessment as a result of ANU's financial rationalisation in response to the COVID-19 pandemic. The need to consolidate resources resulted in the merger of the ANUMS and Research School of Psychology to create the new School of Medicine and Psychology (SMP) under the College of Health and Medicine (CHM).

The CHM consists of:

- The SMP
- The John Curtin School of Medical Research
- The National Centre for Epidemiology and Population Health

The SMP came into operation at the commencement of 2023, and its Director has authority, delegation and budgetary responsibility for the medical program.

The University's main campus is based in Acton, Canberra in the Australian Capital Territory. The medical program has three Clinical Schools – Canberra Clinical School, Rural Clinical School and the Sydney Clinical School with sites in the Australian Capital Territory, New South Wales and the Northern Territory.

Accreditation Background

The medical program at ANU was first accredited by the AMC in 2003. An overview of the School's accreditation and monitoring history is provided below:

Accreditation history

Year	Assessment Type	Outcome
2003	Accreditation	Granted accreditation to 31 December 2009 (MBBS).
2004	Follow up	Confirmed the 2003 accreditation decision (MBBS).
2005	Follow up	Confirmed the 2003 accreditation decision (MBBS).
2008	Comprehensive report for extension of accreditation	Extension of accreditation granted for four years to 31 December 2013
2013	Reaccreditation	Granted accreditation for five years to 31 December 2018 (MBBS - program withdrawn) Granted accreditation for six years to 31 December 2019 (MD)
2014	Year 1 Progress report	Accepted
2015	Year 2 Progress report	Accepted
2016	Year 3 Progress report	Accepted
2017	Year 4 Progress report	Accepted
2018	Year 5 Progress report	Accepted
2018	MBBS concluded	Last cohort graduated in 2017
2019	Year 6 Comprehensive	Extension of accreditation granted for four years to 31 March 2024 (MD)
2020	Year 7 Progress report	Accepted (moved to biennial reporting)
2022	Year 9 Progress report	Accepted

This report

This report details the findings of the 2023 reaccreditation assessment.

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

The members of the 2023 AMC Team are at **Appendix One**.

The groups met by the Team in 2023 during their visit to Canberra (Australian Capital Territory) and Bega and Cooma (New South Wales) are at **Appendix Two**.

Appreciation

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

1 The context of the medical program

1.1 Governance

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

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

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

Responsibility for the ANU's medical program (*Medicinae ac Chirurgiae Doctoranda* – MChD) rests with the School of Medicine and Psychology (SMP), which sits within the College of Health and Medicine (CHM).

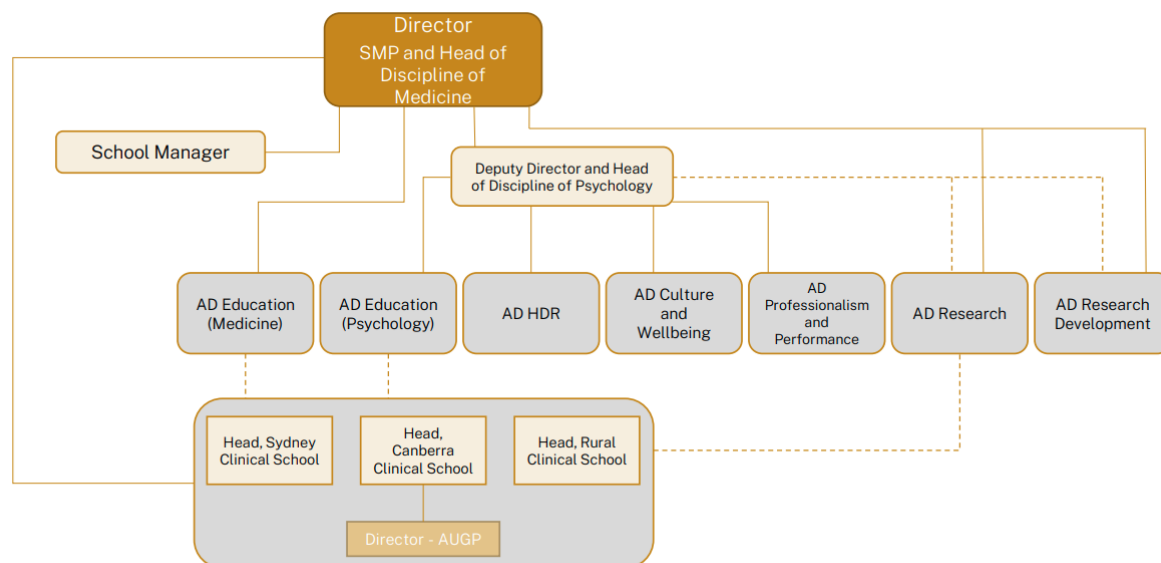
The Vice-Chancellor and University Executive provide day-to-day leadership, working with the heads of the seven academic Colleges and Service Divisions.

ANU Council delegates responsibility for monitoring quality to the Academic Board, which undertakes formal program reviews every 5 years. Since 2014, ANU has been offering the MChD program. The MChD program was last reviewed in 2019 and another review was in planning at the time of the accreditation assessment.

The CHM is led by Professor Russell Gruen as College Dean, who reports to the Vice-Chancellor. The administrative structure of the CHM includes an Executive Committee and a series of Deputy and Associate Dean positions. The CHM comprises three Schools: The School of Medicine and Psychology (SMP), The John Curtin School of Medical Research (JCSMR) and the National Centre for Epidemiology and Public Health (NCEPH).

The School of Medicine and Psychology was established from two separate schools within CHM at the beginning of 2023, following a period of broad review and consultation. Professor Paul Fitzgerald is the Director of the SMP and reports to the College Dean. The Director serves as the Head of the Discipline of Medicine and is supported by the School Manager, and Deputy Director and Head of the Discipline of Psychology. The SMP Executive Committee (Figure 1) also includes seven Associate Directors and the Heads of the three clinical schools (Canberra, Rural and Sydney).

Figure 1: School of Medicine and Psychology Executive Committee Structure



Note. AD = Associate Director; AUGP = Academic Unit of General Practice; HDR = higher degree research; SMP = School of Medicine and Psychology.

Within the newly formed School, there are governance processes for the continued development of the medical program, including processes for regular curriculum planning, implementation and refinement. The committee structure includes the MChD Program Committee, which reports to the School Education Committee, which in turn feeds into the College and broader university governance. While the governance arrangements continue to evolve, they are well understood by those who met with the Team. There was evidence of increasingly positive and effective governance structures involving health service partners.

Some relevant groups, particularly health consumers and Aboriginal and/or Torres Strait Islander community members, did not appear to be systemically represented in decision-making or widely consulted on key issues. An Advisory Board of stakeholders which allowed relevant groups to be represented in decision-making and consulted on key issues was active until several years ago, but the Board no longer exists. It will be important to establish and consolidate mechanisms that promote community input into curriculum review and program governance.

The Team acknowledges that the last few years have been characterised by significant change and budgetary pressures. There is renewed engagement and optimism for the future of the medical program, and considerable excitement and positivity across faculty and stakeholders for the opportunity the newly amalgamated School presents. At the time of the visit, the School was in the process of finalising its vision and mission statement.

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 responsibilities of the Director of the School are clear. The Team heard that responsibility for leading the curriculum review of the medical program rests with the recently appointed Deputy Dean for Health Professions, which is a College-level role.

The Associate Director Education (Medicine) is the operational lead for the medical program and has demonstrated excellent leadership. The relationship between the Deputy Dean for Health Professions (at College level) and the Associate Director Education (Medicine) requires clarification. It would be prudent to review the workload, support and backup for the critical role of the Associate Director Education (Medicine).

More broadly, the School has appropriately identified the need to confirm the arrangements for the curriculum review as a priority, including how the College and School leadership roles will work together, along with the budgetary delegation, process and overall governance of the review.

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.

With effect from 2014, the University reclassified the medical program from an Australian Qualifications Framework (AQF) Level 7 Bachelors program to an AQF Level 9 (Masters Extended). *Medicinae ac Chirurgiae Doctoranda* (MChD) is the AQF Level 9 qualification offered by ANU. The process of reclassifying the medical program was guided by the then Medical School Curriculum Committee in conjunction with the University's Education Committee. The University has assessed the level of the qualification against the AQF and confirmed that it meets the criteria for Level 9 (Masters Extended).

Currently within the SMP, the MChD Program Committee is responsible for planning, implementing and reviewing the medical program. This includes developing and maintaining the strategic direction of the medical program and ensuring compliance with university policies and procedures. The Associate Director Education (Medicine) is the chair of the MChD Program Committee. The MChD Program Committee reports to the SMP Education Committee, which is co-chaired by the Associate Director Education (Psychology) and the Associate Director Education (Medicine). The SMP Education Committee provides oversight of all educational programs offered by the SMP in accordance with School and university vision, policies and procedures, and accreditation standards. As noted above, the MChD program is about to be reviewed and further details have been requested about the leadership, governance and process.

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.

During the visit, the Team met with many talented staff with extensive educational expertise, who are involved in the development and management of the medical program. Some positions have only recently been filled and there continue to be some vacancies.

The SMP Indigenous Health Unit makes a valued contribution to teaching as well as the management of the medical program, ensuring that Aboriginal and/or Torres Strait Islander Peoples' expertise contributes to the implementation and development of the program.

1.5 Educational budget and resource allocation

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

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

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

Responsibility for the medical program sits with the SMP under the leadership of the Director. The total SMP budget for 2023 was slightly below the combined 2022 ANU Medical School and Research School of Psychology budgets. This excludes fixed term strategic funding, as part of the CHM TRANSFORM strategic plan, which is being used to support the medical program.

Within SMP, TRANSFORM funding is being used to cover the costs of the Head of the Canberra Clinical School, new Clinician Educator appointments, and Student Year Coordinator positions. In addition, TRANSFORM funding has also been used for an International Student Coordinator position and additional direct teaching costs to enable the SMP to accommodate a greater number of first-year entry international students. There was an increase in the intake of international students, with 14 in 2023 compared to the average of 5–6 international students in the last 4 years. Between 2014 and 2019, the medical program took in approximately 10 international students per year.

Strategic funding has also been directed to the appointment of a project officer to support the proposed medical program review as well as the creation of the Deputy Dean for Health Professionals role at the College level.

The CHM expects that SMP revenues will rise over coming years due to a modest increase in international student numbers and expansion of executive education and continued professional development activities, for which the initial budget is provided by TRANSFORM. While there is a stated intent from the CHM and university leadership that the Clinician Educator, Student Coordinator and Head of the Canberra Clinical School positions will be permanently funded under increases to the core program budget, the Team was unable to confirm that this staff budget will be protected if the increased revenues from these TRANSFORM-funded activities do not cover the staffing costs. This additional revenue is also expected, at least in part, to support ongoing funding of the curriculum review process.

The current condition on accreditation (15) 'Demonstrate that the university provides adequate financial resources to ensure the medical program can achieve its purpose and objectives' has therefore been satisfied currently. However, given the short-term nature of the TRANSFORM fund and the long-term investment in staff that it is funding, at the time of the assessment, it was not demonstrated that there is sufficient funding in the medium- to long-term to sustain the medical program's teaching and review capacity.

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.

Relationships with health service partners are managed at both the College and School. The College typically takes the lead on strategic decisions with the active involvement from the School, which takes the lead on operationalisation.

The College and School are working closely with Canberra Health Services (CHS) and other key service delivery partners to strengthen the relationship through the ACT Health Partnership Board and its sub-committees. There was clear evidence of commitment and shared vision from both the School and health service partners, particularly CHS, to a mutually beneficial relationship, which was observed by clinical supervisors with positivity for the future. A new relationship agreement with CHS is being developed to support the strengthening partnership.

CHS has recently acquired Calvary Public Hospital, which has been renamed North Canberra Hospital. ANU and CHS are committed to strengthening the academic culture across the local health service with a particular focus on teaching and learning and clinically impactful research. There is a recognition that teaching spaces, especially at Canberra Hospital, need to be improved. This was recognised in the 2021 Health Precinct Masterplan which is yet to be enacted. The Head of the Canberra Clinical School plays a key role in helping to build the community of academic practice.

There is a strong relationship with Southern New South Wales Local Health District to promote the education and training of medical graduates through the Rural Clinical School. The Rural Clinical School receives restricted funding through the Rural Health Multidisciplinary Training (RHMT) program. It operates across six sites with each of the five regional campuses overseen by an academic coordinator, who is employed on a fractional contract. The Rural Clinical School has good partnerships with the University of Canberra, with facilities in Bega, Cooma and Goulburn. These facilities are co-managed by both partners and provide opportunities for working with and learning from other health professions.

The College has recently established a relationship with Adventist HealthCare Limited (AHCL) to create a Sydney Clinical School. AHCL previously provided clinical placement to medical students from the University of Sydney. ANU students typically undertake 4–6-week blocks at the Sydney Clinical School with 14–18 students at any one time. The AHCL regards the relationship as positive recognising the value of clinicians' involvement in education. In addition, they see opportunities for the recruitment of the future workforce and strengthening research culture. The ANU-AHCL steering committee manages the relationship. There are already joint research projects underway and plans for a phase 1 clinical trials program are being operationalised.

Formal agreements underpin the provision of hospital-based placements. Further work is needed to formalise and safeguard the strong relationships with general practices to manage risk, both for students in placements and to ensure the continued provision of these placements overall.

The Team also heard of work underway to increase connections with the Australian Government Department of Health and Aged Care and increase the prominence of public health within the curriculum.

The SMP Indigenous Health Unit has relationships with key Aboriginal and/or Torres Strait Islander organisations including the Australian Indigenous Doctors' Association and National Association of Aboriginal and Torres Strait Islander Health Workers and Practitioners, and with local community groups and Aboriginal Community Controlled Health Organisations.

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 inform learning and teaching in the medical program. Students have a wide range of opportunities to enrich their learning through research both with the University and clinical partners. The School is developing a new Research Strategic Plan and has ambitions to grow the number of medical students who undertake a Higher Degree by Research. Academics have spoken of the potential for the new SMP to leverage the research and scholarship of both medicine and psychology as part of the review of the medical program.

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.

Budgetary pressures at ANU resulted in a loss of academic staff in the last few years and this included teaching leads in microbiology, biochemistry and anatomy, several of whom had been employed through joint arrangements with the College of Science. These losses required not just redistribution of teaching commitments but also reshuffling of leadership roles (e.g. Research Project Convenor, Student Year Coordinator). Replacement of the anatomy and biochemistry positions occurred in 2022 with the appointment of two level B positions. High quality teaching in microbiology is provided through a clinician based at Canberra Hospital and a staff member from the John Curtin School of Medical Research (since 2023), but the sustainability of this arrangement is unclear.

The Indigenous Health Unit has recently moved into the School from the Rural Clinical School. The recently established role of Associate Dean First Nations at the College level is very positive and creates the opportunity for input at an executive level. The Team heard that the Indigenous Health Unit had experienced substantial capacity challenges in previous years, with staff on secondment or moved into different roles and some positions being vacant. However, a new position and a returning staff member have recently strengthened the capacity of the Unit.

There has been considerable change in the professional staff structure. A comprehensive review of the professional staff structure was undertaken in preparation for the establishment of the new SMP. The current focus is on optimising the arrangements for supporting course-wide activities (e.g. curriculum development, assessment, admissions etc.) as well as curriculum implementation functions undertaken by the three clinical schools.

The pressure on academic and professional staff has been compounded by a disinvestment in clinical academic positions within CHS. Several roles are currently unfilled including Chairs in

Medical Imaging, Obstetrics/Gynaecology, Paediatrics and Medicine. The Chair of Psychiatry position has been filled on an acting basis for several years.

In partnership with CHS, plans have been developed to identify education leads in all 32 clinical departments of the health service as well as to appoint a group of ANU funded/employed Clinician Educators. SMP has committed fixed term funding for the part-time Clinician Educator positions across medicine, surgery, women's health, paediatrics and acute care. The Clinician Educators will support the development and implementation of the curriculum within their specialty and related areas, contributing to curriculum and assessment committees and acting as a conduit between the medical program and their colleagues in each clinical department. This process was viewed by many stakeholders as a very positive step, although not a quick one. While the School and CHS are filling these vacancies, there is a risk that existing School staff will be unable to sustain their workload.

At present, the Clinician Educator roles are only under consideration within the Canberra Clinical School and there may be merit in extending the model to further support clinicians at the Sydney Clinical School.

There are several key-person dependencies that also need to be addressed to ensure the sustainability of the program. These include succession planning for the Associate Director Education (Medicine), Head of Assessment and Admissions, as well as the Professor of General Practice and the Acting Head of the Canberra Clinical School. The latter two roles are held by committed and highly experienced individuals who are stepping down imminently. Subsequent to the assessment activities in Canberra and surrounds, the School confirmed the appointment of the Head of the Canberra Clinical School to start on 29 January 2024. This is a joint appointment with CHS. The appointee is an interstate academic clinician with medical education experience. This external appointment underscores the need for the program and the University to demonstrate commitment to and support for the development of local clinicians as partners in the delivery of the program.

Therefore, while progress has been made on addressing condition 16 'Provide evidence that the implementation of the Change Implementation Plan ensures adequate academic and professional staffing of the medical program', further assurance is needed that adequate academic staffing has been secured with long-term funding. Consequently, this condition has been closed and two new conditions addressing the remaining gaps have been identified.

There are appropriate arrangements for indemnification of staff with regard to their involvement in the development and delivery of the medical program.

1.9 Staff appointment, promotion & development

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

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

The University has policies for the appointment and promotion of academic staff that address a balance of capacity for teaching, research and service functions. As noted above, the School is in the process of rebuilding its academic workforce to cover key teaching and medical program leadership responsibilities. There did appear to be challenges for Phase 1 teachers in achieving promotion due to high teaching workloads, which the School is encouraged to address.

The Team acknowledges the work that has been undertaken with professional staff to provide opportunities for professional development and career advancement. The Team also notes the current work with the College Dean and Human Resources to improve the attractiveness of ANU academic titles for clinicians including providing clear and achievable promotion opportunities. Attention on engaging clinicians as academic title holders will need to be maintained as the leadership of the Canberra Clinical School changes.

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 purpose of the ANU medical program (the Program) is largely unchanged since the 2019 accreditation assessment and is clearly stated on the website. The Program 'undertakes to create and maintain an educational environment that encourages students to:

- practice medicine with compassion, conscience and professional excellence
- demonstrate knowledge of Aboriginal and Torres Strait Islander health and societies
- understand the health problems of people in rural and remote Australia
- extend the boundaries of medical knowledge through research and share this knowledge with patients and colleagues, locally, nationally and internationally.'

The new SMP merger opens exciting opportunities to develop a psychologically informed medical program.

The SMP is working to establish a joint vision and purpose statement for the School that is relevant to both the medicine and psychology programs. This has involved consideration of alignment with the impact areas of the CHM TRANSFORM strategy: 'Pushing the Frontiers of Knowledge, Preparing Leaders Who Make a Difference, Strengthening and Reforming Health Systems and Supporting Communities to Flourish. The draft SMP vision and purpose statement was developed following two School Executive Committee planning days and has been endorsed by the SMP Executive Committee. Work will continue over the coming months to consult and obtain input from the new

SMP Advisory Board, SMP disciplines and external stakeholders to socialise and align its purpose to key strategies.

The draft SMP vision and purpose begins with the expectation that it ‘works to advance human health, experience, and wellbeing, enhancing the lives of individuals and strengthening communities locally, nationally and globally.’ There is emphasis on the integration of medicine and psychology informing unique approaches to local, national and international health problems, and leading impactful health and psychosocial change.

While the program’s purpose addresses Aboriginal and/or Torres Strait Islander peoples’ health care needs, it does so at the level of ‘knowledge of’. The draft vision and purpose statement for the School steps further by identifying the ‘health and wellbeing of Aboriginal and/or Torres Strait Islander peoples and communities as a *priority for the School*’ (emphasis added). This statement recognises the continued work needed to integrate Aboriginal and/or Torres Strait Islander communities’ health and wellbeing throughout the School.

The alignment of the Indigenous Health Unit within SMP, previously located structurally under the Rural Clinical School, aims to strategically expand and deliver resources in line with the Program’s purpose. Within the TRANSFORM impact area of ‘Supporting Communities to Flourish’, there is commitment to expand the influence of Aboriginal and/or Torres Strait Islander ways of working and learning across CHM and SMP activities and expand Aboriginal and/or Torres Strait Islander academic capability and knowledge contribution to curricula.

The School has defined its stakeholders and partners in its draft purpose statement. There was evidence of engagement with clinicians, health service providers in public and private sectors, and alumni, although further attention is required to develop strong consultation mechanisms with community organisations and consumer stakeholders.

The planned engagement with stakeholders on the School’s draft vision and purpose statement will be an important step in framing the curriculum review. Feedback during the assessment visit indicates that the program’s current purpose is viewed as continuing to be appropriate, but this view may be influenced by external stakeholder engagement on the new SMP purpose and curriculum review. Any changes to the vision and purpose statement for the program should be reported to the AMC Medical School Accreditation Committee to demonstrate continuing alignment with the accreditation standards.

A strong complement of staff is involved in teaching and support, with educational and health practice experience aligned to the stated purpose of the ANU medical program. While this has been a positive for SMP, some recent staff changes have temporarily disrupted activities.

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.

The School applies different levels of outcomes to define and align ANU graduate outcomes for medicine with the AMC graduate outcomes. These are made available to students on the WATTLE learning management system and published on the ANU website. The levels are: Level 1 - Program outcomes, Level 2 - Phase learning outcomes, Level 3 - Block learning outcomes and Level 4 - Instructional objectives. The course outcomes correspond to the four domains in *AMC Graduate Outcome Statements* (2012).

The School's geographic footprint is primarily based in the Australian Capital Territory but extends into south-east New South Wales, Sydney, Northern Territory/Central Australia and Melbourne. There was evidence of a clear focus on producing medical graduates fit for medical internship in Australia, with skills particularly relevant to practice in the Australian Capital Territory and an emphasis on general practice and rural generalist skills within the program.

Since the last assessment there has been a particular focus on improving the transition from medical student to internship in response to concerns raised by students and findings of the joint AMC/Medical Board of Australia Preparedness for Internship Survey. These initiatives have been successful. There was clear feedback from clinicians and prevocational doctors that ANU graduates are competent to practice safely and effectively under supervision as interns, and with a foundation for further training and lifelong learning. Clinicians across different health services were of the view that ANU medical graduates are of high quality and meet the needs of local health services.

Rural clinical schools have contractual obligations, with stated performance indicators and outcomes relevant to rural and remote services. Work is underway to develop data sets for rural health outcomes from the medical program.

The medical program outcomes are measured through formal and informal methods. The program provided detailed data that demonstrated overall equivalence in the assessment performance on equivalent assessments of students in Phase 2 regardless of whether they were placed at the Canberra Clinical School, Rural Clinical School or Sydney Clinical School. While the various pathways clearly provided students with different experiences, student feedback to the program and the Team indicated that overall, they were all high-quality learning experiences relevant to the curriculum. Informal conversations occur with health partners about student outcomes.

The School ensures that educational experiences in the different sites are broadly comparable, for example through consistent online access to centralised learning opportunities for students placed away from the Canberra Clinical School.

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 ANU medical program is a 4-year graduate-entry program delivered in two phases, each two years in duration. In Phase 1 (Year 1 and Year 2), the program is composed of seven Blocks and Phase 2 (Year 3 and Year 4) is comprised of six teaching Blocks concluding with a compulsory pre-internship preparation Block for all final year students. The program is arranged in courses to meet ANU policy. The year-long courses are arranged in Blocks to facilitate integration of curriculum Themes and Frameworks.

The program is clearly mapped to the *AMC Graduate Outcome Statements* and the duration of the course is sufficient to meet the graduate outcomes as currently outlined. It will be important to review this following the proposed curriculum review. The AMC heard that the SMP plans to develop a psychologically informed medical course building on the strengths of the co-located psychology program. The impact of proposed changes should be considered in light of course duration and reported when the new curriculum plans are finalised.

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 overall program structure and content have not significantly changed since the AMC 2019 Comprehensive Report. However, there have been some enhancements. The program provided a well-articulated and detailed description of the content of the curriculum supported by documentary evidence.

There are four Themes:

- Clinical Skills
- Medical Sciences (encompassing anatomy, biochemistry, cell biology, genetics, histology, immunology, microbiology, neuroscience, pathology, pharmacology, physiology and virology, and in Phase 1 includes their clinical applications to disciplines such as cardiology, haematology, neurology and radiology)

- Population Health
- Professionalism and Leadership

And four Frameworks:

- Indigenous Health
- Social Foundations of Medicine
- Research
- Rural Medicine

The structure of the curriculum is illustrated in Figure 3 below.

Figure 2: Structure of the Curriculum

Year	Course Code	Course Name	Block	Topic	Duration (weeks)	
1	MEDI8011	Medicine 1a	1	Foundations	17	36
	MEDI8012	Medicine 1b	2	Cardiovascular, Respiratory and Renal	12	
			3	Endocrine and Reproductive	7	
	MEDI8015	Professional Practice 1	-		-	
2	MEDI8020	Medicine 2	4	Musculoskeletal and Neuroscience	12	33
			5	Digestive and Nutrition	7	
			6	Oncology/Haematology/Infectious Diseases	10	
			7	Transition	4	
	MEDI8025	Professional Practice 2	-		-	
	*MEDI8022	Research Project	-	Students choose to do EITHER the Research Project or Advanced Research Project, not both.	-	
MEDI8023	Advanced Research Project	-		-		

Year	Course Code	Course Name	Block	Topic	Duration (weeks)		
3	MEDI8030	Medicine 3	FIMS	Foundations of Internal Medicine and Surgery	19	38	
			ICCH	Integrated Community and Child Health	19		
	OR Year 3 Rural Stream at a Rural Clinical School campus					-	
	MEDI8035	Professional Practice 3	-		-		
Elective (Domestic or International)					4-6		
4	MEDI8040	Medicine 4	AC	Acute Care	6	30	
			PAM	Psychiatry and Addiction Medicine	6		
			SMS	Senior Medicine and Surgery	6		
			WHNC	Women's Health and Newborn Care	6		
			PRINT	Pre-Internship Term	6		
	MEDI8045	Professional Practice 4	-		-		

There is a well-documented Phase 1 pre-clinical basic science curriculum that covers the key aspects of medical science. Phase 1 Problem-Based Learning (PBL) tutors are drawn from diverse medicine, public health and allied health backgrounds.

The Population Health Theme is a strong vertical theme which provides students with foundational learning in public health, including health prevention. There is an emphasis on applying the tools of epidemiology to evaluate the outcomes of health prevention and health promotion initiatives in a variety of health settings and patient populations. During Phase 2, students complete online modules addressing clinical audit as a research method, other quality improvement methodology, and health promotion. There is also a group-based Phase 2 Population Health project over two years with a focus on topics and outputs that improve healthcare service delivery, promotion and policy. There are ample opportunities for small research projects or research methods teaching embedded within the program. Peer review activities are undertaken in both Phase 1 and Phase 2.

The curriculum theme in Professionalism and Leadership (PAL), including ethics and law, was well described with articulation and communication between Phases 1 and 2. The Professional Practice courses in each year are zero-credit-point units for assessment of this theme and students must not have any notifications in these units to pass. Ethics and professionalism is emphasised at each year level including contextualised ethics workshops exploring moral dilemmas in clinical practice. The Professional Behaviours Committee has the power to recommend repeating part of a Phase, and to assign an experienced supervisor/role model mentor for additional student support.

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 curriculum at ANU is designed purposefully around AMC Graduate Outcome domains with well-defined vertical themes.

The major review of curriculum initially described in 2019 is still planned. This has not commenced due to the COVID-19 pandemic, staffing vacancies and the school restructure. The new CHM Deputy Dean Health Professions will be developing the approach for this review process. The staff are enthusiastic for this review to occur and feel that there are opportunities to strengthen the curriculum including:

- Enhancing the integration between Phase 1 and Phase 2 by increasing learning in clinical contexts (particularly GP) to support understanding of how theoretical learning applies in practice and to increase preparation for more intensive clinical placements in Phase 2.
- Developing a set of core clinical conditions and presentations for the students to refer to. Work on this has already begun at the instigation of an ANU graduate who is now a prevocational doctor in the Canberra Clinical School. It will be important to develop a consensus across Clinical Schools and settings.
- Reflecting on the drift in hospital-based educator content from the Level 4 outcomes. The program recognises the distinct context and continues to work hard to have a consensus process around curriculum development across the program. The review will present an opportunity to reconsider curriculum content from the perspective of clinicians in different settings.
- Consideration of changes to GP clinical placements. The students spoke very highly of the GP network and high-quality clinical placements. The GP academic leads are very keen to introduce GP placement time in final years by possibly splitting the current Year 3 12-week

term into a 6-week term in Year 3 and a 6-week term in Year 4. The delay in the curriculum review has caused concern for this group and delayed their plans to improve the course structure.

The curriculum review timeframe, process and resource allocation are not clear at the time of the review. The clinical and academic leads in the program have all raised the need for more certainty about these timeframes and some indication of resource implications. Clinical educator engagement in curriculum content review and re-design will be critical.

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.

While there was evidence of detailed documentation of the curriculum, the student report identified some areas where the learning outcomes are less clear. This is most relevant in Phase 2, the clinical phase, as described above. Difficulty managing content delivery and content upload due to the modest number of and turnover in clinical educators has led to a drift in perceived and in some cases documented Level 4 learning outcomes for Phase 2.

The last Learning Management System review was in 2016 with all Learning Outcomes required to be documented centrally to create a single source of truth. A new system of governance for Learning Outcome documentation may be required.

The Team heard that education officers may be able to intervene at the level of the Learning Management System to cull, edit and clarify the materials so that they are better aligned with documented learning outcomes. There is an opportunity for students and staff to collaborate to monitor incoming materials. It is hoped that the new Clinician Educators may be able to assist with engagement of clinicians and familiarisation with course core learning outcomes.

3.5 Indigenous health

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

The Team met with the CHM Associate Dean First Nations, who also leads the SMP Indigenous Health Unit. The Unit is a team of four, comprising one senior lecturer, two lecturers and a professional staff member. This is significantly strengthened from last year, with one member recently returning from a secondment and the Unit having been increased by 1 FTE (the new appointment starting shortly before the assessment). There is a further 0.4 FTE vacancy at present that has proven challenging to fill.

The Indigenous Health Unit very recently moved from the Rural Clinical School, into a standalone unit within the SMP with more autonomy and a clearer relationship to the whole of the School. The Associate Dean First Nations is now on the Executive of the CHM allowing more strategic input. The Unit already teaches into the Psychology program but at the time of the assessment, it was unclear how the merger of medicine with psychology and the new central position of the Unit will impact on staff workload in this unit.

The last review of the Indigenous Health curriculum occurred in 2022 with student input. This was commended in the student report. Previously, there were 12 hours over the four years, now there are 18 hours overall, although the majority is in Year 1.

On the first day of the medical program, new students participate in a smoking ceremony, which is also a teaching session in which they learn their cultural responsibilities. The smoking ceremony recommenced in 2023 after the COVID-19 pandemic.

There are specific lectures and workshops concerned with Aboriginal history, culture and health delivered by Aboriginal staff. Since 2019, there has been work to integrate Indigenous Health with other curricular components, including:

- Topics in the Social Foundations of Medicine framework on different perspectives on health and the medical encounter.
- Understanding ethical approaches to Indigenous research in the Professionalism and Leadership theme.
- Integration of learning culturally safe care within the Clinical Skills theme.
- Integration with the Medical Science theme on eye health, respiratory and cardiovascular topics.

A cultural immersion day for Year 1 students during Rural Immersion 1 was introduced in 2023. The purpose of the cultural immersion day is to create an environment where students can interact with a range of Indigenous people (Aboriginal Elders, Rangers and Youth from the Ngunnawal people and neighbouring nations) to develop an understanding of Aboriginal culture and history whilst developing their skills and attitudes in cultural competency and safety. The day takes place on both the ANU's Aboriginal and Torres Strait Islander Heritage Trail and nearby Yarramundi Cultural Centre to learn on country and facilitate meeting and yarning with Aboriginal and Torres Strait Islander people.

In Phase 2, some students have the opportunity to undertake clinical placements in Aboriginal and Torres Strait Islander Health services, and others interact with Aboriginal and Torres Strait Islander clients/patients attending general practices and hospitals in urban and rural settings. There is a standalone lecture on cultural competence and safety in week 1 of Phase 2, Year 3 before students begin the placement intensive part of the curriculum.

Teaching and learning sessions focussing on cultural competency and safety, healthcare and health service delivery, as well as specific health presentations (e.g. mental health, trauma), are undertaken during whole-cohort sessions (e.g. Lectures) and Block-specific sessions. In Year 3, there is a Professional Practice activity requiring students to write a reflection on an encounter with an Aboriginal and/or Torres Strait Islander patient. This is reviewed by the Indigenous Health team and feedback is provided to each student.

The optional Indigenous Health Stream was introduced in 2010. It is currently funded for 15 students and open for any student to apply for in Year 1. Over the 4-year program, the Indigenous Health Stream provides students with opportunities to gain language skills, undertake cultural immersion activities, participate in mentoring from Elders, undertake research with Indigenous people and complete clinical placements with Indigenous staff and patients. The number of places available in the Stream has been steadily expanded and it remains popular and over-subscribed. The Indigenous Health Unit has sought further funding to support more student places.

The Unit is eager to strengthen the Indigenous Health curriculum content against the AMC standards using a curriculum integration approach. The plan is for Indigenous Health coverage representing 2% of the curriculum. Members of the Indigenous Health Unit represent the Indigenous Health Framework on all medical program committees and subcommittees to facilitate progression of these curriculum initiatives, but it is not clear how this work will fit with the curriculum review work or what autonomy/decision-making the Unit will have in relation to the

curriculum changes. It was also unclear whether there would be any budget for the Unit to undertake community engagement and/or codesign work to achieve the 2% target. There was recognition among School leadership that the Indigenous Health curriculum needs further enhancement and prioritisation, and a commitment to provide the resources to undertake this work.

An integrated Aboriginal and Torres Strait Islander curriculum pedagogy will need to be supported by a cultural safety framework to support delivery. This may include Indigenous experts running simulated Indigenous Health scenarios, ensuring balance in deficit and strength-based approach and monitoring cultural safety among students.

The Team also heard that the Indigenous Health strategy is being updated to bring Psychology as well as Medicine into the Indigenous Health curriculum development.

While recognising that the Tjabal Indigenous Higher Education Centre primarily provides support for First Nations students at the University, there is an opportunity to engage the Centre in the curriculum review and development, to benefit from the university's learning and expertise on First Nations communities' health and wellbeing needs. It may also be that the Centre is able to encourage and support First Nations students to collaborate in the review and development of curriculum content.

3.6 Opportunities for choice to promote breadth and diversity

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

There are clear opportunities for students to pursue studies of choice that promote breadth and diversity of experience both in medicine and outside the medical program. These include:

- A mandatory Research Project in Phase 1 – students select a topic of their choice from options disseminated via the Research Project Committee and/or via negotiation with supervisors. A wide variety of choice is available.
- An optional annual Interprofessional Health Challenge.
- An optional Rural stream in Year 3 – 30% of the cohort undertake the whole of Year 3 in one of the Rural Clinical School campuses.
- An optional clinical placement in the Northern Territory.
- A mandatory 4–6-week clinical elective placement between Year 3 and Year 4 – students can undertake their elective in a medical or allied health discipline of personal interest, at a location of their choosing, within Australia or internationally.
- An optional Indigenous Health Stream – an optional development program open to all students, currently funded for 15 students per cohort, that runs across the four years of the program.
- The Medical Venture Fund – supporting 12 applications each year for a range of non-medical development opportunities including language and music lessons, pottery classes, establishing a program to support the socialisation of young migrants.

The Team heard of an optional Medical Education Stream that consisted of a medical education training curriculum delivered using blended learning that ran longitudinally throughout the 4-year medical degree. Unfortunately, this excellent initiative does not have continuing funding.

There are also evolving opportunities to collaborate with Psychology on the science of wellbeing, vicarious trauma, coping with discrimination and harassment.

The Team heard that the students were satisfied with the range of options, electives and special placements that students were able to access.

4 Learning and teaching

4.1 Learning and teaching methods

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

The medical program employs a combination of traditional face to face and technologically enhanced learning opportunities. There has been extensive leveraging of lessons learned during the intense disruption of the COVID-19 pandemic to enhance the technological and online delivery.

The School has an impressive, well-resourced Technology-Enhanced Learning and Teaching team that has developed program specific resources that are embedded into the Learning Management System.

While multiple online platforms are utilised, and this appears complex on paper, they are largely integrated into the WATTLE Learning Management System, predominately with single sign on and linkage from that point. Students did not report any significant access issues.

Problem Based Learning is at the core of the approach to learning in Phase 1. There is also a substantial reliance on traditional didactic sessions. The laboratory sessions provide a mix of direct scientific method, demonstration, technology and small group hands-on activities. The learning is largely integrated in nature and scaffolded to enable students to begin to develop clinical reasoning capabilities.

The spread of staff expertise is extensive and highly appropriate although, like many small programs, there are some staff undertaking multiple roles which creates workload, succession planning and redundancy issues.

Some of the learning opportunities, e.g. dissection week, only accommodate a limited number of participants and the timing of these sessions relative to assessment may inhibit participation.

Phase 2 learning is predominately workplace based and has the inherent variability of experience that this generates. Overall, it appears that there is a wide range of enthusiastic clinical teachers, and the standard of bedside and hospital-based teaching appears to be appropriate and well received. There are, however, some placement terms where student learning opportunities appear quite limited, and students report that they have difficulty feeding that information back to the medical program in a way that they felt would be heard.

The ward-based teaching appears to be balanced with directed learning through Case Based Learning and lectures, tutorials and clinical skills development. There appears to be adequate protected time for students to learn core content while maintaining clinical application.

The recently enhanced pre-internship block focused on transition to practice appears to be a valuable learning opportunity.

4.2 Self-directed and lifelong learning

The medical program encourages students to evaluate and take responsibility for their own learning, and prepares them for lifelong learning.

The delivery in Phase 1 was described quite differently by different stakeholders across both staff and students, with some in each category describing it as very directed and some describing it as a student-led independent learner methodology. This may just represent variability in the style of sub-topics and in the engagement with activities between learners.

There are good learning opportunities in research and self-reflection that encourage self-directed learning.

There is a high degree of collegiality between student peers that also extends to student-staff interactions and this collegiality appears to build confidence in students to seek help as required and to assist their peers, building their own confidence along the way.

4.3 Clinical skill development

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

The clinical skills program appears to be comprehensive and well scaffolded. The utilisation of doctors in the clinical teaching environment allows role modelling early in the program and ensures student can align their clinical skills learning to clinical relevancy. The use of several GPs in this space helps promote the expertise and skill range of these practitioners. Other health professionals contribute to clinical skills teaching. The Clinical Skills Theme is also reported to have exemplary administrative support.

There is a deliberative buildup of task acquisition from simulated to clinical environments which finally leads into the pre-internship preparation term. Assessment of clinical skills acquisition occurs at spaced intervals. There are opportunities for unsupervised and supervised practice. Formative assessment of procedural skills occurs across two years. Remediation is offered at each phase. Bidirectional feedback occurs between these teams with input from students and supervisors.

The use of simulation labs with good infrastructure and experienced simulation educators are a highlight for students to transition their skills from theoretical to work readiness. The programs are well supported by online resources – Clinical Skills Theme leads, working with the TELT team, have developed more than 30 new clinical skills teaching resources.

Clinical skills teaching is considered to be a real strength of the program from the student perspective and the students report very clear framework learning outcomes and excellent teachers.

Modelling of impact on staffing, space and simulation if the cohort size increases would be advisable so that this excellent program is not compromised.

4.4 Increasing degree of independence

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

The Clinical Skills Theme has a well-developed scaffolding of increasing exposure and competence expectations with clear opportunities to practise skills before using them in the clinical setting. There are also clear opportunities for increasing independence over Phase 2.

The presence of a longitudinal academic supervisor in Phase 2 is a laudable endeavour. This is valued by students and appears to provide an important safety net and opportunity for student development.

However, there is also a clear opportunity for improvement; students reported that the transition from Year 2 to Year 3 with a move from academic to clinical focus is challenging. The readiness for the degree of independence required to negotiate on-ward learning opportunities at the beginning

of Year 3 appears variable. When this is added to the variability of learning opportunities it risks compounding if a less independent student is placed on a less-directed term.

In contrast, students, graduates and staff report that those students who participated in the rural longitudinal placement in Year 3 were more confident in their skills and knowledge in Year 4 and as they transition to internship.

4.5 Role modelling

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

There is a wide variety of enthusiastic clinicians involved in teaching across both phases that are a source of role modelling for students.

The students have extensive early access to medically qualified staff who provide role modelling. Students, even in Phase 1, appear to have a clear identity as future medical practitioners. There is clear involvement of Phase 2 students in role modelling for Phase 1 students and by alumni in teaching. The addition of the longitudinal academic supervisor in Phase 2 is commendable and appears to be a valuable role modelling resource for students.

ANU is a well-established, research-intensive university with a national and global mission as defined in the *ANU Strategic Plan 2021–2025*. A key priority is to ‘conduct research that transforms society and creates national capability’. The SMP reflects the research focus of ANU with a commitment to provide students with a sound understanding of high-quality research for improving clinical practice and there is clear role modelling in place.

Research activities are embedded in the curriculum. For example, a Phase 2 group population health research project over two years allows students the opportunity to develop publication-worthy papers. The merger of the ANU Medical School and Research School of Psychology brings new opportunity for medical students to engage in interdisciplinary research at the point of translation to health care delivery. The complementary approach to service and research is highlighted by the attractive opportunity for the Sydney Adventist Hospital and ANU to work together to build research and executive leadership in clinical schools. Similar opportunities exist through the Rural Clinical School.

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 teaching methodology clearly demonstrates content that promotes a patient-centred model of care. This includes the use of patient-centred online resources such as Konstantine’s story, the PBL approach and the inclusion of some patient lived experience sessions. The attitude of staff was consistent with this, and it appears to be a valued topic in Phase 1.

Deliberate demonstration of patient-centred care and collaborative engagement in Phase 2 is more limited, although there were some initiatives to utilise the patient journey through the system as a means of assisting in student orientation to how the health system works in a practical sense.

While there was some evidence of teaching that focuses on the patient experience, including challenges accessing and navigating healthcare, this is an area that could be developed to enhance students understanding of patient-centred care and the needs of patients, particularly in light of the program’s location in the Australian Capital Territory and the availability of public health expertise.

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.

There is a 1-day interprofessional learning placement in Year 2 and an introductory lecture. Learning outcomes are clearly outlined. In Phase 2 students are placed in two 4-hour observational placements at North Canberra Hospital and Canberra Hospital and then have a reflective practice workshop.

Interprofessional learning has been recently enhanced by placement and portfolio experiences/reflections. The reports of Year 4 vs Year 3 students suggest these enhancements are working and that the standard is now being met. There are health professionals from a variety of backgrounds teaching into Phase 1 and opportunities for students to work alongside other health professionals in Phase 2. It was reported that an increase of up to 20 students could be accommodated before the number of placements per student would need to be reduced.

There was clear evidence of a close and effective relationship between the CHS interprofessional education (IPE) Coordinator and the University of Canberra (which delivers a range of health professional programs) that is producing continuous enhancements to IPE across the program. The IPE Coordinator articulated a vision for further enhancements over the coming years and CHS stakeholders were supportive of this ambition to increase IPE. The plans for enhancing IPE in the Rural Clinical School and Sydney Clinical School delivery of the program, beyond well-regarded but ad-hoc hospital emergency simulation activities in Bega, were less clear at the time of the assessment.

The recent School merger may also generate more opportunities for collaboration and learning in the overlapping space between psychology and medicine.

The reporting lines of the medical program IPE Coordinator and team are unusual and may not be in the best interests of enhancing the curriculum. It may be more ideal for the IPE Coordinator to report into the combined curriculum committee. The IPE Coordinator is extremely passionate but if this is not anchored to the whole-of-course curriculum governance it will not be sustainable.

5 The curriculum – assessment of student learning

Overview

The accreditation submission provided a comprehensive overview of developments, changes and innovations to assessment in the medical program since an external review of assessment was undertaken in 2017. A number of the recommendations from that review have been implemented in full, and some remain to be considered in the context of the proposed curriculum review and the current staged implementation of the Phase 2 electronic portfolio platform.

Currently, there is an evolutionary approach to assessment change and a commitment to a programmatic approach. Of note, there is a positive response from academics and students to the changes to summative assessment timing in relation to the Transition Block in Phase 1 and the preparation for internship (PRINT) in Phase 2.

The School acknowledges that the planned curriculum review and revision will include a re-consideration of assessment in the medical program.

5.1 Assessment approach

5.1.1 The medical education provider's assessment policy describes its assessment philosophy, principles, practices and rules. The assessment aligns with learning outcomes and is based on the principles of objectivity, fairness and transparency.

5.1.2 The medical education provider clearly documents its assessment and progression requirements. These documents are accessible to all staff and students.

5.1.3 The medical education provider ensures a balance of formative and summative assessments.

Assessment in the medical program is aligned with the assessment policy and procedure framework of the University, and these University policies and procedures are explicit about the unique requirements of the medical program. The program guideline document, *Doctor of Medicine and Surgery Assessment Principles*, establishes the foundation for all assessment validity, reliability, purposefulness, efficiency and integrity. Guidance notes set out the operational application of these principles. The overarching philosophy of assessment is a programmatic approach designed to support student learning, reflect increasing capability through the program, provide opportunities for remediation where needed, and balance formative and summative assessments.

The MChD Assessment and Academic Progress Subcommittee (AAP Subcommittee), chaired by the Head of Assessment, reports to the SMP MChD Program Committee. The membership is appropriately representative of the course content (Phases, Year levels, Research Project, Professional Practice), clinical schools and operations. The membership of the committee does not include student representation, which is appropriate given the terms of reference relating to assessment content and operations. These terms of reference, however, also give the AAP Subcommittee a broad remit to include monitoring and evaluation of assessment.

Given several recent developments related to assessment, consideration could be given to direct engagement of students with the AAP Subcommittee as students are a key stakeholder group in assessment evaluation. The recent developments include: changes to the number and type of assessment events for each student in line with programmatic assessment philosophy, the implementation of the electronic portfolio (e-portfolio) in Phase 2 and changes to timing of some summative assessment. Potential benefits of direct engagement with students include obtaining early insights into: the impact and burden of assessment load on students, challenges to implementation in the clinical environment and the overall feasibility across all clinical sites. A

similar model may be appropriate to engage Phase 1 and 2 academics, clinical site academics and affiliates with regard to assessment matters.

The learning outcomes for the medical program are available to students, published on the ANU Programs and Courses website and the WATTLE Learning Management System. There is alignment of Level 1 to 3 learning outcomes, with demonstrable mapping to the *AMC Graduate Outcome Statements* and the *Australian Curriculum Framework for Junior Doctors*. Assessments are blueprinted to the Level 3 learning outcomes, identified by curriculum Phase and Block level, as well as course code. Blueprinting for assessment is a formal and comprehensive process to ensure accurate, balanced curriculum representation across the suite of written and clinical summative assessments. Students are aware that assessment is blueprinted to the Level 3 learning outcomes. However, they reported that there are some gaps in teaching to these and therefore perceive they may not be adequately prepared for some assessments. Specific feedback from students about perceived gaps could be sought to strengthen and maintain constructive alignment of learning outcomes and assessment. The strengthening of alignment of Level 4 learning outcomes with Level 3 learning outcomes would also be helpful.

The University policy *Student Academic Study Load and Progression* includes the unique requirements for the medical program. High-level summary information of the assessment for each course is publicly available on the ANU Programs and Courses website. Assessment requirements for progression in the course are clearly documented and available to students. More detailed information is available on WATTLE about hurdle and summative requirements for each Phase and Block. Students advise that there could be greater clarity about which assessments are hurdle requirements, and also report that notification about summative exam scheduling is often at fairly short notice. Student briefings prior to summative assessments are viewed positively, and the degree of detail in these could be a template for information about assessment on the Learning Management System. The grading system of pass/fail/higher-level pass is understood and accepted by students, and the rationale for this approach is sound.

Assessment in the medical program has a programmatic structure and overall appropriate balance of formative and summative assessments in each Phase of the program. The medical program has taken steps to progressively increase opportunities and resources for formative assessment (assessment for learning) of students in line with the recommendations from the 2017 assessment review. These include increased numbers of practice exam questions and formative assessments embedded with online learning resources, which are optional.

The programmatic assessment approach also incorporates formative written assessment in Year 1, Semester 1 as well as low stakes summative block MCQ tests in Phase 1. Students find this approach helpful. However, some instances of delays in advising students of formative and low stake assessment results undermines the formative assessment value.

A new digital assessment management system (Inspira) is being implemented in 2023 and when fully functional, it is expected to improve tracking of student assessment task completion, identification of students requiring additional support and the timeliness of assessment feedback.

In Phase 1, the clinical skills attendance and progressive reviews are hurdle requirements and students have multiple opportunities to achieve the required standard, supported by targeted remediation. Summative assessments include a number of low stakes assessments and high stakes written and clinical assessments. The Phase 1 low stakes Block assessments are viewed positively by students and this model could be considered for translation to Phase 2.

Phase 2 assessments include multiple clinical tasks, completed in the clinical environment or clinical school site. Some are Block specific and others are completed in any Block as the

opportunity arises. Formats are varied (DOPS, mini-CEX, long case etc.) and appropriate to the task. The stated intent is to enable performance-based feedback to students. The implementation of the updates to this assessment that forms the Phase 2 portfolio is in early stage and is concurrent with the introduction of the e-portfolio in Year 3 (2023) and Year 4 (2024). Active evaluation of this assessment in the clinical environment will be critical to understand issues such as: the burden for students, clinicians, patients and health services, alignment of assessment tasks with clinical practice, achievement of intended outcomes and feasibility/sustainability. An example is the 6 long cases requirement for each of medicine and surgery during Year 3, with students spending considerable amounts of time in preparation and presentation, or experiencing differing expectations and opportunities for clinician engagement between medical and surgical contexts, or across clinical sites. Similarly, meaningful 360-degree assessment for students may be challenging to implement in busy clinical contexts.

5.2 Assessment methods

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

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

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

The medical program uses a range of methods to assess knowledge, clinical skills and performance, and professionalism. These methods are, in general, well aligned with assessment objectives and intended learning outcomes. Assessment is structured to progressively change the weighting and emphasis from factual recall to knowledge application, problem solving and clinical reasoning. For written assessments, scientific foundations of medicine are heavily weighted in Phase 1, progressing to clinical reasoning in Phase 2. Similar progression is apparent for clinical skills and practice, with higher weighting of basic clinical skills of history taking and physical examination in Phase 1, progressing to an emphasis on gathering and interpreting information (Year 3) and clinical reasoning and patient management (Year 4). The balance of assessment formats in each year of the course reflects this progression.

Throughout the medical program written examinations use a number of item formats (MCQ, extended matching questions (EMQ), short answer questions (SAQ) and structured essays), appropriate to the assessment task. Students are introduced to written format examinations in Year 1 where formative and low-stakes summative assessments are embedded in the Block structure. Barrier written examinations use the same item formats as formative assessments.

Summative clinical examinations are conducted in objective structured clinical exam (OSCE) format (Years 3 and 4), and a single Long Case examination (Year 4). The OSCE assessments are blueprinted to curriculum domains and therefore are appropriate high stakes summative assessments of student clinical performance. The Year 4 summative long case has been retained after reconsideration in response to the 2017 assessment review, and has been repositioned with the Year 4 barrier written assessment before the PRINT. Evaluation of this assessment after substantive revision to the marking scheme suggests it has validity. The rationale for positioning this barrier assessment prior to PRINT includes the opportunity for students who are below standard to remediate during the PRINT.

The Year 4 OSCE continues to be administered after PRINT, and the rationale is that this examination is designed to assess 'readiness for practice' and is therefore best situated after the pre-internship experience. An unintended consequence of maintaining this timing could be that

students are focussed on preparing for the OSCE rather than a rich and authentic pre-internship experience. In the context of the curriculum review it would be appropriate to reconsider the timing of the suite of final barrier assessments, and the benefit of a PRINT unencumbered by examination preparation.

Competency-based assessment of clinical and procedural skills occurs in both Phases of the medical program, with increased clinical task emphasis and volume of assessment in Phase 2. While the increase in emphasis in the clinical phase is appropriate, the resultant assessment load is significant and should be carefully monitored. Competency-based assessments use rubrics in various formats including mini-CEX and DOPS which are highly structured and developed by a peer review process. Some of these rubrics are highly prescriptive as to the performance of the skill or procedure and this 'one safe way' approach may be a disincentive for clinical assessors to engage. Some flexibility in the rubrics to accommodate acceptable variations in practice could be considered if implementation evaluation of the Phase 2 portfolio identifies this as an issue. With regard to the reflective tasks and learning development plans, student feedback indicates that refinement is needed to ensure these are meaningful, and that clinical supervisors can engage more easily with the tasks.

The vertical integration of the Professionalism and Leadership Theme with associated assessment and requirements for progression via the Professional Practice courses is a positive element of the medical program. Multiple in-semester and workplace-based assessments of student professionalism are embedded in both Phases of the medical program. In Phase 1, these include peer and tutor assessments and reflective reports. In Phase 2, students are required to complete clinically relevant learning modules and 360-degree feedback. For students with identified concerns about professionalism, remediation is instituted on a formal and documented plan. The hurdle requirement for progression is good standing with the Professional Behaviours Committee. In addition to specific professionalism assessments there is intentional inclusion of this element of practice in the OSCE examinations.

As noted above, the revisions to the Phase 2 assessment approach are in early implementation and evaluation of the fitness for purpose of all methods to specific clinical contexts would be beneficial. For example, traditional medical long case format may not be the most appropriate for some other specialty practice contexts and modification of the task and/or assessment rubric may be appropriate. There was evidence that opportunities to complete some clinical assessments may be limited at some clinical sites. Students at those sites with limited opportunities may be offered assessment in a simulated setting, resulting in site specific differences in assessment. Once again, careful evaluation of the implementation of assessment in clinical settings is needed to understand and address this issue and ensure required assessment is feasible at all clinical sites. The implementation of the e-portfolio across both years of Phase 2 in 2024 should facilitate this evaluation.

The submission indicates the current approach to assessment blueprinting has been refined and implemented after the 2017 assessment review and consists of a 'layered approach'. The systematic and formal approaches to blueprinting assessments are articulated and documented in the 'Medical Program Blueprinting Methodology (2014)' distributed to Year Assessment Committees by the AAP Subcommittee. The process sets out the function and responsibilities of each group involved (Year Assessment Committees and Phase Subcommittees, discipline leads) and the approvals pathway for individual and course assessment blueprints. As described in the submission, current blueprinting is consistent with the 2014 methodology, with involvement of Year Assessment Committees and a dynamic review process to develop the assessment map and examination blueprints each year. Students have access to an outline version of the assessment blueprint on the WATTLE Learning Management System.

The course assessment blueprint demonstrates progressive changes to the weighting of task taxonomy from knowledge recall/application early in the course to clinical reasoning and clinical skills in Phase 2. Constructive alignment of assessment and curriculum is achieved by blueprinting against the published Level 3 learning outcomes. In the context of curriculum review, it may be appropriate and timely to formally review the high-level assessment blueprint, particularly with respect to including generalist and specialist approaches to clinical practice in urban, rural and remote contexts. Attention should also be paid to alignment of assessment to course purpose with respect to demonstrated knowledge of Aboriginal and/or Torres Strait Islander health and societies.

The submission indicates that assessment standard setting procedures have not changed since the 2019 Comprehensive Report to the AMC. Accepted methods of setting pass/fail standards are used for each summative examination format and a clear rationale is provided for these. For knowledge examinations, modified Angoff method is employed pre-assessment, allowing item substitution adjustment if the assessment does not meet blueprint parameters or is outside the accepted range for difficulty. The Cohen method is utilised post administration to determine the pass/fail cutoff score. The rationale for this approach is sound. For OSCE examinations, borderline regression is used to determine individual station pass/fail cutoff scores. Scoring rubrics for stations are criterion-based. Students are required to meet average station score requirements and pass 75% of OSCE stations. Essay and the Year 4 summative long case assessments are scored according to criterion-based rubrics with pre-agreed pass criteria.

In keeping with the programmatic structure for assessment in the medical program, clinical skills assessments are competence based with well-defined and detailed performance criteria to meet the competency standard. For these assessments, the marking schemes and rubrics are available to students, and multiple attempts to achieve competency are allowed.

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.

There are procedures for timely identification of underperforming students, although feedback from students indicates that the process may warrant review. Noting that the overall retention and graduation rates are high, there appears to be a widely held perception by students that identification occurs late, and the requirements then imposed are overwhelming.

Students in Phase 1 who are underperforming may be identified through various mechanisms including: formative and summative examination performance, peer review, tutor review or referral, tracking of hurdle assessments and self-referral. The key contact staff member for referrals is the Student Year Coordinator who undertakes a diagnostic review in consultation with the Associate Dean Phase 1 and the student. Remediation is then individualised to each student's needs.

There are challenges identified by the School to implementing a similar framework in Phase 2. The complexity of the clinical environment, asynchronous rotations, multiple supervising clinicians, and administrative burden are some of the contributing factors. The introduction of the e-portfolio

is expected to facilitate tracking of student progress relative to cohort in Phase 2, and the appointment of Academic Supervisors in the clinical schools to provide site-based support for remediation. The Academic Support Pathway is a recent Phase 2 initiative and students reported variable experiences.

The Team understood that University policy may prevent sharing of student performance information outside of University staff. Given the importance of clinical supervisors to medical students' learning and remediation, the School is encouraged to work with the University to review this. Close monitoring of the implementation of the Academic Support Pathway in Phase 2 will be required as these initiatives are implemented.

Formal high-level feedback is provided to all students as an Assessment Feedback Report after release of results for each course in the program. Students can also review their marked responses for some assessments including short answer questions, mini-cases and OSCE stations and value this opportunity to identify learning gaps. Review of MCQ papers is not accommodated, and the rationale and reasons for this could be more clearly communicated to students. For the formative and low stakes summative written examinations in Phase 1, students receive an individual assessment report of their performance relative to the cohort.

With respect to formative examinations the timeliness of feedback could be improved so that students have the benefit of this prior to summative assessments. Full implementation of the new Inespera assessment management system is expected to improve results reporting timelines.

In Phase 1, there are multiple other opportunities for student feedback from Clinical Skills assessors and other tutors and from peers. For Phase 2, in addition to formal examination feedback, the intention is that the portfolio task assessments provide students with constructive feedback from a supervisor after each attempt until a 'competent' rating is achieved. Students then enter a reflective comment and review and discuss their experience with their Academic Supervisor. The programmatic structure for assessment promotes immediate performance feedback for many of the assessments, particularly those within the electronic portfolio.

Students report that the format of some assessment instruments is too generic and does not support the feedback conversations they find most useful. Feedback on assessments in the clinical setting has not always been timely and students report some difficulty in following up with assessors. The 360-degree feedback task in Year 3 is also intended to provide feedback about professional practice. Full implementation of both the e-portfolio and the Inespera platform may facilitate improvements in the recording of assessments as they occur and therefore student access to the associated written feedback.

The challenge for Phase 2, identified by the School and students, is to ensure that Clinical Supervisors assessing students are well equipped to provide meaningful feedback. Early steps taken to build the feedback skills of assessors include descriptive prompts in the e-portfolio platform and cross-site training of academics. Ongoing attention to the provision of meaningful feedback will be required to ensure all clinical assessors have these skills.

The current process to inform supervisors and teachers about student cohort performance relies largely on the assessment governance structure. For summative assessments, including clinical assessment tasks in Phase 2, reports from the AAP Subcommittee are provided to the MChD Program Committee, Phase Subcommittees, and Year Assessment Committees. Clinical discipline representatives can request specific topic-based reports. The Year Assessment Committees are responsible for disseminating information to their discipline groups. The geographically dispersed structure of Phase 2 placements is a challenge to providing meaningful information to site-based academics and non-academic teachers and assessors. Again, it is anticipated that the e-portfolio

will be an enabling technology. It will be important to also further develop procedures to ensure relevant information is available to all clinical teachers and assessors.

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 are formal review processes undertaken by the assessment team to monitor the quality of examinations and to enhance validity. These include ongoing blueprinting against curriculum learning outcomes, item review panels with specific content expertise, a formal item review process by Year Assessment Committees and high-level oversight by the AAP Subcommittee and its chair, the Head of Assessment, in constructing knowledge-based examinations.

Post-administration analysis of psychometric data is employed to evaluate internal consistency and reliability and to identify poorly performing items for review. Similarly, robust item construction and review processes are in place for the OSCE assessments. Re-use of items (with known performance) and exam-equating using linked items is employed to standardise across sittings. Student cohort performance on examinations is tracked year to year and it is reassuring that necessary adjustments to examination administration as a result of the COVID-19 pandemic in 2020–2022 did not substantively affect this. Analysis of the psychometric data relies heavily on the Head of Assessment, and the School could consider what additional measurement expertise may be needed as the curriculum review (and associated reconsideration of assessment) proceeds.

For assignment-based assessments and the research project, there are processes in place to review content, marking rubrics and consistency of assessors on a yearly basis.

Clinical skills assessments in Phase 1 are standardised competency assessments with a robust development and review process underpinning the assessment instrument. In Phase 2, a similar process ensures alignment of the clinical tasks with progressive transition to clinical practice. Due to recent implementation of the Phase 2 programmatic approach and e-portfolio in the clinical environment, systematic evaluation of these assessments has not yet been undertaken.

Reporting of assessment quality metrics including psychometric analysis, assessment outcomes and student attrition rates is through the governance structure of assessment to the MChD Program Committee. The Year Assessment Committees are responsible for ensuring information is disseminated to the clinical discipline representatives, and the School is encouraged to ensure this level of feedback is formalised. The SMP reports that recruitment of discipline representatives and other item writers for Phase 2 assessments has been challenging in the past few years due to pressures in the clinical environment related to the COVID-19 pandemic. The appointment of Clinician Educators, and recruitment of honorary clinical academics is put forward as a solution, and these strategies are likely to be enhanced by feedback to all item writers about assessment quality and performance as well as intentional training for the writing task.

The planned curriculum review will inherently result in further reconsideration of assessment in the medical program and provide an opportunity for updates to the local policies and procedures. Some of these documents are now nearly 10 years old. Additionally, attention to systematic documentation of standard operating procedures relating to assessment development, implementation and monitoring would mitigate risks associated with changes to staff and committee membership.

The medical program has processes in place to facilitate consistency for high stakes examinations. In both Phase 1 and Phase 2 of the medical program, students attend the ANU campus for high stakes written and clinical assessments. Assessors from the various clinical sites are recruited as examiners in the OSCE, promoting a common understanding of expected standards of performance in Phase 2. The submission notes some variation in student cohort performance between sites. However, the numbers are small, and this will be monitored in future.

Ensuring consistency of clinical skills assessment across the diversity of clinical sites is likely to present ongoing challenges as the Phase 2 portfolio requirements are embedded and the e-portfolio implemented. The standardised scoring rubrics should facilitate consistency; however, there are also multiple context-specific factors for further consideration. These factors include the use of assessors who are not university staff, training of clinical assessors, access by students to required clinical encounters, whether simulation-based assessment meets the intended assessment objectives, and assessment burden leading to gaming of assessment by students and assessors. Each Clinical School has delegated responsibility to train assessors and the assessment team will need to ensure the delivery of training achieves consistency of standard across sites.

Some faculty development has been implemented for clinical assessors, including junior doctors, and the School intends to build on this to promote a shared understanding of expected standards of student performance to achieve consistency across sites and assessors. At some sites, opportunities to complete portfolio assessments in the clinical environment are limited and simulated context assessments are offered. Evaluation of Phase 2 assessment could be expected to identify if there are significant differences between clinical sites.

6 The curriculum – monitoring

6.1 Monitoring

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

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

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

The School is committed to review and quality improvement. There is a substantial volume of evaluation and monitoring of the medical program including contributions to national surveys of medical school graduates, central University surveys, and routine and targeted evaluation activities within the program. There is an important focus on evaluation of student perceptions of individual courses, innovative teaching and graduate performance. The School describes an evaluation paradigm which follows the health service evaluation elements of structure, process and outcomes.

Student Experience of Learning and Teaching (SELT) surveys are the primary method of obtaining feedback in the University and are standardised to assist in benchmarking. The SELT surveys are online and evaluate courses and teachers. Likert-scale results and free text are available through this method. Aggregated data is considered by College and School executives to monitor staff teaching performance, and student satisfaction for all courses.

As is the case at many medical schools, the SELT process is not entirely fit for purpose for evaluation of medical program courses and requires evaluation processes beyond University requirements. The University-wide surveys are supplemented by local surveys to better evaluate some of the unique aspects of the School and medical program such as the Blocks, vertical Themes and Frameworks that do not easily fit into the University evaluation structure. These surveys can be administered by a course convener without external approval to obtain immediate feedback about a course.

There is a process and intention to conduct routine and systematic Block, Theme/Framework and Phase reviews. The sequence of evaluations includes Block surveys every second year for alternate Blocks in both Phases. Theme/Framework reviews and formal reviews by independent assessors are scheduled once every three years. The structured evaluation sequence has been stalled since 2019 due to the COVID-19 pandemic.

Several examples of specific evaluation activities were described by the School:

- Routine course reviews, required by the university at least every five years, with input from an academic external to that course. An impressive comprehensive review of the MEDI8011 course in 2021, which suggested a number of potential improvements, was provided as an example.
- The PRINT program evaluation with input from student, graduates and supervisors and adjustments to the program made in response to these results.
- A survey of harassment and bullying was administered to the whole cohort and identified that there were issues with sexual harassment in the pre-clinical phase. A concerted effort to address culture and manage any difficult staff was put in place. A subsequent survey showed a dramatic reduction in reported events.

- The Team heard that an anonymous portal to report concerns related to academic, pastoral or safety issues has been useful to rapidly respond to any concerns. The students that the Team subsequently spoke with were aware of this portal and felt it was a good development.
- The Clinical Skills Theme is included in a Block assessment but is also used for evaluation of individual or team teaching quality. Clinical Skills teams can use QR codes for internal assessments.

The Rural Clinical School has evaluation activities related to specific learning components, using an evaluation form and debriefing for short-term rural placements. Year 3 Rural stream students have end of year evaluations. The Federal of Rural Australian Medical Educators collect survey data on Rural Clinical School students, which are collated and provided to rural academics and students. Outcome/graduate longitudinal tracking of Rural Clinical School students is not consistent and there is potential to implement a working group on evaluation to help with planning. It is unclear whether the Rural Clinical School evaluation processes are aligned and coordinated within an evaluation framework.

Student response rates to online feedback surveys are low and often below the expected proportion to obtain reliable and useful results, particularly when compared to previous paper-based surveys. In response to this, the School plans to shorten surveys and use QR codes. They have also introduced focus groups to improve response rates and mitigate survey fatigue. A proposed evaluation site on WATTLE does not yet seem to be functioning. Students have been involved in an evaluation working group for Year 1 teaching activities, but the extent of student-society-led evaluation activities to support or replace program-led activities was not clear. Students had concerns that the quality of clinical supervision had not been recently evaluated.

There is no dedicated evaluation committee in the medical program's governance structure as evaluation governance is currently delegated to the Phase Subcommittees and Assessment/Admission Subcommittee with reporting to the MChD Program Committee. These committees have an evaluation item in their terms of reference to 'review and respond to evaluation reports to monitor and improve the medical program' but do not have a committee member listed as responsible for evaluation. A similar situation occurs at the School level in the School Education Committee.

The current academic evaluation lead is doing an excellent job of running evaluation activities. The evaluation lead has no formal role description and the role is not part of the formal membership list of the Phase Subcommittees or MChD Program Committee where evaluation processes are delegated. The process for generating, prioritising and controlling evaluation activities is unclear and delegated from the MChD Program Committee to the Phase Subcommittees and distributed thereafter to academic staff and course coordinators.

The evaluation lead also has other substantial commitments with Admissions and Higher Degree Research leadership roles. There may be some inherent conflicts or difficulties relating to this. The Head of Assessment also has a fraction dedicated to evaluation but this is focussed only on assessment data. There is concern that there is insufficient administrative support for the evaluation processes. This lack of dedicated personnel may result from evaluation being delegated across the committee structure of the medical program. There is student representation on these committees but their input into the governance of evaluation activities appears to be minimal. Students felt comfortable raising issues in relevant committees and had timely responses to their concerns.

The incoming CHM Deputy Dean Health Professions described a possible approach to evaluation with a focus on PGY1 performance, patient safety and readiness for practice which reaches back

into the program as far as admissions to identify pivotal areas for development. He also articulated that a course evaluation strategy would be developed as an integral part of the planned curriculum review.

A review of the current distributed delegation of evaluation would be useful and having the Evaluation lead role separated from other leadership roles may be prudent. Having a formally defined evaluation academic position with associated governance structure including committee membership roles may be advantageous, particularly if accompanied by a formal evaluation framework in readiness for more extensive curriculum review. This may ensure that the curriculum review can be informed by context-appropriate logical evaluation processes that includes a range of stakeholder inputs and outputs. This should draw on and potentially contribute to medical education research and policymaking. There should be broad consideration of staff, the health system and other external stakeholders in the evaluation processes.

6.2 Outcome evaluation

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

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

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

The School participates in several national benchmarking programs and in collaborative review of teaching and assessment with other medical schools. Data regarding graduate outcomes are obtained from student feedback surveys, student enrolment and demographic data, assessment performance, graduate surveys and direct feedback from clinicians about the quality of graduates.

In the 2019 joint AMC/Medical Board of Australia Preparedness for Internship Survey, ANU medical graduates were ranked 15th of the medical schools for overall preparedness, with an above-average 29% response rate. The School has found these surveys to be useful, but they have not been undertaken for a number of years. The School used the findings of the 2019 survey specifically to develop the PRINT program, which is being refined in response to ongoing evaluation.

Permission is required from the Director, Planning and Service Performance Division to undertake surveys of ANU students. When permission is granted, the surveys are registered as approved surveys. These include the national Student Experience Surveys and Graduate Outcome Surveys which provide benchmarking for Quality Indicators for Learning and Teaching (QILT) data. The School also has access to the Medical Schools Outcomes Database. It is unclear how information from these sources informs feedback and program improvement processes within the School.

Student outcomes and career destinations are tracked, particularly by staff of the Rural Clinical School. The tracking of outcomes has tended to focus on graduate location tracking and data from the Australian Health Practitioner Regulation Agency (Ahpra), relevant to Rural Health Multidisciplinary Training (RHMT) program reporting. Communication of these outcomes is linked back to the Admissions Unit. The longitudinal Ahpra data since 2017 describes approximately 28% of Ahpra-registered ANU medical graduates are of rural background and 17% are working in rural areas. An impressive 30% of graduates enter GP training.

There is tracking of rural and Bachelor of Health Science pathway students and information from graduate outcomes data. The Team received cohort progression data for the whole cohort and for Aboriginal and/or Torres Strait Islander students.

There was positive feedback from health services about the quality of graduates, but the Team did not hear of formal processes to evaluate and obtain feedback regarding intern performance, and this may be an area for future development. The local Canberra Hospital employs ANU medical graduates as 75% of their intern workforce, and anecdotally, there is a high level of satisfaction with ANU graduates in their intern roles. The Sydney Clinical School is proposing to better define its envisaged outcomes for graduates. It is unclear what evaluation processes will be conducted to measure these outcomes.

During the accreditation assessment, the Program did satisfy Condition 17 'Provide evidence of the outcomes of monitoring and review of the Indigenous Health curriculum' by providing clear examples of the changes to the curriculum in 2022, which were noted by students as a particularly positive development. As noted under Standard 3, further work is required and planned for the Indigenous Health component of the curriculum.

Evaluation activities are evident which are not necessarily coordinated within the described theoretical paradigm, particularly for overall program outcomes and graduate performance. There is also minimal involvement of external stakeholders. Evaluation processes are not currently anchored to an overarching evaluation strategy or vision related to the new School and its strategic directions. Recent evaluation activities appear patchy and focused on reactive evaluation of program elements and innovations that have been recently implemented. The recent loss of evaluation routine and structure may be due to the impact of the COVID-19 pandemic, lack of an overarching evaluation framework, insufficient resources including lack of dedicated staff, and reluctance to commit to evaluation and change due to an impending curriculum review.

More proactive and strategic activities could include greater use of graduate performance data and assessing whether the graduates are fulfilling the vision of the program and addressing the needs of the communities they serve. Description of graduate performances should consider student characteristics to better inform earlier medical school processes of selection, teaching and learning, assessment, and student support.

The Team is concerned that the lack of a robust evaluation framework limits the quality of monitoring of student and graduate outcomes and subsequent opportunities for improvement of the medical program.

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.

Historically, data on graduate outcomes and their eventual destination has been presented at regular intervals in a number of forums including CHM and SMP Executive Committee and to the former ANUMS Advisory Board. Within the new SMP structure, it is intended that reports be presented to the following:

- CHM Executive Committee
- SMP Executive Committee

- All of School end of year faculty and staff meeting
- The to-be-implemented SMP Advisory Board

There is review of student satisfaction data within Blocks and in program committees/subcommittees, but less evidence of dissemination of whole-of-course outcomes to committees, students and staff. Benchmarking of assessment outcomes at sites occurs regularly and in-semester monitoring of student performance at each clinical site is now facilitated by the longitudinal portfolio. Assessment outcomes and data are made available to sites and schools through the Head of Assessment, although the Team heard that this is not a formalised process across sites. Formal pathways for feedback to and from staff are also difficult to identify, with many staff unaware of mechanisms to provide or receive feedback. No recent staff surveys have been performed although other less formal consultations have taken place.

The Team did not hear of a mechanism where community and other stakeholders may review program outcomes and provide feedback. Examples of evaluation results have been provided by the School, but it is unclear how the process closes the loop and how the results can be used for quality improvement. Self-review of courses is now mandated by the University and the School is currently considering how to integrate this into its current review process.

7 Implementing the curriculum - students

7.1 Student intake

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

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

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

The medical program has enrolled 115 students into the MChD program for the 2023 intake. This is noted to be an increase of approximately 15 students compared to the intake of 95–105 per year between 2020 and 2022. This moderate increase results from an expanded intake of international students (16 in the 2023 intake, compared to 5–6 per year during 2019–2022). It appears to be consistent with capacity of existing facilities for Phase 1 students at the ANU campus and the Rural Clinical School, and for Phase 2 students across the three clinical schools, with the addition of new clinical placements at the Sydney Clinical School in Phase 2.

The extent of further increases to the student intake beyond 2024 has been signalled but not defined. The SMP indicated in its submission that the University has ambitions to increase the cohort size by increasing the number and proportion of international students. Stakeholders are aware of this planned expansion of international student numbers. SMP staff have undertaken modelling of the impact of increases across program delivery, which appeared careful and sound. In the short term, the Team understands that the international student intake would not expand beyond 20, with the total cohort not exceeding 120 students, in line with current capacity.

A wide cross-section of stakeholders indicated confidence in the Program's capacity to increase to a total annual cohort of 120 students per year. While recognising some additional capacity for Phase 2 students at the Sydney Clinical School, the Team observed that the current staffing profile and facilities across the footprint would likely be severely strained in both Phases 1 and 2 should the intake increase beyond 120 students. In particular, the anatomy and physiology laboratory spaces and staff at Acton, and the lecture theatre and clinical skills spaces at Canberra Hospital (which is responsible for delivering clinical skills to all students in Phase 1 and all Canberra-based students in Phase 2) are already constrained. Should the University decide to further increase the cohort size, assurance would be required that the requisite facilities, staffing, resources and placements had been secured. Further attention would also need to be given to models of student support.

Positively, it was clear in conversations with stakeholders that the smaller cohort size has created a positive and collegial culture between students themselves and between students and academics. Students consistently remarked on the smaller cohort size as being a significant strength of the program.

Selection pathways for the program include ANU undergraduate programs such as the Bachelor of Health Science (BHlth), Bachelor of Philosophy (PhB) and Tuckwell Scholarship, and entry through the Graduate Entry Medical School Admissions System (GEMSAS). There is also an Indigenous Pathway and there have been two admissions pathways for international students (direct entry and into Phase 2 although the latter was suspended at the time of the assessment). Approximately half of the cohort entered through the GEMSAS in 2023 and the School has expressed interest in

expanding the number of local students in the program through the undergraduate entry programs in line with the School's stated desire to create a community of local graduates in Canberra and the surrounding region.

The School has targeted access schemes for Aboriginal and/or Torres Strait Islander students and rural-origin students. The School's target of 29% for rural-origin students aligns with the RHMT program targets. The school meets their requirements for RHMT reporting in line with this. The program failed to reach this target for the 2023 intake, despite previously being within 2% of the target (27–29% from 2018–2022 intake years). The School is able to undertake manual adjustments through the GEMSAS pathways for postgraduate applicants and has maintained a 30% rural-origin student intake into the larger BHLth and PhB pathways. The Tuckwell Scholarship usually has no more than 3 students per year pursuing entry into medicine. The School has flagged the disproportionate impact of COVID-19 related changes on rural-origin students resulting in much lower than normal application numbers. There also appears to be limited specific support for rural-origin students.

There is no target intake; however, the SMP aims to graduate three Aboriginal and/or Torres Strait Islander medical students per year, which translates to just under 3% of the cohort. The School has not met the graduation target. SMP did not graduate any Aboriginal and/or Torres Strait Islander medical students in 2022 and none are in the 2023 graduating cohort. In the last eight years, the Program has only met this target for the 2020 graduating cohort. Since 2011, the School has only enrolled a maximum of three Aboriginal and/or Torres Strait Islander students per year. The School has established a Rural and Indigenous Student Working Party to investigate the causes and propose solutions to the challenges in these targeted access pathways.

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 processes for selection that are evaluated and improved on each year through the Admissions Subcommittee. There is a clearly blueprinted and longstanding interview process. There is an emphasis in including interviewers with a connection to the medical school, including academics, clinical supervisors, alumni and community members. The inclusion of a wide variety and large pool of interviewers is positive, especially with the inclusion of academics and clinicians from the Rural Clinical School. However, the School notes that its engagement from community members not directly associated with the medical program has diminished over time. There is an opportunity to use the community engagement process that will be part of the curriculum review to strengthen community engagement in selection.

A University-wide policy covers students with infectious diseases, including blood-borne viruses. These concerns are managed through the School's placement compliance team.

The program follows the University's disability policy and has been a leader among medical schools in achieving inclusive selection processes. Acknowledging the unique requirements of medical programs, the School has created a working party on widening access to medicine, including to develop a specific process for supporting students with disabilities. Current processes and procedures rely on two-way communication between the prospective applicant and the SMP and broader University staff. While the flexible approach of the staff who create accessibility and inclusion plans during the admission process has resulted in successful recruitment, current processes place a burden on the prospective student. The burden is a result of the lack of available information specific to the program and the prospective student having to determine whether and how to make a case for their ability to practise medicine after graduation. The working group aims to develop a plan that allows for inclusive education, while balancing the inherent requirements for medical practice and ensures students and applicants are involved and supported in this decision-making process.

The targeted access schemes for Aboriginal and/or Torres Strait Islander students include a separate interview process with staff from the Tjabal Centre and the School's Indigenous Health Unit on the team. Additionally, interviewees are offered the opportunity to have the interview at the University at no cost, with tours of the campus included.

While there are specific policies for recruitment, retention and support, the Program acknowledges challenges around the implementation of these and has recently appointed an additional staff member to the School's Indigenous Health Unit with responsibilities for student support and engagement. There was clear evidence of a range of available supports, which include scholarships, pastoral support from the Tjabal Centre and professional development support. The School's Indigenous Health Unit provides additional program-specific supports.

However, a consistent theme of disengagement was reported as the experience for Aboriginal and Torres Strait Islander students. Delineation of responsibilities for student support and pastoral care between the Tjabal Centre and Indigenous Health Unit is unclear to students. Particularly in Phase 2 of the program, where students on clinical placement are often located away from the main ANU campus, Aboriginal and/or Torres Strait Islander students felt unable to access central supports. This disconnect was also evidenced through, for example, a lack of take-up of mentoring and professional development opportunities. Retention is also a concern as, despite modest numbers of Aboriginal and/or Torres Strait Islander students enrolling into the medical program, there have been withdrawals from every cohort since 2018 (that included Aboriginal and/or Torres Strait Islander students). There is an opportunity to increase the Indigenous Health Unit's engagement with the Tjabal Centre to explore students' experiences with current support mechanisms and to develop shared strategies for academic and pastoral support for students throughout their program and shared mechanisms to receive student feedback on the effectiveness of these strategies.

There is also an opportunity to develop a Cultural Safety framework to better support academics to create safety for Aboriginal and/or Torres Strait Islander students in the teaching and learning environment.

The program lists application requirements and an overview of selection criteria on its website. Mechanisms for appeal fall under the broader University-wide policy and procedure which is also readily available on the website. This information is openly accessible to prospective applicants.

7.3 Student support

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

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

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

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

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

The School and University offer an appropriate range of support services to address the financial, social, cultural, personal, physical and mental health needs of students. The Student Support Centre website designed in conjunction with the ANU Medical Students' Society (ANUMSS) is notable for its collation of information and documentation relating to various areas of student support. However, students had mixed feedback on the accessibility of the supports overall. Students on rural placements particularly reported feeling isolated from the School, and concerns were raised about the separation of academic progression and student support.

There is a MChD Student Welfare Subcommittee, composed of members of ANU academic and clinical staff, who meet quarterly to confidentially manage student wellbeing and support (in the absence of student representation). A subgroup of the Subcommittee – the Wellbeing Working Party – meets monthly, with student representation, to troubleshoot ongoing issues and offer opportunities to discuss student matters with the ANUMSS Wellbeing Officer.

There is a Student Support Lead for the program. This position is 0.2 FTE and therefore relies on delegation to the Student Year Coordinators and the Associate Deans for each of the two program Phases to address students' requests for support.

Academic supervisors at the Canberra Clinical School and Sydney Clinical School, and dedicated support staff at Rural Clinical School sites, are also reported by students to be key support resources in Phase 2. There is a recently established Academic Supervisors Group, that comprises supervisors who support students who have failed assessments or are identified as struggling. Additionally, there is a Phase 2 Medical Advisor who is a clinical member of staff who offers opportunities for students to debrief and discuss clinical-related concerns that the Phase 2 students may encounter on their day-to-day clinical placements. Students receive information and contact details for the Advisor before beginning Year 3. It may be helpful to find alternative ways to communicate the details and purpose of the Advisor, as not all Phase 2 students who spoke to the Team were aware of this support. Those students who had contacted the Advisor spoke highly of the support provided.

With regards to international students, it is noted that the 0.1 FTE appointments have been made to Year 3 and Year 4 Coordinators for this role, and there are active efforts to recruit a separate 0.2

FTE International Student Coordinator. Given the program has already expanded the Year 1 intake of international students by 50% to 16 students, there is an urgent need to fill this position.

Students reported some challenges in accessing support, particularly at rural sites. The Team heard of examples where weather events and other challenges had affected students on placements in regional New South Wales and there had been no contact from the School with either students or supervisors to check on wellbeing or impact on learning.

Though the Year and Phase leads were considered approachable, students expressed a desire for more centralised support with a clearer delineation from academic staff who are also responsible for progression decisions and/or management of the program. Additionally, a more proactive approach to student support was also requested. The SMP did provide clear examples of how progression decisions and support were separated within the program. The School is encouraged to discuss the support mechanisms with student representatives and the wider student body given their reported concerns.

Students also expressed their desire for tighter mechanisms for detecting underperformance to help reduce anxiety about their progress, citing feedback on formative assessments that was received late.

Key academic and support staff described well-established processes for directing students to support services both within and outside the university. Students reported challenges in accessing mental health support services, particularly counselling services, although this appeared to reflect broader challenges faced by the local community in Canberra. The new School structure presents an opportunity for the program to strengthen its focus on wellbeing within the program and strengthen connection with mental health services across the School's footprint. The Team notes efforts to create School-wide committees covering student support and wellbeing and would encourage further efforts in this area.

The School and the University have in recent years faced challenges in addressing bullying and harassment. In 2017, the School and the ANUMSS developed a booklet on bullying, sexual harassment and discrimination. In 2022, an Anonymous Reporting Portal (adapted with permission from the University of Otago) was made available for students to report informally on any unwanted behaviour they had experienced directly or witnessed. These reports are received by a small select group of SMP academics who meet at a frequency dictated by the rate and number of reports submitted. The group triages, analyses and discusses the outcome of such reports. Both staff and students spoke positively of the impact of the portal and perceived an improving culture that appears also to be related to students' perception that the School is taking action in response to concerns reported through the portal. There was an acknowledgement of room for further refinement in processing and responding to these anonymous reports.

A School Administration Team manages the screening and vaccination requirements of students in conjunction with, where relevant, ACT Health, NSW Health and other placement providers. Part of this management includes appropriate direction for students with infectious diseases.

Regarding students with disabilities, there are clear and sufficient policies, and the staff demonstrate effort and willingness to support and make bespoke adjustment plans for students with disabilities, collaborating with ANU Access and Inclusion (now known as Accessibility) as appropriate.

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.

Professionalism and fitness to practise concerns are proactively addressed through formal and informal mechanisms. Professionalism and behaviour expectations are an integrated part of the Professionalism and Leadership Theme with teaching and assessment occurring across all years. This includes zero-unit Professional Practice courses which formalise the assessment of professionalism. Additionally, students sign a Code of Conduct upon commencement of the degree. The Program maintains multiple mechanisms to identify professionalism issues across Phases 1 and 2. All students undergo a peer and tutor review process in Phase 1, and in Phase 2 there is 360-degree feedback. The reporting pathways are recognised by both the professional and academic staff.

There is a detailed pathway which outlines how students with impairments or professionalism concerns are assessed and managed. Issues warranting review can be referred by staff to the Professional Behaviours Committee by written statement. The PBC has several pathways for management after appropriate investigation. The pathway includes staged referral to a variety of appropriate services and bodies within the medical program, School and University, or referral to Ahpra where mandatory reporting obligations exist.

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.

Representatives of the ANUMSS sit on all appropriate Program and School committees. These include the following committees (with specific ANUMSS positions listed where relevant):

- SMP Education Committee
- MChD Program Committee (ANUMSS President and Academic & Advocacy Officer)
- MChD Phase 1 Subcommittee (Year 1 and 2 Academic Representatives)
- MChD Phase 2 Subcommittee (Year 3 and 4 Academic Representatives)
- The Wellbeing Working Party (ANUMSS Wellbeing Officer)
- Clinical Skills Committee
- Integrated Child and Community Health (ICCH) Committee
- Medicine and Surgery Committee
- Professionalism and Leadership (PAL) Committee

Additionally, the following regularly scheduled meetings occur with the ANUMSS representatives listed below:

- Biannual meeting with Director, Associate Director Education (Medicine) and Associate Deans Phase 1 and 2, Heads of Clinical Schools (with all ANUMSS academic representatives)
- Bimonthly meeting with Director (with ANUMSS President and Academic & Advocacy Officer)
- Monthly meeting with Associate Director Education (Medicine) (with ANUMSS President and Academic & Advocacy Officer)

Overall, student representatives feel that their opinion is valued they can bring agenda items to meetings and their issues are treated seriously. Continued monitoring of these committees and the effectiveness of student representation will be necessary given the addition of the new SMP

committees to an already significant number of program committees. For new SMP committees being developed, such as the SMP Culture and Wellbeing Committee and the Inclusion, Diversity and Equity Activities (IDEA) Committee, strong consideration should be given to the nature of student representation. The complexity of structures for addressing student welfare, wellbeing and representation in the new proposed committees should be strongly considered and reviewed.

As the Program undergoes review, students should be included in relevant committees and working groups. Curriculum change offers an opportunity for genuine and meaningful codesign with students if resourced and organised appropriately.

7.6 Student indemnification and insurance

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

The Program is insured for Public and Products Liability and Medical Malpractice through Gallagher International. Insurance certificates appear appropriate for the nature of medical education.

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 Program has important relationships with health service partners including but not limited to CHS, NSW Health, Department of Health and Aged Care, Adventist HealthCare Limited as well as various General Practice and rural health partners, which support the delivery of the medical program.

The physical facilities of the Canberra Clinical School, the Sydney Clinical School and the Rural Clinical School sites at Bega, Cooma, Goulburn, Young, Cowra and Eurobodalla all meet the current needs of the medical program and are of an appropriate standard.

The Team visited and virtually toured excellent facilities, particularly at the Sydney Clinical School and Rural Clinical School. The new Rural Clinical School sites that were visited in Bega and Cooma were modern and built for purpose. There is currently major construction ongoing at Canberra Hospital and redevelopment at North Canberra Hospital. The current lecture theatre was reported by staff and students to be inadequate for current student numbers, though there was no evidence of planning for a larger lecture theatre (or other student spaces). However, there is evidence of increasing School engagement with ACT Health in development planning.

The living and teaching environments in the remote Northern Territory have a higher risk from a safety perspective than most other sites. The SMP has clear mitigation strategies in place to address this risk. There were comments from students that the safety training is overdone; however, the Team considered that the risks were appropriately stated. Potentially some of this training could be carried out by remote staff to assist students in understanding the realities of work in remote sites.

The partnerships with other universities, in particular the University of Canberra, are very positive. The utilisation of the health service facilities for student teaching as well as multidisciplinary clinical teaching for medical, nursing, paramedicine and emergency teams across the region is particularly impressive. The current agreed contracts for partnership, however, may require some review to ensure that the current process is not based on individual interpretation, as it is understood that while the universities have an overarching agreement for all facilities, the funds are split between them for the different facilities.

The physical facilities of the ANU Acton campus are also well maintained and appropriate to the curriculum. The main learning and teaching facilities used to deliver the medical program are co-located with the John Curtin School of Medical Research and National Centre for Epidemiology and Population Health. The SMP uses two university-managed lecture theatres with capacity for 96 and 240 students respectively and modern facilities that enable live-streaming. There are three teaching laboratories, a 24-hour student space, further student spaces, 15 teaching and learning rooms, staff office spaces, and staff and student common rooms. The Team viewed these during the assessment.

The Program provided an update on planned developments which were outlined in the 2019 *Acton Campus Master Plan*. These include the development of a health and medical precinct on the Acton campus, bringing staff and students of medicine and psychology close together and creating shared spaces.

While the current facilities are well maintained and sufficient, there was clear concern across staff and students that facilities could not sustain a substantial increase in student numbers; this included the Acton campus laboratory, class and student spaces, and student and teaching spaces

at the clinical schools. Detailed modelling had been undertaken that indicated that 120 students per year was the maximum capacity based on the existing use of current facilities.

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.

Access to information resources and library services, including for students on rural and remote placements, was sufficient. There were two notable exceptions to this. One was at sites in the very remote Northern Territory, but the Team heard of a proposal to move to Starlink and this appeared likely to address this issue. The other related to the lack of reliable internet at North Canberra Hospital, though the School has little influence on the availability of internet as it does not own or control the physical infrastructure. The School has taken steps to mitigate the impact of this on students, such as by providing wi-fi dongles to students.

There is recognition of the importance of providing adequate connectivity to Rural Clinical School students in different rural and remote environments including the student accommodation. The Team noted the provision of satellite phones and processes for use.

Expansion of the medical program into new sites, and with a view to increasing placements, requires more planning in the sites where accommodation is provided by the University. Internet connectivity should be an early priority.

The University has a wide range of information communication technology (ICT), software and reference databases that are utilised by the School. There are ICT and AV support staff within the Canberra and Rural Clinical Schools, who support students and staff and manage projects as they arise. In addition, there is a School-specific Technology-Enhanced Learning and Teaching (TELT) team. There are clear strategies to maximise resources within this team to ensure efficient service provision.

The Team acknowledges the expertise of the TELT team and the clear examples of evaluation and innovation in the technology supporting delivery of the medical program.

The software systems currently in use are appropriate and relatively user friendly. The Team did hear from students and staff that the SONIA software, which is utilised for student placements, was less straightforward to use. While there are some local 'experts', there is no one individual that oversees and manages any issues with this program.

Students expressed concerns that some of the online resources required updating and many had unrealistic guidance for the amount of time modules take to complete. The TELT team acknowledged that its capacity to review and update old material while producing new material was limited and had a plan to address this known issue.

The ANU library is well resourced and functional, with ICT systems. This is also seen in the Rural Clinical School sites, where students have access to wi-fi to allow them to view electronic learning resources. There is a reference collection adequate to meet curriculum and research needs.

Medical students have access to a number of online resources that complement and facilitate their learning. The licensing for some of these resources is reported by the students to be limited.

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 varied clinical learning environments appear to provide sufficient opportunity for patient contact. Students can achieve the expected learning outcomes and are sufficiently prepared for clinical practice on completion of the medical program. Phase 2 is the clinically based element of the 4-year program and consists of rotations through discipline-specific Blocks at locations throughout the rural and urban networks of hospital and community health settings.

The Program provided detailed analysis of student numbers and capacity across the range of different types and locations of clinical placements within the written submission. It was clear that across the Program, the clinical learning environments span a large footprint across three states (Australian Capital Territory, New South Wales and Northern Territory). In these different locations, the Program is delivered in a way that is sustainable across different contexts, with a mix of block versus integrated delivery by both sub-specialised and generalist clinicians. The clinical teaching facilities encompass multiple general practices (ranging in size and patient profiles, metropolitan and rural settings), nursing homes, small multipurpose centres, and public and private hospitals. Since the AMC 2019 Comprehensive Report, the clinical sites have expanded to include the Sydney Clinical School, based at Sydney Adventist Hospital, in addition to the Canberra Clinical School (covering Canberra Hospital, North Canberra Hospital and General Practices) and the Rural Clinical School (General Practices and hospitals located in Bega, Cooma, Cowra, Eurobodalla, Goulburn and Young.)

There were examples of proactive management of student placements to ensure all students gained an appropriate breadth of experience when clinical exposure to a particular discipline may be limited in a placement site. Examples of this include paediatrics in the New South Wales sites of the Rural Clinical School, where students may be moved from smaller sites to Bega for a short period of time specifically for a paediatrics placement. This is also managed at North Canberra Hospital where surgical experience may be limited.

The student experience is positive about access to patients and learning opportunities for clinical experience. There were some concerns raised about the GP placements in some of the rural sites, with concerns that their allocated sessions were not sufficient; however, this was not consistent among the cohort.

The Program provided evidence of a high uptake of General Practice careers by graduates, predominantly in Canberra, but also in the rural sites. In comparison to the national average of

medical school graduate intentions this is very impressive and is something the school can be proud of. The Team was told by stakeholders that they believe that this is, at least in part, a result of the excellent learning opportunities that students have in their GP terms, both in Canberra and the rural sites. There may be opportunities to build on this success, particularly given that there are more placements than students at times. Consideration of longer-term attachments in General Practice, starting in Phase 1 may contribute to this.

At present, rural medicine is perceived by students and supervisors as somewhat siloed in the Program and contained within the Rural Clinical School. There are opportunities to increase the contribution of rural specialist and generalist clinicians into the teaching program for all students, particularly in Phase 1 to support the whole cohort to better understand the rural context and increase the profile of rural medicine as a career.

There are opportunities for students to gain experience in the provision of culturally competent health care to Aboriginal and/or Torres Strait Islander peoples, although these are not currently sufficient for all students, or even the subset of particularly interested students, to gain substantial experience.

In Phase 2, many of the clinical placements for students in Aboriginal and/or Torres Strait Islander health in the Australian Capital Territory and New South Wales have been placed on hold due to COVID-19 restrictions and have not been recommenced.

- In the Australian Capital Territory, Winnunga Nimmityjah Aboriginal Community Health and Community Services previously took students for the Year 3 6-week urban GP placement as well as for selectives in Year 4. Placements have been on hold since the start of the COVID-19 pandemic due to staffing challenges at the health service (they were operating as a GP respiratory health centre during the pandemic) and due to the increased vulnerability of the patient population. Discussions are being held with the service to seek to reinstate the clinical placements from 2023.
- In rural New South Wales, placements have been in Katungul Aboriginal Corporation Regional Health and Community Services, which operates medical clinics in Bega, Narooma and Batemans Bay. After being placed on hold during the COVID-19 pandemic, placements restarted in 2022 at Bega but have not yet restarted at Narooma and Batemans Bay.
- In the Northern Territory, placements have been re-established post the COVID-19 pandemic in both remote community and hospital settings. There is work at the College level to increase placements as part of broader partnership projects, and it is anticipated that this would involve further remote community placements.

Students who had participated in the Northern Territory placements reported highly engaged valuable learning experiences. However, only 25 students (approximately one quarter of the cohort) can access a placement in the Northern Territory.

Students reported a clear desire to strengthen learning opportunities to develop the skills to provide culturally safe care for Aboriginal and/or Torres Strait Islander Peoples.

While there are complex reasons for this, there may be opportunities to work with the services to build capacity and support student placements to resume. Given the current situation of limited opportunities within the medical program to gain experience in culturally safe care for Aboriginal and/or Torres Strait Islander peoples in clinical contexts, the Program is encouraged to invest in developing relationships and capacity across both Aboriginal Community Controlled Health Services and in General Practice to improve placement opportunities.

There are multiple points in Phase 2 where students are actively mixing with other health professional students from other education providers. This is most commonly students from the

University of Canberra in different health disciplines. There was evidence of increasing engagement with the University of Canberra and a positive rather than detrimental impact on ANU medical students.

There were, however, examples where lack of formal agreements with the University of Canberra could at some stage impact medical students and their learning opportunities. An example of this is in the Rural Clinical School sites where facilities are shared without formal agreements as to how the facility may manage students when there are competing requirements. This will work in favour of all institutions, as the fund holder of the sites is also shared across the footprint to ensure equity of access as needed. However, as knowledge of this understanding is lost with staff and manager changes, this could become a significant issue in the future.

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.

There is an effective system of clinical supervision of students across the range of clinical placements in the medical program.

In Phase 2, all students in each Block are assigned a Clinical Supervisor. In hospital and general practice placements, this is an experienced medical practitioner who has experience in teaching and supervision. In the Year 4 PRINT Block, students are attached to a Junior Medical Officer (JMO) rotation and are supervised directly for elements of the Block by the JMO (with registrar and consultant oversight). Clinical Supervisors are responsible for the orientation to the placement, day-to-day contact with students, completion of Phase 2 Portfolio items and Block assessments and liaison with Academic Supervisors and Student Year Coordinators when needed for students' progression and wellbeing concerns.

Additionally, students beginning Year 3 are now assigned a single clinician who remains their Academic Supervisor throughout Phase 2. The exception are students in the Rural stream who are supervised by a rural Academic Supervisor (local Academic Coordinator) for Year 3 and then assigned a new Supervisor for Year 4. This additional support was developed in response to feedback from academics and students which revealed a gap in longitudinal progress feedback.

The responsibilities of Academic Supervisors are clearly documented in a comprehensive handbook. An hour-long introductory session covers their roles, the curriculum, training on the portfolio and a handover feedback tool. The Academic Supervisors that the Team spoke to reported being well supported by the SMP. While some students reported varying experiences, overall, these positions are well regarded by students and other supervisors.

Similarly, for Clinical Supervisors employed directly by the University the educational responsibilities are defined in comprehensive documentation and well understood. There is a supporting introductory session covering the same ground as for Academic Supervisors. Clinical

Supervisors reported that they are given sufficient allocated time for teaching. These supervisors have ready access to and demonstrated an understanding of University processes. They reported receiving appropriate training to deliver teaching and clinical supervision and spoke very highly of the support from and engagement with the medical program.

The roles, responsibilities, training and evaluation of day-to-day supervisors who do not have a University appointment was less clear. Those supervisors who are not directly linked to the ANU are often highly valued by students as inspiring and engaged supervisors. However, they reported that they did not always have a clear understanding of the requirements of them and the objectives the students are required to achieve within their placement. Students reported similarly that there was an inconsistent approach to induction for placements and sometimes lack of clarity about which learning outcomes are expected to be achieved. The Program has begun to develop an induction overview including helpful prereading for each clinical placement and where these had been implemented there was positive feedback from supervisors and staff.

Clinicians have access to a range of training opportunities to support them in their teaching role:

- A two-part Teaching for Clinicians course of 12 hours offered to all doctors working across the health system from junior doctors to senior staff in the Canberra Region and Southern NSW Local Health District. It focuses on the key teaching skills required for clinical supervision in medicine across all specialties. The course is run by the Canberra Region Medical Education Council.
- Teaching in Medicine Pathway – Associate Fellowship of the Higher Education Academy (AFHEA). Doctors who have completed the Teaching for Clinicians course are eligible to apply for the Teaching in Medicine Pathway if they are actively teaching medical students in their clinical role.
- Web-based resources to support teaching in General Practice.
- A new community of educational practice that is developing training opportunities for clinicians within the Canberra Clinical School.
- The Australian Indigenous Doctors' Association cultural safety training has been offered to clinical skills tutors, Phase 1 and 2 academics and PBL facilitators.

The numbers of clinicians who have undertaken both parts of Teaching for Clinicians is impressive.

Monitoring of performance appears to relate mainly to student satisfaction through surveys (both end of term and real time polling). Many clinical supervisors that the Team spoke to would welcome opportunities to have peer evaluation of their teaching to strengthen their skills and confidence.

Appendix One Membership of the 2023 AMC Assessment Team

Professor Tony Celenza (Chair), Head, Division of Emergency Medicine, Anaesthesia and Pain Medicine, University of Western Australia

Professor Stuart Carney (Deputy Chair), Dean, Medical School, Faculty of Medicine, University of Queensland

Dr Sarah Chalmers, Senior Lecturer, General Practice Rural Medicine, College of Medicine and Dentistry, James Cook University & Medical Superintendent, Joyce Palmer Health

Mr Ashraf Docrat, Doctor of Medicine student, Griffith University

Professor Michelle Leech, Deputy Dean, Faculty of Medicine, Nursing and Health Sciences, Monash University

Associate Professor Jenepher Martin, Medical Education Research, Eastern Health Clinical School, Monash University & Consultant Breast Surgeon, Eastern Health

Associate Professor Julie Mudd, Academic Lead, Foundation Medical Studies, College of Medicine and Dentistry, James Cook University

Mr Donald Whaleboat, Senior Lecturer, College of Medicine and Dentistry & Indigenous Lead, Tropical Health and Medicine

Ms Kirsty White

Director, Standards and Accreditation, Australian Medical Council

Mr Daan Verhoeven

Manager, Medical School Assessments, Australian Medical Council

Ms Esther Jurkowicz

Program Support Officer, Australian Medical Council

Ms Georgie Cornelius

Program Co-ordinator, Accreditation Assessments, Australian Medical Council

Appendix Two Groups met by the 2023 Assessment Team

Meeting	Attendees
<i>Monday, 31 July 2023</i>	
<u>ANU Acton Campus</u>	
Acknowledgement of Country and Welcome	Director, School of Medicine and Psychology (SMP) School Manager, SMP Associate Director Education (Medicine) Education Manager Project Officer
Governance	Director, SMP School Manager, SMP Acting Head, Canberra Clinical School Head, Sydney Clinical School Head, Rural Clinical School Associate Director Education (Medicine) Associate Dean Phase 1 Associate Dean Phase 2 Head of Assessment and Admissions Associate Director Higher Degree by Research (HDR) Education Manager
Indigenous Strategy, School Perspective	Senior Lecturer Indigenous Health; Chair of Indigenous Health Framework SMP; Associate Dean First Nations, College of Health and Medicine (CHM) Lecturer, Indigenous Health and Wellbeing Lecturer, Indigenous Health Aboriginal and Torres Strait Islander Health and Student Development Officer
Professional Staff	School Manager, SMP Education Manager
College Executive	Dean, College of Health and Medicine General Manager, College of Health and Medicine
Curriculum	Associate Director Education (Medicine) Head of Assessment and Admissions Associate Dean Phase 1 Associate Dean Phase 2 Phase 1 Education Support Officer Clinical Education Co-ordinator Population Health Theme Chair Professionalism and Leadership Theme Chairs Clinical Skills Theme Chairs Medical Science Theme Chair Research Framework Chairs

Meeting	Attendees
	Indigenous Health Framework Chair Social Foundations of Medicine Framework Chairs Rural Medicine Framework Chair Project Officer
Tour of the Florey Building	Associate Director Education (Medicine) Education Manager Associate Dean Phase 1 Medical Science Theme Chair
Assessment	Head of Assessment and Admissions Associate Dean Phase 1 Associate Dean Phase 2 Education Manager Assessment and Evaluation Coordinator TELT Manager Learning Designer Learning Technologist Project Officer
Information Technology	School Manager, SMP TELT Manager IT Manager, SMP IT Support Officer Rural Clinical School Project Officer
Debrief with Director	Director, SMP School Manager, SMP Associate Director Education (Medicine) Education Manager Project Officer
<i>Tuesday, 1 August 2023</i>	
<u>ANU Acton Campus</u>	
Teaching and Learning	Associate Dean Phase 1 Associate Dean Phase 2 Population Health Theme Chair Professionalism and Leadership Theme Chairs Clinical Skills Theme Chair and Academic Coordinators Medical Science Theme Chair Research Framework Chair Indigenous Health Framework Chair Social Foundations of Medicine Framework Chair Rural Medicine Framework Chair Phase 1 Block Chairs (Blocks 1,2,3,4,5,6 &7)

Meeting	Attendees
	Phase 2 Block Chairs (ICCH, Medicine and Surgery, Acute Care, PAM, WHNBC) Associate Director Education (Medicine) Head of Assessment and Admissions Education Manager TELT Manager
Canberra Health Services	Chief Executive Officer, Canberra Health Services Executive Director, Office of Research and Education, Canberra Health Services
Rural Clinical School Overview	Head, Rural Clinical School Manager, Rural Clinical School RCS Lecturer Rural Education Co-ordinator (Rural Stream) Rural Education Co-ordinator (ICCH Rural)
Student Services	Education Manager Student Administration Coordinator Assessment and Evaluation Coordinator Technical Coordinator TELT Manager Learning Designer, TELT Clinical Education Coordinator Manager, Rural Clinical School RCS Admin Education Support SCS Clinical Education Coordinator SCS Clinical Skills Education Coordinator
Admissions and Selection	Head of Assessment and Admissions Associate Director HDR Senior Lecturer Indigenous Health; Chair of Indigenous Health Framework SMP; Associate Dean First Nations, CHM Student Administrative Officers
Student Support	Associate Director Professionalism and Performance SMP; Co-chair Professional Behaviour Committee Co-chair Professional Behaviour Committee Chairs of Professionalism and Leadership Theme Lecturer in Medical Education (Student Support) Associate Director Culture and Wellbeing Years 1-4 Medical Student Year Co-ordinators Student Administration Coordinator Rural Clinical School Associate Professor
Student Experience	President, ANU Medical Student Society (ANUMSS) Academic and Advocacy Officer, ANUMSS

Meeting	Attendees
	Years 1, 2, 3 & 4 Academic Representatives, ANUMSS Years 1, 2, 3 & 4 General Representatives, ANUMSS Year 3 Rural Representative, ANUMSS
Lunch with Students	ANUMSS Representatives Other Available Students
Chair of Academic Board	Chair, Academic Board
Research in the Curriculum	Associate Dean Phase 1 Research Project Convenor Advanced Research Project Convenor; Associate Director HDR Chair of Population Health Theme; Associate Professor in Population Health Lecturer in Population Health and Social Science Senior Lecturer in Population Health Phase 1 Education Support Officer Assessment and Evaluation Coordinator
Biomedicine Staff	Phase 1 Associate Dean; Lecturer in Anatomical Pathology Chair of Medical Science Theme; Associate Professor in Anatomy Teaching Staff Representing Pathology, Pharmacology, Physiology, Biochemistry, Immunology, Microbiology, Haematology Disciplines
<i>The Canberra Hospital</i>	
IPE Curriculum	Lecturer in Pharmacology; Lead of Phase 2 PAL Canberra Health Services IPL Coordinator
Simulation	Academic Coordinator Phase 2 Clinical Skills Academic Coordinator Year 2 Clinical Skills Academic Coordinator Year 1 Clinical Skills Clinical Skills Coordinator Chair of Clinical Skills Theme
<i>Weston Creek Medical Practice</i>	
General Practice	Director, Academic Unit of General Practice Associate Professor, Academic Unit of General Practice Clinical Supervisors, General Practice
<i>Wednesday, 2 August 2023</i>	
<u>The Canberra Hospital, Canberra Clinical School</u>	
Clinical School Leadership	Acting Head, Canberra Clinical School
Clinical Placement Supervision and Placement Strategy	Associate Dean Phase 2 Acting Head, Canberra Clinical School Clinical Education Coordinator Clinical Education Officer Associate Professor, Academic Unit of General Practice

Meeting	Attendees
Academic Staff and Clinical Title Holders	Acting Head, Canberra Clinical School Head, Academic Unit of General Practice Associate Dean Phase 2; Emergency Medicine Professor, Cardiology Professor, Psychiatry Professor, Haematology Doctor, Neurosurgery Professor, Gastroenterology Professor, Rheumatology
Students on Placement	President, ANUMSS Academic and Advocacy Officer, ANUMSS Year 3 General Representative, ANUMSS Year 4 Academic Representative, ANUMSS Year 3 Rural Representative, ANUMSS Year 3 Students Year 4 Students
Junior Medical Staff	Resident Medical Officer, Gastroenterology Canberra Health Services Intern Medical Officers, Canberra Health Services
General Practice Clinical Unit	Head, Academic Unit of General Practice (AUGP) Associate Professor, (AUGP) Senior Lecturers, (AUGP) Lecturer, (AUGP) Academic Registrar, General Practice Senior Lecturer, Indigenous Health
Virtual Meeting with North Canberra Hospital	Sub-Dean, North Canberra Hospital Education Manager Doctor, Geriatrics Doctor, Surgery Doctor, Gastroenterology Clinical Lecturer, North Canberra Hospital
<u>Rural Clinical School</u>	
Tour of South-East Regional Hospital (SERH)	Head, Rural Clinical School Manager, RCS Academic Co-ordinator (Bega) RCS Lecturer, Anaesthetics, RCS
Academic Staff and Clinical Titleholders and Hospital Executives	Head, RCS Manager, RCS Executive Director Medical Services, Southern New South Wales Local Health District (SNSW LHD) Site Manager, Bega SERH

Meeting	Attendees
	Acting Director Medical Services, SNSW LHD Coastal General Manager, SNSW LHD Coastal Chief Executive, SNSW LHD Head, Medical Ward SERH Head, Paediatrics, SERH Emergency Department Supervisor, SERH Year 4 Orthopaedics Supervisor, SERH Clinical Lecturer, RCS Senior Lecturer, RCS Lecturer, RCS
Clinical Placement Supervision and Strategy	Head, RCS Associate Professor, RCS Senior Lecturer, RCS Lecturer, RCS Manager, RCS Rural Education Coordinator (Rural Stream) Rural Education Coordinator (ICCH Rural) Academic Coordinator (Young) Academic Coordinator (Goulburn) Academic Coordinator (Cowra) Academic Coordinator (Eurobodalla) Academic Coordinator (Bega) Academic Coordinator (Cooma)
Students Currently on Placement	Year 3 Rural Stream Student (Cooma) Year 3 Rural Stream Students Year 4 Students
Academic Staff and Clinical Titleholders, Cooma	Academic Coordinator (Cooma) Lecturer, Obstetrics, RCS Lecturer, RCS Head, RCS Manager, RCS Administration Officer (Cooma)
Tour of facilities	Year 3 Rural Stream Students Year 3 ICCH Rural Students
<u>Sydney Clinical School (Virtually, via Zoom)</u>	
Clinical School Leadership, Academic	Head, Sydney Clinical School (SCS) Senior Lecturer, SCS Senior Lecturer, Clinical Skills and Simulation Learning Academic Lead, Medicine Academic Lead, Surgery Academic Lead, Acute Care

Meeting	Attendees
	Academic Lead, Women's Health and Newborn Care Clinical Education Coordinator Clinical Skills Education Coordinator Clinical Education Officer Director Research Development Clinical School Manager, SCS
Sydney Adventist Hospital Executives	CEO, Adventist HealthCare Limited (AHCL) Medical and Clinical Governance Executive (AHCL) Head, SCS
Students Currently on Placement	Year 3 Students Year 4 Students
Meeting with Indigenous Remote Health Services	Associate Professor, RCS Clinical Doctor, Yuendumu Clinic of NT Health Central Medical Director, Central Australia Congress Director Medical Services, Tennant Creek Hospital Deputy Director Medical Services, Tennant Creek Hospital
Indigenous Students	Year 1 Students Year 2 Student Year 3 Students
College of Health and Medicine, Associate Dean Education	CHM Associate Dean Education Director, SMP
College of Health and Medicine, Deputy Dean Health Professions	CHM Deputy Dean Health Professions
Remote Placement Students	Year 3 Students, Yuendumu Year 3 Students, Tennant Creek
Psychology Leadership	Deputy Director, SMP and Head of Psychology Associate Director Education (Psychology)
<i>Thursday, 3 August 2023</i>	
<u>ANU Acton Campus</u>	
Indigenous Strategy, University Perspective	ANU Vice President, First Nations Director, ANU Tjabal Centre First Nations Portfolio Executive Officer to the Vice Chancellor Associate Director, National Centre for Indigenous Studies
Vice Chancellor and President	Vice Chancellor and President
Associate Director Education (Medicine)	Associate Director Education (Medicine)

