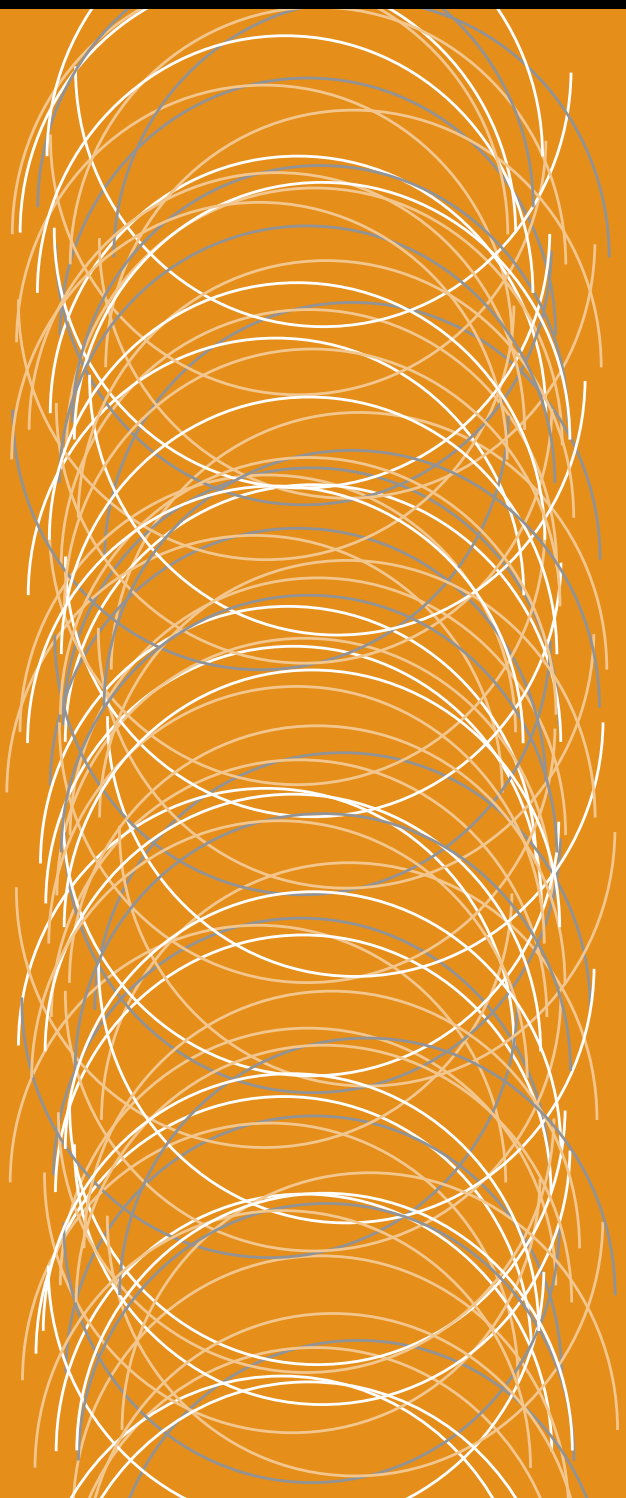
Australian Medical Council Limited

Accreditation of University of New South Wales Faculty of Medicine and Health medical programs

AMC



Medical School Accreditation Committee
December 2023

February 2024

ABN 97 131 796 980
ISBN 978-1-923118-10-2

Australian Medical Council Limited
PO Box 4810
KINGSTON ACT 2604

Email: amc@amc.org.au
Website: www.amc.org.au

Contents

List of Tables

List of Figures

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 Kensington campus of the University of New South Wales is located on the land of the Bidjigal people, and the Faculty of Medicine and Health operates across many lands across NSW.

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 Bachelor of Medical Studies and Doctor of Medicine (BMed MD) and Doctor of Medicine (MD) medical program of the University of New South Wales, Faculty of Medicine and Health expires on 30 June 2024.

An AMC team completed the Reaccreditation assessment. It reviewed the Faculty's submission and the student report and visited UNSW in Kensington and associated clinical teaching sites in the week of 25-29 September 2023.

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.

**In the case of UNSW, due to the short period of extension of three months granted in September 2022, accreditation may be granted for a period of up to five years and nine months.*

The AMC's finding is that the medical programs of the University of New South Wales substantially meets the approved accreditation standards.

AMC Directors, at their 8 February 2024 meeting resolved:

(i) that the medical programs of the University of New South Wales, Faculty of Medicine and Health substantially meet the accreditation standards,

(ii) that accreditation of the six-year Bachelor of Medical Studies and Doctor of Medicine (BMed MD) medical program of the University of New South Wales, Faculty of Medicine and Health be granted for five years and nine months, to 31 March 2030,

(iii) that accreditation of the three-year Doctor of Medicine (MD) medical program of the University of New South Wales, Faculty of Medicine and Health be granted for five years and nine months, to 31 March 2030; and,

(iv) that accreditation of the programs is subject to the following conditions and the monitoring requirements of the AMC.

To be satisfied by 2024	
3.	Demonstrate health consumer/community member representation within relevant governance structures, and consultation of health consumers/community on key issues including the purpose, curriculum, outcomes and governance. (Standard 1.1.2 and 1.1.3/2024 1.3.1 and 1.2.1) by 2024
8.	Urgently review the Aboriginal and/or Torres Strait Islander health curriculum, guided by the expertise of Aboriginal and/or Torres Strait academics and engagement with local Aboriginal communities, to ensure that AMC Graduate Outcome 3.4 is fully met, Aboriginal and/or Torres Strait Islander health pedagogies are reflected, and all course

	and assessment materials adopt a strengths-based orientation and are free from stereotypes and disrespectful, inappropriate and racist framing and language. (Standards 3.5 and 3.2 (2012 outcome 3.4)/2024 2.2.2, 2.2.3 and 2.2.8) by 2024
10.	Ensure that assessment items that include Aboriginal and/or Torres Strait Islander patients are fit for purpose and address learning outcomes. Establish a systematic approach to developing future Aboriginal and/or Torres Strait Islander health assessment scenarios for stereotyping and cultural safety that is led or overseen by Aboriginal and/or Torres Strait Islander people. (Standard 5.2.1/2024 3.1.4) by 2024
15.	Ensure that the process for identifying unprofessional student (or staff) behaviour is culturally safe and students are supported to raise their concerns without impacting their portfolio. (Standard 7.4.2/2024 4.3.2) by 2024

To be satisfied by 2025	
1.	Review, develop and formalise the Faculty of Medicine and Health governance structures and arrangements relevant to the medical program to ensure internal stakeholders can access and understand governance, and that accountability for decisions is clear. The steps of this process must be effectively communicated to all stakeholders. (Standard 1.1.1, 1.1.2 and 1.1.3/2024 1.3.1 and 1.2.1) by 2025
2.	Demonstrate that Aboriginal and/or Torres Strait Islander staff are represented in governance such that they have appropriate opportunities and authority to develop the Aboriginal and/or Torres Strait Islander health curriculum, student support and other areas of their portfolio, particularly so the program can address cultural safety risks. This should be supported by broad consultation with Aboriginal and/or Torres Strait Islander communities and organisations on whose country UNSW Medicine has a footprint. (Standard 1.1.2 and 1.1.3/2024 1.3.1 and 1.2.1) by 2025
4.	Evaluate needs, and design strategies, to ensure the educational expertise of Aboriginal and/or Torres Strait Islander staff is effectively utilised to guide the development and management of the medical program, including having adequate support in place for these roles to effectively participate in this governance and the program redesign. (Standard 1.4.1/2024 1.4.4 and 5.2.4) by 2025
6.	Demonstrate processes for and outcomes of increased support for Aboriginal and/or Torres Strait Islander staff, listening to and hearing from them, including the development and implementation of a business case for the expansion of the Indigenous Health and Wellbeing Unit. (Standard 1.8.3/2024 5.2.3) by 2025
11.	Establish and implement a clear and formalised program evaluation strategy and processes for the implementation of the evaluation framework, led through the Faculty governance structure. This should be designed to support an evidence-based revision of the medical program and include outcome evaluation. (Standards 6.1.1 and 6.2.2/2024 6.1.1 and 6.2.2) by 2025
12.	Ensure that relevant external stakeholders have consistent access to evaluation findings and outcomes, and the medical program demonstrates responsiveness to their input. (Standard 6.3.2/2024 6.2.3) by 2025
13.	Ensure the strategic provision of adequate support for students who access the program through targeted access schemes, particularly culturally safe support services for Aboriginal and/or Torres Strait Islander students. (Standard 7.1.2, 7.1.3, 7.2.3 and 7.3.2/2024 4.1.3, 4.2.1, 4.2.3 and 4.1.4) by 2025

14.	Ensure sufficient resourcing such that the Faculty and support staff can meet student needs and have time to review, learn from and improve the service by undertaking a strategic approach to operationalising student support in the medical program. (Standard 7.3.1/2024 4.2.2) by 2025

To be satisfied by 2026	
5.	Engage with the Aboriginal and/or Torres Strait Islander health sector and local Aboriginal communities to promote the education and training of medical graduates and increase the medical program's responsiveness to the health needs of those communities in the various sites where the medical program is delivered. (Standard 1.6.2/2024 1.2.3) by 2026
9.	Develop and implement a systematic, comprehensive, evidence-based approach to ensure that students work with, and learn from and about other health professionals (ideally with students from multiple professions), including experience working and learning in interprofessional teams. (Standard 4.7 and 3.2 (2012 outcome 4.8)/2024 2.3.3 and 2.2.8 (2024 outcomes 2.2, 2.6 and 2.12)) by 2026.
16.	Guided by Aboriginal and/or Torres Strait Islander staff, create adequate opportunities in mainstream health services and, where possible, in community health services, for students to experience the provision of culturally safe health care to Aboriginal and/or Torres Strait Islander people. (Standard 8.3.3/2024 5.4.2) by 2026

To be reported on annually	
7.	Provide data and evaluation on the outcomes of each cohort when they are available. (Standard 2.2.3/2024 2.1.2) (To be reported in annual monitoring submissions.)

Key findings

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

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

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

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

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

Standards 1.1, 1.4.1, 1.6.2 and 1.8.3 are substantially met

Conditions

1. Review, develop and formalise the Faculty of Medicine and Health governance structures and arrangements relevant to the medical program to ensure internal stakeholders can access and understand governance, and that accountability for decisions is clear. The steps of this process must be effectively communicated to all stakeholders. (Standard 1.1.1, 1.1.2 and 1.1.3/2024 1.3.1 and 1.2.1) by 2025
2. Demonstrate that Aboriginal and/or Torres Strait Islander staff are represented in governance such that they have appropriate opportunities and authority to develop the Aboriginal and/or Torres Strait Islander health curriculum, student support and other areas of their portfolio, particularly so the program can address cultural safety risks. This should be supported by broad consultation with Aboriginal and/or Torres Strait Islander communities and organisations on whose country UNSW Medicine has a footprint. (Standard 1.1.2 and 1.1.3/2024 1.3.1 and 1.2.1) by 2025
3. Demonstrate health consumer/community member representation within relevant governance structures, and consultation of health consumers/community on key issues including the purpose, curriculum, outcomes and governance. (Standard 1.1.2 and 1.1.3/2024 1.3.1 and 1.2.1) by 2024
4. Evaluate needs, and design strategies, to ensure the educational expertise of Aboriginal and/or Torres Strait Islander staff is effectively utilised to guide the development and management of the medical program, including having adequate support in place for these roles to effectively participate in this governance and the program redesign. (Standard 1.4.1/2024 1.4.4 and 5.2.4) by 2025
5. Engage with the Aboriginal and/or Torres Strait Islander health sector and local Aboriginal communities to promote the education and training of medical graduates and increase the medical program's responsiveness to the health needs of those communities in the various sites where the medical program is delivered. (Standard 1.6.2/2024 1.2.3) by 2026
6. Demonstrate processes for and outcomes of increased support for Aboriginal and/or Torres Strait Islander staff, listening to and hearing from them, including the development

and implementation of a business case for the expansion of the Indigenous Health and Wellbeing Unit. (Standard 1.8.3/2024 5.2.3) by 2025

Recommendations

A. Review the positioning of and/or communication around the General Practice Unit being placed outside the School of Clinical Medicine. (Standard 1.1.1/2024 1.3.1)

B. Communicate to internal stakeholders the decision-making responsibilities and accountabilities of the academic head of the medical program and other key leadership roles. (Standard 1.2.2/2024 1.4.2)

C. Provide secretariat support to the Curriculum Development Committee and review the framing of its terms of reference to ensure that the committee's functions are clearly stated and that it can carry out these functions effectively. (Standard 1.3.1 and 1.1.1/2024 1.3.1 and 1.3.2)

D. To complement ambitious aims for increased diversity, look at how the Faculty supports those students who have increasing needs, such as reviewing the workload of the Wellbeing Officer. (Standard 1.8.1/2024 5.2.1)

Commendations

- The strong and productive relationships the Faculty has built with key partners including health service and local health district partners, the local community in Wagga Wagga through the School Oversight Council, and the La Perouse Bidjigal community. (Standard 1.6.1/2024 1.2.2)
- The drive, commitment and passion of professional staff and leadership, who have delivered the recent restructures positively. (Standard 1.8.2/2024 5.2.2)
- The investment in and commitment to professional staff development opportunities. (Standard 1.9.2/2024 5.3.2)

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

Standard 2.2.3 is substantially met

Conditions

7. Provide data and evaluation on the outcomes of each cohort when they are available. (Standard 2.2.3/2024 2.1.2) (To be reported in annual monitoring submissions.)

Recommendations

E. Work with Aboriginal and/or Torres Strait Islander staff and communities to define how they will provide leadership and evaluative feedback to drive the implementation of the Health 25 Strategy. (Standard 2.1.4/2024 1.1.2).

F. Increase the variability of methods of access to tutorials and simulation learning across different sites. (Standard 2.2.3/2024 2.1.2).

Commendations

- The communication with the UNSW community and engagement both internally and externally around the Health 25 Strategy. (Standard 2.1.3/2024 1.2.1)

3. The medical curriculum	Substantially Met

Standard 3.2 is substantially met

Standard 3.5 is not met

Conditions

8. Urgently review the Aboriginal and/or Torres Strait Islander health curriculum, guided by the expertise of Aboriginal and/or Torres Strait academics and engagement with local Aboriginal communities, to ensure that AMC Graduate Outcome 3.4 is fully met, Aboriginal and/or Torres Strait Islander health pedagogies are reflected, and all course and assessment materials adopt a strengths-based orientation and are free from stereotypes and disrespectful, inappropriate and racist framing and language. (Standards 3.5 and 3.2 (2012 outcome 3.4)/2024 2.2.2, 2.2.3 and 2.2.8) by 2024

Recommendations

G. Revise the general approach to development and delivery of Aboriginal and/or Torres Strait Islander health learning and assessment activities to enable a culture in which this area of work is seen as the responsibility of the whole educational team, guided by Aboriginal and/or Torres Strait Islander academics, rather than this work being primarily seen as for the Aboriginal and/or Torres Strait Islander staff to do. (Standard 3.5/2024 2.2.2 and 2.2.3)

H. Further efforts to design an educational program which builds cultural safety and reflective practice skills appropriately. (Standard 3.5 and 3.2/2024 2.2.2, 2.2.3 and 2.2.8)

I. Review the ways in which the required learning outcomes for the program are communicated to learners and teachers to improve clarity about what students need to learn in order to meet the outcomes. (Standard 3.4/2024 2.2.9)

J. Investigate the feasibility of providing regular short opportunities to continue learning in clinical settings while undertaking the research project in Year 4 of the program. (Standard 3.6/2024 2.2.10)

4. Teaching and learning	Substantially Met

Standard 4.7 is substantially met

Conditions

9. Develop and implement a systematic, comprehensive, evidence-based approach to ensure that students work with, and learn from and about other health professionals (ideally with students from multiple professions), including experience working and learning in interprofessional teams. (Standard 4.7 and 3.2 (2012 outcome 4.8)/2024 2.3.3 and 2.2.8 (2024 outcomes 2.2, 2.6 and 2.12)) by 2026

Recommendations

K. Broaden the diversity of simulated patients with whom students interact during learning activities in order to enhance their ability to engage effectively with patients from a wide range of backgrounds. (Standard 4.4/ 2024 2.3.5)

5. The curriculum – assessment of student learning	Substantially Met

Standard 5.2 is substantially met

Conditions

10. Ensure that assessment items that include Aboriginal and/or Torres Strait Islander patients are fit for purpose and address learning outcomes. Establish a systematic approach to developing future Aboriginal and/or Torres Strait Islander health assessment scenarios for stereotyping and cultural safety that is led or overseen by Aboriginal and/or Torres Strait Islander people. (Standard 5.2.1/2024 3.1.4) by 2024

Recommendations

L. Establish a governance process to oversee all assessment, including formative assessment and assessment across sites. This process should focus on facilitating the move to programmatic assessment and ensuring good balance and reasonable assessment burden for students. (Standard 5.1/2024 Standard 3.1)

M. Evaluate the impact and alignment of the Year 5 Biomedical Science Viva and other high-stakes exams in Phase 3, in terms of its fitness for purpose to assess the intended learning outcomes. (Standard 5.2.1/2024 Standard 3.1.4)

N. Through the process for oversight of assessment, document a formalised process for timely identification of underperforming students. (Standard 5.3.1/2024 Standard 3.2.2)

Commendations

- Securing University-level policy support to keep abreast of developments in assessment, for example, enabling the implementation of programmatic assessment methodologies. (Standard 5.1/2024 Standard 3.1)

6. The curriculum – monitoring	Substantially Met

Standards 6.1.1, 6.2.2 and 6.3.2 are substantially met

Conditions

11. Establish and implement a clear and formalised program evaluation strategy and processes for the implementation of the evaluation framework, led through the Faculty governance structure. This should be designed to support an evidence-based revision of the medical program and include outcome evaluation. (Standards 6.1.1 and 6.2.2/2024 6.1.1 and 6.2.2) by 2025

12. Ensure that relevant external stakeholders have consistent access to evaluation findings and outcomes, and the medical program demonstrates responsiveness to their input. (Standard 6.3.2/2024 6.2.3) by 2025

Recommendations

O. Review the terms of reference for the Program Evaluation and Implementation Group. The aim is to ensure independence from operational delivery of the program, to ensure broad representation across the membership, and to provide a focus on receiving and reviewing the breadth of evaluation data available in order to make recommendations to the Curriculum Development Committee. (Standard 6.1.1/2024 6.1.1)

P. Consider ways to implement broader use of the Perceived Effectiveness of Clinical Teaching Scale evaluation tool and to encourage sharing of those data, as part of the evaluation strategy. (Standard 6.1.2/2024 6.1.2)

Commendations

- There is a systematic approach to analysis of student characteristics across cohorts and the relationship to performance in the course, including informing approaches to admissions and selection processes. (Standard 6.2.3/2024 6.2.3)

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

Standards 7.1.2, 7.1.3, 7.2.3, 7.3.1, 7.3.2 and 7.4.2 are substantially met

Conditions

13. Ensure the strategic provision of adequate support for students who access the program through targeted access schemes, particularly culturally safe support services for Aboriginal and/or Torres Strait Islander students. (Standard 7.1.2, 7.1.3, 7.2.3 and 7.3.2/2024 4.1.3, 4.2.1, 4.2.3 and 4.1.4) by 2025
14. Ensure sufficient resourcing such that the Faculty and support staff can meet student needs and have time to review, learn from and improve the service by undertaking a strategic approach to operationalising student support in the medical program. (Standard 7.3.1/2024 4.2.2) by 2025
15. Ensure that the process for identifying unprofessional student (or staff) behaviour is culturally safe and students are supported to raise their concerns without impacting their portfolio. (Standard 7.4.2/2024 4.3.2) by 2024

Recommendations

Q. Define and describe the target for recruitment and graduation of Aboriginal and/or Torres Strait Islander students to support a strategic approach for recruiting and retaining these students. (Standard 7.1.2/2024 4.1.3)

R. Formalise the mechanism for identifying and supporting students at risk. (Standard 7.3/2024 4.2).

S. Review and communicate about the Faculty's complaints process to ensure that students know who key contact people are and that complaints are handled fairly, consistently and appropriately. (Standard 7.3.4/2024 4.2.6)

Commendations

- The strength of the relationship between the Faculty and MedSoc. (Standard 7.5/2024 1.3.4)

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

Standard 8.3.3 is substantially met

Conditions

16. Guided by Aboriginal and/or Torres Strait Islander staff, create adequate opportunities in mainstream health services and, where possible, in community health services, for students to experience the provision of culturally safe health care to Aboriginal and/or Torres Strait Islander people. (Standard 8.3.3/2024 5.4.2) by 2026

Recommendations

T. Address the reliability of information communication technology infrastructure to ensure it is adequate and comparable across teaching sites. (Standard 8.2.1/2024 5.1.4)

U. Ensure greater opportunities for student clinical experiences in primary care. (Standard 8.3.2/2024 2.3.8)

V. Undertake higher-level engagement among medical education providers to ensure ongoing adequacy of clinical facilities. (Standard 8.3.4/2024 5.4.3)

Commendations

- The consistent quality of physical facilities in learning sites away from the main Kensington campus, particularly at Liverpool Hospital. (Standard 8.1/ 2024 5.1)
- The commitment of Clinical Teaching Support professional staff to providing high-quality and supportive clinical experiences to students. (Standard 8.3/2024 5.4)

Introduction

The AMC accreditation process

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

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

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

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

The AMC appoints an accreditation assessment team to complete a reaccreditation assessment. The medical education provider's accreditation submission forms the basis of the assessment. The medical student society is also invited to make a submission. Following a review of the submissions, the team conducts a visit to the medical education provider and its clinical teaching sites. This visit may take a week. Following the visit, the team prepares a detailed report for the Medical School Accreditation Committee, providing opportunities for the medical school to comment on successive drafts. The Committee considers the team's report and then submits the report, amended as necessary, together with a recommendation on accreditation to the AMC Directors. The Directors make the final accreditation decision within the options described in the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 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 Faculty and the School

The University of New South Wales (UNSW) traces its origins back to 1949, and today, the UNSW Faculty of Medicine and Health stands as a prominent medical school in Australia. Over the years, the Faculty has continued to expand, attracting and graduating students from diverse backgrounds, both domestic and international. Notably, the Faculty has a strong commitment to supporting students from rural areas through initiatives such as the Rural Student Entry Scheme (RSES) and the Rural Clinical Campuses.

In 2020, UNSW underwent a structural transformation that led to the merger of the Faculty of Medicine with the School of Optometry and Vision Science and School of Health Science. This significant change resulted in the renaming of the Faculty of Medicine to the Faculty of Medicine and Health.

The Faculty of Medicine and Health is one of seven faculties within the University, each offering a distinct area of expertise and study:

- UNSW Arts, Design and Architecture
- UNSW Business School
- UNSW Engineering
- UNSW Law and Justice
- UNSW Medicine and Health
- UNSW Science
- UNSW Canberra, the Australian Defence Force Academy (ADFA).

The primary campus for the Faculty of Medicine and Health is located in Kensington, Sydney. It is overseen by a Dean and comprises five schools, each providing students with valuable clinical exposure.

- School of Biomedical Sciences
- School of Clinical Medicine
- School of Health Sciences
- School of Optometry and Vision Science
- School of Population Health.

Students enrolled in the Faculty have the opportunity for hands-on clinical exposure, enhancing their educational experience.

The Faculty offers a diverse range of programs, including nine undergraduate programs and ten postgraduate coursework programs. In 2022, there were 4,725 students enrolled in coursework programs, including 1684 Medicine students, 437 Exercise Physiology students, 522 Optometry and Vision Science students, 85 International Public Health students and 1983 postgraduate coursework students.

As of January 2023, the Faculty boasts a team of 676 FTE academics. This group comprises 418 males (332 FTE positions; 49%) and 447 females (344 FTE positions; 51%). Academic positions are categorised as teaching/research, research only or education-focused. There are currently 181 academic staff (148 FTE; 22%) dedicated to teaching/research and 471 staff focus on research only.

The Faculty places a strong emphasis on student support and wellbeing by incorporating relevant learning activities into the curriculum. These activities address aspects like self-care, stress management, work-life balance, and the handling of issues such as bullying and harassment. In 2018, the Student Wellbeing Action Group (SWAG) was established conjunction with the UNSW Medical Society (MedSoc), emphasising the inclusion of students as vital members of the governance committee.

The Faculty medical program offers a 6-year Bachelor of Medical Studies and Doctor of Medicine (BMedMD) and 3-year graduate entry stream leading to the Doctor of Medicine (MD) qualification.

The BMedMD is delivered in three phases of equal duration. Phase 1 consists of eight modules across Years 1 and 2. Phase 2 is conducted in Years 3 and 4 and centres on research and practice-based learning. Phase 3 sees students immersed in clinical learning environment in hospital-based, ambulatory and general practice settings.

In 2023, the Faculty launched three 5-year Bachelor/Master programs in Nutrition/Dietetics and Food Innovation, Pharmaceutical Medicine/Pharmacy and Exercise Science/Physiotherapy and

Exercise Physiology, as well as a new Applied Exercise Science/Clinical Exercise Physiology program, which replaces the previous Bachelor program in Exercise Physiology.

Accreditation Background

Year	Assessment Type	Outcome/Notes
1990	Initial Accreditation	Granted accreditation of the six-year MBBS for five years to 30 June 1995.
1993	Follow-up Assessment	Extension of accreditation of the six-year MBBS to ten years to 30 June 2000.
2000	Reaccreditation Assessment	Granted accreditation of the six-year MBBS for six years to 31 July 2006.
2003	Material Change – Introduction of four-year MBBS	Granted accreditation of the four-year MBBS to 31 December 2011 (two full years after the full course implementation).
2004	Follow-up Assessment	Confirmed the 2003 accreditation decision of the four-year MBBS.
2006	Notice of Change – Introduction of four-year MBBS	
2006	Material Change – Introduction of BMedSc	Granted accreditation for five years to 31 December 2011.
2010	Comprehensive Report	Extension of the six-year and four-year MBBS programs to 31 December 2013.
2012	Progress Report	Accepted.
2012	Notice of Change – Introduction of BMedMD and MD	Minor change, not considered a material change.
2013	Reaccreditation Assessment	Granted accreditation of all programs for six years to 31 March 2020.
2015	Progress Report	Accepted.
2016	Progress Report	Accepted.
2016	Notice of Change – Delivery of Years 1 to 6 of the program at Port Macquarie	Not considered to be a material change.
2017	Progress Report	Accepted.
2018	Progress Report	Accepted.
2019	Comprehensive report for extension of accreditation	Extension of the six-year BMedMD and three-year MD to 31 March 2024 and MBBS to 31 March 2022. Moved to biennial reporting.
2020	Material Change – MDMSN at Wagga Wagga	Accreditation confirmed to 31 March 2024.
2021	Progress report	Accepted.
2022	Monitoring submission	Accepted.
2022	Administrative extension of accreditation	Extension of accreditation of all programs to 30 June 2024.

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 AMC team in 2023 in New South Wales are at **Appendix Two**.

Appreciation

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

1 The context of the medical program

1.1 Governance

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

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

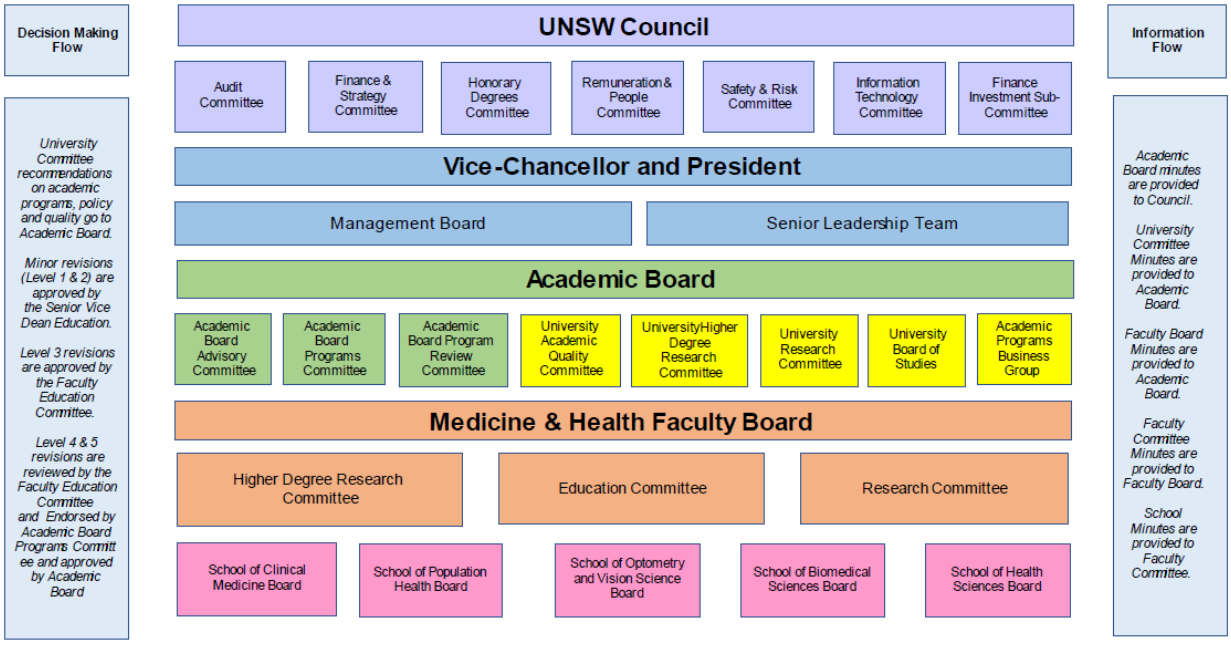
1.1.3 The medical education provider consults relevant groups on key issues relating to its purpose, the curriculum, graduate outcomes and governance.

The University of New South Wales (UNSW) is governed by a Council of 15 members chaired by the UNSW Chancellor. The Vice-Chancellor and President is the principal executive officer of the University and is responsible for the overall direction of corporate planning, budget activities and external relations. The Vice-Chancellor and President leads the UNSW Management Board of senior University leaders. These include the Provost and Deputy Vice-Chancellors responsible for University-wide portfolios.

The Academic Board is the principal academic body of the University responsible for approving academic proposals, including those for new courses and major changes to existing courses, and for providing advice on academic policy, strategy and standards.

Below this structure are the six Faculties of UNSW, including the Faculty of Medicine and Health (see Figure 1).

Figure 1 Overview of UNSW Medicine and Health Governance Framework



The UNSW Medicine Program (the medical program), delivered as a combined BMed MD program, is based in and provided by the Faculty of Medicine and Health. It is largely a school-leaver program, although some students enter through a graduate entry pathway or transfer from one of two international medical programs. The Faculty was named the Faculty of Medicine until 2020 when it expanded to include the School of Optometry and Vision Science, and the creation of the School of Health Sciences. In 2021, the seven previous clinical and discipline Schools were merged into a

single School of Clinical Medicine (SoCM). There are now five Schools within the Faculty, the other two being the School of Biomedical Sciences (SBMS) and School of Population Health (SPH).

All the Schools contribute to the delivery of the medical program. The SoCM has the largest role in the program, hosting all clinical disciplines except General Practice, which is based in the SPH. The SBMS contributes substantially to medical science learning and teaching in the medical program.

The consolidation of individual clinical schools into a combined SoCM has generally been well received. However, the Team heard from some stakeholders that they perceive the placing of General Practice outside of the SoCM in the SPH as devaluing the discipline of primary care.

The Faculty is overseen by the Faculty Board. Board membership includes the Dean, who leads the Faculty and is responsible and accountable for the medical program. It also includes senior Faculty leaders and nominees from academic staff and the student body. The Board provides advice to the Dean and oversight of the academic governance arrangements at a high level.

The Faculty Board delegates decisions on academic matters to the Faculty Education Committee, which is chaired by the Senior Vice Dean (Education). Committee membership includes Faculty leadership with academic portfolios, professional staff leadership and student representatives.

The Curriculum Development Committee (CDC) is responsible for the ongoing evaluation of the medical program specifically, reporting into the Faculty Education Committee and Dean. The CDC is chaired by the Program Authority, who has responsibility for the development and implementation of the medical program. The CDC is where the subcommittees of the medical program and working parties come together to make decisions on and develop proposals for the delivery of the medical program (see Figure 2).

The delivery of the curriculum is divided into three blocks of two years, Phases 1–3. Each Phase is managed by a Phase Committee, which is chaired by the Phase Co-Convenors. Course Convenors represent individual Courses on the Phase Committees, and the Courses are developed and managed by Design and Implementation Groups (DIGs). The Phase Committees also include representatives of the vertical elements in the program, representatives from relevant campuses and major disciplines, student representatives and teaching support team members. Other committees have responsibility for aspects of student recruitment, assessment, simulation, and the Year 4 Independent Learning Project. Working Groups provide advice on evaluation, student wellbeing, professionalism and Aboriginal and/or Torres Strait Islander health.

Internal stakeholders had mixed views of how well they understood the governance structures and whether they were appropriately formalised to allow them to provide relevant and timely influence on decision-making. In particular, many stakeholders were unclear about where key decisions were made in the governance structure, making it challenging for them to know where to bring feedback, proposals and policy reform ideas. The Team noted informality around decision-making processes and secretariat support and procedures for committees, particularly considering the large size of the medical program and complexity of delivery across multiple sites. The terms of reference, minutes and agendas provided to the Team showed an inconsistent approach to committee management.

The core Faculty committee structure has remained relatively constant and centralised since the inception of the medical program. The recent addition of other health profession programs to the Faculty has expanded the responsibilities of the Senior Vice Dean (Education) and the Faculty Education Board. In 2013, the Faculty had 2950 enrolled students which included 1667 medical students, while in 2022, the Faculty had 4725 enrolled students with 1684 of these being medical students. The number of enrolments has continued to increase with the introduction of new health professional education programs in nutrition and pharmacy into the Faculty in 2023. In addition to the opportunities for change presented by the expansion of the education programs other than the medical program, the medical program is undergoing a redesign, providing further impetus to consider a review of, and changes to, the governance structure.

The Faculty should review, develop and formalise its governance structure to ensure the needs of the medical program and internal stakeholders can continue to be met. This process should be effectively communicated to all stakeholders.

Student representatives and many groups of academic staff, including those from geographically dispersed sites and different discipline areas and Schools, are well represented at various levels in program governance. The health sector, including clinicians, Local Health Districts and government, are also consulted and represented in governance appropriately.

The Team considered that the representation of, and ability to participate in, decision-making for Aboriginal and/or Torres Strait Islander staff is inadequate. While the Associate Dean (Indigenous) participates in Faculty governance at a high level, his ability to hold the entire weight of the needs of the medical program has been compromised with secondments to University-level Aboriginal and/or Torres Strait Islander leadership roles and a large work portfolio. The remaining small Aboriginal and/or Torres Strait Islander team is not consistently able to access governance bodies. The Team heard several examples of cultural safety risks that had not been addressed due to this lack of representation and involvement in decision-making.

The Faculty should ensure Aboriginal and/or Torres Strait Islander staff are represented in governance such that they have appropriate opportunities and authority to develop the Aboriginal and/or Torres Strait Islander health curriculum, student support and other areas of their portfolio, particularly so the program can address cultural safety risks.

Health consumers and local communities are represented in the governance of rural campuses through innovative and inclusive arrangements. These include the School Oversight Council at the Wagga Wagga campus, and the Community Liaison Committee at the Albury-Wodonga campus.

Community members are also involved in admissions as interview panel members.

Health consumer and community member consultation and representation is largely limited to the rural campuses. With the exception of a high-level relationship between a group of Bidjigal Elders and Faculty leadership, there are no consumer or community members on central governance bodies related to the medical program.

The Faculty should identify groups of health consumers and community members who are served by the medical program and ensure that they are adequately consulted on key issues and represented appropriately in governance.

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 Dean leads the Faculty and is responsible and accountable for the medical program as the head of the program. The Dean is supported operationally by the Faculty Leadership Team which includes the Senior Vice Deans, Faculty Executive Director, Deputy Faculty Executive Director, Director Strategy & Precincts, Head of Schools and Centre Directors. The Dean and the Leadership Team together acting as the Faculty have sufficient budgetary autonomy and academic independence to design and develop the medical program.

The Senior Vice Dean (Education) provides overall academic leadership and is responsible for developing and implementing educational strategies and policies for all Faculty education programs as the Chair of the Faculty Education Committee.

The Program Authority has responsibility for the development and implementation of the medical program and is chair of the CDC, which reviews the development, implementation and evaluation of the program.

Decisions that require strategic input are taken to Faculty Executive by the Senior Vice Dean (Education), who is a member of the CDC. The Faculty Executive is a smaller subgroup of the Faculty Leadership Team. Both groups are chaired by the Dean. Higher level strategic decisions are brought by the Dean to the University-level Senior Leadership Team.

Stakeholders delivering the medical program understand that the Dean is accountable for the medical program, but the Team noted that many stakeholders refer to the Senior Vice Dean (Education) as having authority over many key aspects of the medical program. Internal stakeholders lack clarity around which key people make, and are responsible for implementing, decisions. In particular, there is confusion around the responsibilities and accountabilities of the three key executive roles: the Program Authority, the Senior Vice Dean (Education) and the Dean.

1.3 Medical program management

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

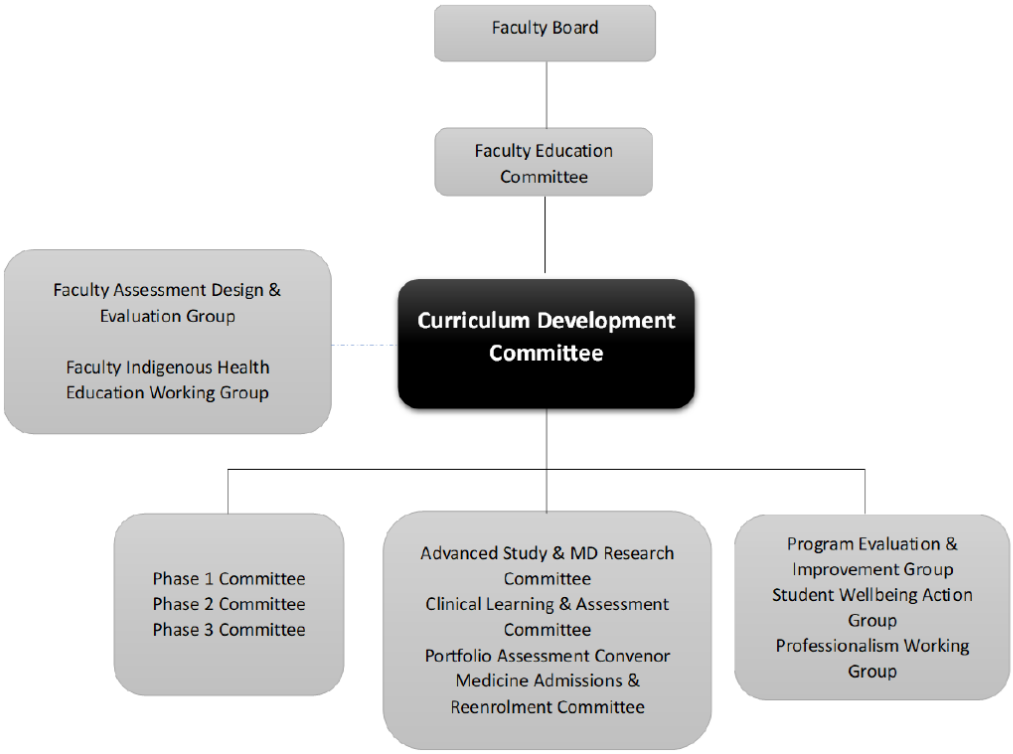
1.3.2 The medical education provider assesses the level of qualification offered against any national standards.

The responsibility to plan, implement and review the curriculum to achieve the objectives of the medical program sits with the CDC. The CDC delegates responsibilities for some specific planning, implementation and review activities to the Phase Committees and other committees. It receives advice from a range of working parties. The CDC reports to the Faculty Education Committee (see Figure 2).

Formal decisions on proposed revisions to the program are referred up, being ultimately reviewed and approved by the Chair of the Faculty Education Committee (the Senior Vice Dean (Education)), the whole Faculty Education Committee, or the Academic Board, depending on the nature and level of the proposals.

The CDC has gained increasing responsibility and primacy in the program's governance structure over time, while maintaining a degree of informality. While the centralisation of authority appears to work well for the dispersed medical program, the Team considers that secretariat support for, and increased formality of, decision-making within the CDC would help the Committee to action proposals and effectively communicate its role and outcomes.

Figure 2 Curriculum Development Committee reporting lines



The Faculty is undertaking a medical program redesign process, due to be completed in 2026. Substantial work on the redesign has been paused pending the arrival of the incoming Associate Dean Education (Innovation), who will lead the redesign.

The Faculty indicated that the medical program degree (BMed MD) meets the Australian Qualifications Framework Level 9 requirements for a Masters qualification.

1.4 Educational expertise

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

The Team noted the high quality of educational expertise that is available for the development and management of the medical program. The interim Dean has particularly notable educational expertise and provides leadership in this space. The Office of Medical Education, led by the Senior Vice Dean (Education), provides substantial academic leadership and supports academic staff in their professional development and the pursuit of innovation and research in education. The establishment of the Medicine & Health Education Academy in 2021 promises to further foster educational expertise in the program, though the Team found limited evidence of activity by the Academy during the assessment visit. The Team noted that the Faculty has recently filled the vacant Association Dean Education (Innovation) position, which has a key role in this space.

The education expertise of the small number of Aboriginal and/or Torres Strait Islander academic staff is not effectively used in the development and management of the medical program. The Aboriginal and/or Torres Strait Islander staff across the Faculty lack the necessary support to be able to input effectively. Staff do not have sufficient authority or resources to be able to provide input on key areas related to Aboriginal and/or Torres Strait Islander health curriculum and wellbeing, and do not have good information on where to leverage their expertise to contribute to the curriculum model and governance.

The Team heard evidence and examples that Aboriginal and/or Torres Strait Islander staff expertise is not consistently listened to, and that staff must often make a place for themselves in management/governance or risk being involved in a tokenistic manner. For example, Aboriginal and/or Torres Strait Islander staff have raised at various levels that some Aboriginal and/or Torres Strait Islander health curriculum content is based on stereotypes and therefore is not culturally safe. The program has been slow to address these issues, allowing inappropriate and deficient content to continue to be taught to new student cohorts despite staff being clear about the harm that the content poses.

The Team was encouraged that members of University, Faculty and medical program leadership acknowledged this shortcoming and outlined a clear intention to make the Faculty a place where Aboriginal and/or Torres Strait Islander staff and students felt culturally safe. They acknowledged that they bore responsibility for furthering the Aboriginal and/or Torres Strait Islander health curriculum and wellbeing. The Faculty must urgently and authentically listen to its Aboriginal and/or Torres Strait Islander staff and strategically address the shortcomings around representation, authority and resources to ensure that the outcomes of the medical program can be met.

1.5 Educational budget and resource allocation

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

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

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

The medical program has a budget allocated at a Faculty level with revenue from a number of sources. This includes teaching revenue, University Strategic Funds budgets and capital expenditure budgets. The University budget model is flexible in response to movements in student load, to ensure teaching-related costs are covered and staff to student ratios are maintained.

Budget parameters are set annually by the UNSW Management Board, and budgets of faculties are then set through a collaborative and iterative process. The University approach to budgets, with a quarterly forecast, allows for agility in responding to requests for additional spending.

The Dean is responsible for the overall financial management of the Faculty and has discretion regarding how budgets are allocated within the Faculty. The Dean works in collaboration with the Heads of Schools (and Centres and Units) and the Faculty Leadership Team to manage the Faculty's budget. Heads of Schools report to the Dean and are accountable for the financial management of their respective Schools. Any changes to allocation or short-term resourcing issues are typically able to be resolved within the annual budget. Major resourcing requests are made as part of the annual budget process.

Leaders and staff indicated consistently that the medical program is well resourced and sustainable. The Faculty acknowledged that the establishment of new health professional education programs, as well as reduced public research infrastructure funding, presented financial risks. The Faculty appeared well equipped to deal with these risks.

UNSW Finance and the Medicine Finance Unit provides sufficient financial management capacity and accounting services to sustain the medical program and manage risks.

1.6 Interaction with health sector and society

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

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

The medical program has built strong and productive relationships with health services and Local Health Districts, appropriately supported by formal agreements. Relationships with communities local to the Rural Clinical Campuses are robust. These relationships are exemplified by the deep involvement of community members through the UNSW Riverina Medical School Oversight Committee, which advises the program's Wagga Wagga campus, and engagement with local Aboriginal Community Controlled Health Organisations (ACCHOs) at many of the rural sites.

The Rural Clinical Campuses have these partnerships with ACCHOs, and there are opportunities to deepen and, for other parts of the Faculty, to build these collaborations. Relationships are also being built with Aboriginal and/or Torres Strait Islander staff and health practitioners in mainstream health services. Faculty leaders and staff perceive the existing relationships and potential for new relationships as being limited by capacity concerns and local politics. The Faculty should consider how it can create mutual benefit for ACCHOs and health service staff, for instance through providing resources and professional development opportunities, to enable effective partnerships.

The Faculty has an exemplary relationship with the La Perouse Bidjigal community and a group of Elders. The Elders facilitate an immersive on-Country experience for Year 1 medical students and provide cultural guidance to leaders and staff.

Acknowledging that these community and health sector relationships take time and continual effort to build – particularly the time and effort of Aboriginal and/or Torres Strait Islander staff of the Faculty – the Team looks forward to being updated on the continuous building of effective partnerships to ensure consistent opportunities for medical students.

1.7 Research and scholarship

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

The Faculty and University have impressive research and scholarship track records. Within the Faculty, along with the Schools, several research centres and institutes contribute world-class research. On measures of research performance, including impact, external funding and publications, UNSW Medicine and Health consistently scores highly. In general, these measures have consistently trended up over time, except for some forms of public research grant awards for which budgets are being reduced nationally.

The medical program aims to introduce students to research, primarily through supervised research projects. The key component of this research learning focus is the BSc (Med) Honours Independent Learning Project year in Year 4. Notably, the proportion of students who get their research published has increased from 28% in 2007 to 50% in 2015. Almost all students (96%) negotiate their research topics with supervisors, indicating a high degree of research literacy and independence. While some students and stakeholders expressed concerns that this research year is disruptive to building and maintaining core clinical skills, the design of the post-Year 4 Clinical Transition Course appears effective in smoothing out this shift.

Research carried out within the Faculty informs learning and teaching in the medical program in two key ways. First, the research outcomes of Faculty and Faculty-affiliated research centres and institutes directly influence the medical program, through their involvement in Faculty governance and through the role of Dean, responsible for both the medical program and the centres and institutes. An excellent example of this is in the development of the Faculty's Health 25 Strategy, which included deep consultation with these research centres and institutes. The Strategy, in turn, strongly informs the strategic priorities and direction of the medical program. Second, the Office of Medical Education and related medical and health education groups promote, facilitate and conduct medical education research that feeds back into the delivery of learning and teaching in the medical program. For instance, in 2022, leaders of these groups created a series of webinars for Faculty staff on innovative learning and teaching, bringing together international thought leaders.

1.8 Staff resources

1.8.1 The medical education provider has the staff necessary to deliver the medical program.

1.8.2 The medical education provider has an appropriate profile of administrative and technical staff to support the implementation of the medical program and other activities, and to manage and deploy its resources.

1.8.3 The medical education provider actively recruits, trains and supports Indigenous staff.

1.8.4 The medical education provider follows appropriate recruitment, support, and training processes for patients and community members formally engaged in planned learning and teaching activities.

1.8.5 The medical education provider ensures arrangements are in place for indemnification of staff with regard to their involvement in the development and delivery of the medical program.

The Faculty is well staffed to deliver the medical program. There are 676 FTE academic staff and 550 FTE professional staff employed by the Faculty, with an additional 2300+ conjoint appointees. (See Tables 1–4). Historically low turnover in staff within the Faculty has allowed for continuity of regular activities and new initiatives, and stability in governance. Anecdotally, a high proportion of graduates pursue continued affiliation with the Faculty. This level of staff commitment reflects well on the Faculty and medical program.

Table 1 Academic staff FTE by level of appointment and gender

Level	Male FTE	Female FTE	All genders FTE
Associate Lecturer	65	81	146
Lecturer	71	92	163
Senior Lecturer	80	81	161
Associate Professor	45	47	92
Professor	70	44	114
All levels	332	344	676

Table 2 Academic staff FTE by School

School	FTE
School of Biomedical Sciences	54
School of Clinical Medicine	91
School of Population Health	42
School of Health Sciences	20
School of Optometry and Vision Science	27
Faculty Office and Office of Medical Education	19
Research Centres	12

Table 3 Conjoint appoints by level of appointment and School

	School of Biomedical Sciences	School of Clinical Medicine	School of Health Sciences	School of Optometry and Vision Science	School of Population Health	All Schools
Conjoint Associate Lecturer	15	651	1	1	8	676
Conjoint Lecturer	34	643	3	2	46	728
Conjoint Senior Lecturer	41	424	1	3	22	491
Conjoint Associate Professor	13	222		1	8	244
Conjoint Professor	34	113		5	14	166
Total	**137**	**2053**	**5**	**12**	**98**	**2305**

Table 4 Professional staff by organisational unit

Organisation Unit	Persons	FTE
School of Biomedical Sciences	39	35.0
School of Clinical Medicine	214	178.0
School of Health Sciences	10	8.1
School of Optometry and Vision Science	35	26.0
School of Population Health	31	22.0
Education & Student Experience	25	22.8
Teaching support	28	28.0
Rest of Faculty office	57	53.6

The Faculty continues to prioritise its relationship with conjoint appointees. The recently appointed Director of Academic Conferrals has pursued several initiatives with the aim of better understanding and more effectively engaging conjoint appointees.

The Team was impressed by the drive, passion and commitment of the professional staff working in the various portfolios and located in the diverse sites of the Faculty. These staff benefit from good leadership and solid cohesion. Recent restructures which centralised some professional staff and impacted the organisation of Schools have been exceptionally well received. The staff restructure was accompanied by an additional 12 FTE professional staff and resulted in professional development and considered collaboration opportunities that have been seen positively.

Both the Faculty Wellbeing Officer and the Student Experience Officer, Indigenous have contributed to addressing the unique wellbeing needs of medical and health profession students from under-represented communities and Aboriginal and/or Torres Strait Islander communities in conjunction with central University services. The Faculty has ambitious goals for recruiting and graduating increasing numbers of students from these communities and should consider whether these roles are sufficient to support these students.

The current Aboriginal and/or Torres Strait Islander academic and professional staff employed within the Faculty and those employed centrally by UNSW who contribute to the medical program all have significant workloads. The Team considers that current plans to address this pressure will not enable the medical program to meet its needs in Aboriginal and/or Torres Strait Islander health and wellbeing, including developing its Aboriginal and/or Torres Strait Islander health curriculum and supporting students. The Team notes that, while the recent and planned recruitment of new Aboriginal and/or Torres Strait Islander staff is positive, the intended staffing level is still modest considering the large and still-expanding size of the Faculty, and the complex design of the medical program. At the time of the assessment visit, Aboriginal and/or Torres Strait Islander leaders were evaluating needs and preparing a business case for the expansion of the Indigenous Health and Wellbeing Unit, which encompasses Aboriginal and/or Torres Strait Islander Faculty staff who focus on health and wellbeing. The Team looks forward to receiving an update on this review of needs and the Faculty's implementation of the business case.

Aboriginal and/or Torres Strait Islander staff face a high cultural load. The Team perceived a widely held expectation, implicit in how non-Indigenous staff speak about these issues, that Aboriginal and/or Torres Strait Islander staff are largely responsible for ensuring cultural safety and delivering the Aboriginal and/or Torres Strait Islander health curriculum. While this activity should be overseen by Aboriginal and/or Torres Strait Islander staff, the Faculty must ensure that all staff understand that this is the shared responsibility of all who contribute to the medical program.

The Faculty has some involvement of patients and community members in structured learning and teaching activities, and they are supported and, where relevant, trained. Community members are mainly involved as simulated patients for clinical skills examinations and objective structured clinical exams (OSCEs). Visiting speakers, with lived experience of illness, teach students. In Year 3, students have an interactive paediatric skill-focused session with children from a local primary school.

The University indemnifies its staff in relation to work carried out in performing their duties as employees, including specific insurance cover required for medical practitioners and researchers. If a claim is made against a staff member as a result of the work they perform, the University reports that it has a broad insurance program in place to meet the cost of claims.

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 Faculty and University have appropriate appointment and promotion policies for academic staff that address a balance of capacity for teaching, research and service functions. The Team heard that the professional development process was well scaffolded, centred around the twice-yearly meeting utilising the 'myCareer' planning tool. Development and training opportunities, particularly those focused on medical education skills, are robust. The Team was reassured that those with a teaching focus were not disadvantaged in the promotion process.

Conjoint appointees have benefited from the recent introduction of an online learning module focused on clinical medical education (C-MED) which is reportedly well utilised. Faculty leadership and the Faculty's submission mention the implementation of a teaching evaluation tool, the

Perceived Effectiveness of Clinical Teaching Scale (PECTS). However, the Team found that only a small proportion of conjoint appointees were aware of, and using, the PECTS. The Team hopes this promising tool will be rolled out further in the coming months.

The Team was impressed by the development and training of professional staff especially in areas such as leadership and change management. This demonstrated the excellent support of senior Faculty staff, especially the Faculty general manager and Deputy GM, for the professional staff team.

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 medical program has been clearly defined within the 2020 UNSW Medicine and Health strategic plan, Health 25. The strategy outlines the Faculty's vision to improve the health of people and communities in Australia and around the world through four priority areas: People & Culture, Education, Research and Partnerships.

Health 25 includes expansive references to the health needs of Aboriginal and/or Torres Strait Islander communities. There is a recognition of the importance of staff and student cohorts accurately reflecting the communities they serve, and an investment in growing and developing Aboriginal and Torres Strait Islander students and staff. In the 'Education' priority, the Faculty details its intention to 'respect and embrace the knowledge systems of Aboriginal and Torres Strait Islander peoples both within the University's footprint and further afield.' The Faculty also describes its 'commitment to use inclusive research practices that prioritise meaningful and reciprocal engagement with all end-users, especially our Aboriginal and Torres Strait Islander communities.'

The Team was impressed by the extensive consultation with internal stakeholders and health-related sectors of society and government to develop the strategy. This began with an information gathering phase comprising town hall meetings, discussions with schools, centres and institutes, and meetings with health and industry partners. This culminated in 32 workshops run during the 'Future of Health Week' in late 2019 to identify the position of UNSW Medicine and Health in addressing and shaping the future of health. Community engagement in the Health 25 development was primarily organised through regular consultations with Local Health Districts, industry partners and UNSW-affiliated Medical Research Institutes.

There is a clear commitment throughout the Health 25 Strategy that the teaching, service and research activities of the Faculty align with the healthcare needs of the broader community. However, it was not clear from the stakeholders the team spoke to how this commitment translated

into support for Indigenous leadership or how communities would provide direction on the prioritisation of research activities or feedback on the impact of activities undertaken and whether they were beneficial to the community. The Faculty can enhance its collaboration with the Aboriginal and/or Torres Strait Islander communities it serves across its campuses and clinical context.

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 medical program is guided by its eight graduate capabilities, grouped under three areas that represent the minimum expectations for the level of achievement of graduates. See Table 5. The capabilities are consistent with the AMC's four Graduate Outcome Statement domains, but they do not map exactly. This difference arises because the intention of the UNSW Graduate Capabilities is to ensure student learning is led by these outcomes, as well as to represent the level of achievement/skill that students are to obtain on graduation.

Table 5 UNSW medical program Graduate Capabilities

Personal Attributes	Interactional Abilities	Applied Knowledge and Skills
Self-directed learning and critical evaluation skills	Effective communication with patients, team members, colleagues and the community	Using basic and clinical sciences in the practice of medicine
Understanding ethics and legal responsibility in medicine and acting in an ethical and socially responsible manner	Working as a member of a team	Understanding the social and cultural aspects of health and disease
Development as a reflective practitioner		Patient assessment and management

The graduate capabilities have levels of achievement that have been designed to ensure student learning and assessment is guided towards these outcomes throughout the program. Each Capability is cumulative and is developed across the three phases of the program through sub-standards and expectations set out for each phase. The Capabilities have remained unchanged since the AMC accreditation report in 2013, with some revision to the ethics capability and summary tables in 2016 and 2017.

Student feedback suggests a gap in student understanding of the purpose of each Graduate Capability in becoming better doctors and may benefit from more explicit and practical demonstrations.

The medical program includes a wide range of dispersed clinical campuses and sites and runs both time-limited placements in various locations and end-to-end programs at Kensington, Port Macquarie, and more recently Wagga Wagga. Rural students and staff reported inequitable access to some virtual lectures, tutorials and simulation learning content based on location and timetable differences with the central Kensington campus. There is a perception across rural campuses that utility of the scenario groups is of significantly different quality compared to Kensington due to variation in expertise of the teaching workforce.

The team heard of work being done by the Clinical Learning and Assessment Committee and the Simulation Based Learning Advisory Committee who have produced a set of standardised teaching resources for UNSW educators covering clinical skills and procedures across all phases of the program. Assessment Review Groups review all high-stakes exams, including a comparison of results according to sites. The Faculty will need to continue to undertake analysis to ensure that outcomes are comparable, particularly once the initial student cohort at Wagga Wagga has progressed further.

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 6-year structure of the UNSW medical program provides ample opportunity for the achievement of the learning outcomes required of Australian medical practitioners. The program is delivered in three Phases of two Years each.

Phase 1 (Years 1 and 2) consists of eight 8-week courses each year. Learning and teaching in this Phase follows the model of Scenario Based Learning, and courses are organised broadly around the human life cycle. Clinical experience begins early in Year 1 with one half-day per week of bedside teaching.

Phase 2 comprises the Year 3 Integrated Clinical Courses and the Independent Learning Project (ILP) or the BSc (Med) Honours year in Year 4. The Integrated Clinical Courses include four 6-week courses, and two 4-week courses, again organised around the human life cycle. Learning and teaching in this Phase follows the model of practice-based learning. Students spend 3 days per week in clinical environments by the end of Year 2. The ILP or BSc (Med) Honours are completed over 30 weeks. These programs provide the opportunity to undertake a research program that prepares graduates for subsequent PhD study and a pathway to the role of clinician-researcher, which represents a significant workforce need for the country. Following Year 4, students must complete a 4-week Clinical Transition Course to refresh their clinical reasoning, skills and communication after an in-depth period of research.

Phase 3 consists of ten 8-week clinical courses in Years 5 and 6 with an additional summer teaching period. Clinical courses in this Phase are organised around major clinical disciplines. Learning and teaching follows an independent reflective learning model. After final examinations, students undertake the final clinical course – a 6-week Preparation for Internship (PRINT) course.

3.2 The content of the curriculum

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

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

3.2.2 Clinical Practice: The medical graduate as practitioner.

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

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

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

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

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

The curriculum is organised strategically around eight graduate capabilities which map onto the AMC graduate outcomes. Each of the three phases builds on the capabilities cumulatively. Phase 1 content is largely taught through scenario-based learning and expanded upon through self-reflection, tutorial discussions and presentations to the cohort.

The curriculum content in Phase 1 (Years 1 and 2) and Year 3 of Phase 2 is broadly organised around the human lifecycle under four domains:

1. Beginnings, Growth & Development
    a. Conception, pregnancy and birth
    b. Childhood growth and development
    c. Puberty, adolescence, sexuality and relationships
    d. Nutrition, growth and body image
2. Health Maintenance
    a. Homeostasis, sustenance and equilibrium
    b. Education, health promotion and disease prevention
    c. Host defence
    d. Lifestyle factors that risk health
3. Ageing & Endings
    a. The ageing process
    b. Degenerative disease
    c. Death, dying and palliative care
4. Society & Health
    a. Society, cultures and genes
    b. Socioeconomic determinants of health
    c. Health delivery systems
    d. Health and human rights.

Each of these domains are revisited across the program, alongside three vertically integrated central elements relevant to the practice of medicine:

- Quality of Medical Practice
- Ethics
- Clinical Skills.

Some courses in Phase 1 are integrated with Years 1 and 2 learning together whereas other courses, such as the Foundations course for Year 1, are separate. Students feel positively about the Phase 1 content generally, although some expressed confusion over the term structure and lack of explicit learning outcomes for each term.

Phase 2 pivots to more explicit practice-based learning and has two components: Integrated Clinical Courses in Year 3, and the option of an ILP or a BSc (Med) Honours degree in Year 4. In Year 3, students attend campus for two days (or its equivalent) per week, and three days are spent in a clinical setting. The teaching revolves around a weekly theme related to a clinical presentation relevant to the students' clinical setting and follows the four core domains introduced in Phase 1 and described above.

In Phase 3, the curriculum is focused on independent reflective learning and comprises clinical courses and placements in hospital, ambulatory and primary care settings across seven core courses:

- Medicine
- Surgery
- Psychiatry

- Primary Care
- Paediatrics
- Critical Care
- Obstetrics & Gynaecology.

Students also have the opportunity for 12 weeks of selective placements within UNSW affiliated teaching sites, and an 8-week elective course anywhere in Australia or overseas. The final course is a PRINT term of six weeks. Students are required to complete at least four weeks of placement in a rural location. Tutorials are taught in clinical settings, and the team heard from students that there is a desire for universal clinical tutorials to be available to all students across campuses.

Science and scholarship

Biomedical sciences are primarily taught in Phases 1 and 2 but continue to be addressed and assessed across the Medicine program, including the Year 5 Biomedical Sciences Viva examination. Phase 1 introduces students to basic concepts in each biomedical science discipline through courses which are structured around and focus on each body system. In Phase 2, greater emphasis is applied to biomedical knowledge in the context of clinical cases and patient management. This case-based learning continues into Phase 3.

Research skills are gained through research and scholarship projects and assignments spread throughout the medical program, with the pinnacle of research learning and teaching being the Year 4 ILP or BSc (Med) Honours program.

The Quality of Medical Practice (QMP) element aims to provide students with a good grounding in evidence-based practice, medical statistics and critical thinking, as well as knowledge and skills for quality and safety. The QMP curriculum is a fully blended curriculum, combining face-to-face and online learning. It is taught across all three Phases of the medical program.

Teaching in this domain is captured in the Graduate Capability 'Using Basic and Clinical Science in the Practice of Medicine', with research competencies aligned to 'Self-Directed Learning and Critical Evaluation Skills'.

Clinical practice

The approach to preparing students for clinical practice is broadly addressed over the 6 years of the program through acquiring medical knowledge, development of clinical skills and clinical experiences across different disciplines and clinical settings. The vertical Clinical Skills element is key to this.

Specific objectives of the Clinical Skills element are encapsulated by the Graduate Capabilities, particularly 'Patient Assessment and Management' and 'Effective Communication'. Students develop clinical skills within a vertically integrated program acquiring increasing levels of competence and sophistication as they progress. The Phase 1 and 2 Clinical Skills Guides contain the details of teaching of clinical skills, including communication skills, across the medical program. The QMP element's emphasis on quality and safety is also relevant here.

Learning and teaching in the clinical disciplines, particularly in Phase 3, also support the achievement of the Clinical Practice domain of the AMC graduate outcomes.

Health and Society

The medical program integrates the teaching of public health concepts throughout the program and emphasises their importance through the Graduate Capability of 'Social and Cultural aspects of Health and Disease'.

Teaching expertise is drawn primarily from the academic staff in the School of Population Health and a number of high-profile public health practitioners who are conjoint appointees. There is also significant public health teaching that is delivered through other Schools. Firstly, many public health concepts are embedded within clinical practice and patient care (e.g. screening and prevention). Especially for more senior medical students, this learning is coordinated by clinicians. Secondly, some elements are intrinsically interdisciplinary in nature and are shared with other

curriculum themes in the Medicine program (e.g. cultural competence in communication, and public health ethics).

In the latter Phases of the medical program, teaching in the medical program increasingly occurs within the integrated clinical environment and public health teaching and assessment takes place within this context.

Students expressed their desire for more breadth in their LGBTQIA+ learning, expanding on the limited content currently explored.

Professionalism and Leadership

The Faculty has emphasised the learning, teaching and assessment of professionalism through a number of mechanisms. This work has been spearheaded by the Professionalism Working Group. The Working Group has identified desired observable behaviours and how this learning links to existing teaching around ethics, professional behaviour and reflective practice. The Working Group also established a process to monitor and remediate lapses in professional behaviour.

Reflective practice is integrated into teaching and assessments throughout the program as aspects of professionalism, such as understanding ethical and personal values, honesty and integrity, are components of many of the tasks the students are required to complete. To illustrate how professionalism is taught within the curriculum, one aspect of professionalism, ethical practice, is discussed in more detail.

An emphasis on the development of teamwork skills, goal setting, and peer- and self-evaluation within the assessments in the program fosters the development of skills for future leadership. The opportunities for students to apply leadership skills are primarily provided through extra-curricular activities including student organisations.

This domain links to the Graduate Capabilities of 'Development as a Reflective Practitioner', 'Understanding Ethics and Legal Responsibility' and 'Working as a Member of a Team'.

The team has concerns that the program may not currently be ensuring full achievement of AMC graduate outcomes 3.4 (concerning Aboriginal and/or Torres Strait Islander health) and 4.8 (concerning interprofessional collaborative practice). Issues related to the Aboriginal and/or Torres Strait Islander health curriculum are dealt with under Standard 3.5. In relation to AMC graduate outcome 4.8, student learning currently appears to rely largely on ad hoc informal interactions with other health professional practitioners during clinical placements and utilisation of other health professionals as teachers in the program. Some organised activity is undertaken with exercise physiology students as part of the Clinical Transitions Course at the end of Year 4. This appears to be well designed and valuable, but the Team does not consider this to be sufficient to ensure student achievement of AMC graduate outcome 4.8 without a more comprehensive, evidence-based approach to interprofessional learning and assessment across the medical program.

3.3 Curriculum design

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

In 2019, UNSW transitioned from a 2-semester system to a 3-term structure known as the 3+ calendar. The Medicine program underwent administrative adjustments but maintained its structure. The curriculum is organised for horizontal integration within each course and vertical integration across the program, with a Curriculum Map facilitating comprehensive recording and mapping of learning activities. The program's design around the life cycle allows content organisation in broad domains relevant to medical practice.

The teaching structure is designed for horizontal integration, with activities developed by multidisciplinary groups. Scenario-based learning is used in Phase 1, integrating formal and informal learning within a health context. Assessments drive integration, aligning with clinical contexts and graduate capabilities. Vertical integration is supported by near-peer teaching and transition courses.

The Medicine program has specific courses for stages of transition, like the Foundations Course and Clinical Transition Course. The curriculum includes a Portfolio examination reviewing a student's performance across the six years. The School of Clinical Medicine (SoCM), formed in 2021, aligns teaching and resources, fostering communities of practice.

Clinical Academics play key roles in leadership, governance, and curriculum design. Graduate capabilities align well with the AMC statements. The program prepares students for postgraduate training, including a PRINT term. ClinConnect provides access to training modules, and students have been employed by NSW Health in response to the COVID-19 surge.

The program offers advanced standing in Pathology, and there is ongoing redesign to adapt to changes in health care, technology, and education. The redesign aims to provide a transformative educational experience, aligning with the Health 25 Strategy. The 6-year program will continue with undergraduate entry. The curriculum as currently enacted shows evidence of purposeful design and ongoing refinement. Each Domain and element is integrated into each Phase through a variety of teaching methods, learning activities and clinical practice exposure.

However, the team identified, and the provider acknowledged, that it is currently strongly oriented toward tertiary and secondary care settings, with less emphasis on the specific knowledges and capabilities required for primary care, which is the site of provision for the vast majority of medical care in Australia and where the greatest workforce need exists.

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.

Graduate capabilities and their sub-standards guide student expectations over the three phases of the program. The *Medicine Program Student Guide* provides an overview of all the teaching and assessment in the program, the graduate capabilities, and University, Faculty and NSW Health policies and guidelines. Each Phase has a corresponding Phase guide, as does each course or term. These guides outline the learning, teaching and assessment outcomes associated with that phase or course. Guides are updated annually and available in Moodle, the learning management system. Each Phase, course and term also has a Moodle site with relevant information including guides, timetables, information on assessments, as well as forums and message boards for announcements and other ad hoc communication with students. The team heard of other forms of communication including Faculty websites, phase newsletters, information evenings and regular interaction with the student society, MedSoc.

The provider has made a deliberate and considered pedagogical decision not to specify learning outcomes for students at levels lower than relatively broad statements of graduate capability. The team found evidence that some students in the earlier years of the program found this approach to be anxiety-provoking, giving rise to a sense that they did not know what to learn or what to expect in assessment activities. That said, students in higher years of the program exhibited a more nuanced understanding of the inherent complexity of medical curricula and a recognition that attempts at more granular specification might not actually be as meaningful or useful as they might have thought at an earlier time. While the Program, Phase and Course Guides were a widely utilised and well-regarded resource, the Faculty may consider how to communicate the relevance and utility of the high-level learning outcomes more effectively.

3.5 Indigenous health

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

The Indigenous Health content in the Medicine program is mainly covered in Phases 1 and 2. An Indigenous Health Education Working Group was formed in 2017, composed of Aboriginal and/or Torres Strait Islander and non-Indigenous academic staff and students. The group aims to review and update the curriculum, teaching methods, and assessments related to Indigenous Health,

utilising resources from the LIME (Leaders in Indigenous Medical Education) Network and relevant frameworks. Objectives include establishing an Indigenous Health Education Unit, developing a learning pathway, organising cultural immersion programs, expanding clinical placements, and ensuring recruitment and retention of Aboriginal and/or Torres Strait Islander medical students.

Current initiatives include on-Country experiences for students, a trauma-informed care workshop in Phase 2, and various lectures and projects across all phases to promote cultural awareness and understanding. Assessment methods include reflective assessments, group projects, and oral presentations.

The Team acknowledges the very considerable work undertaken by the small number of current and prior Aboriginal and/or Torres Strait Islander academics to embed content into the medical program related to Aboriginal and/or Torres Strait Islander health. The provision of early on-Country learning experiences, focused on culture and history, is valued but needs to be developed further to ensure purposeful learning experiences.

The Team noted that the program's Aboriginal and/or Torres Strait Islander health curriculum delivery more broadly was perceived by many stakeholders to be neither comprehensive nor coherent. The Team also learned of multiple examples where learning and assessment materials reinforced negative stereotypes and included disrespectful, inappropriate and racist framing and language. Accordingly, the curriculum and learning activities need to be reviewed urgently and aligned with contemporary evidence and Aboriginal and/or Torres Strait Islander pedagogies, including anti-racism and a strengths-based approach. This work needs to be undertaken by the whole program team, informed and guided by the expertise of the UNSW Aboriginal and Torres Strait Islander Sovereign Strategy Group. It will require appropriate resourcing and commitment throughout all levels of the Faculty, including oversight and advisory input from well-resourced Aboriginal and/or Torres Strait Islander academic and professional staff.

3.6 Opportunities for choice to promote breadth and diversity

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

The Team found that the UNSW medical curriculum provided clear opportunities for students to pursue studies that promote breadth and diversity of experience. The University-wide requirement to undertake two 'general education' courses appears to be a valuable distinctive feature of the program, enabled by its 6-year duration. Some stakeholders questioned the value of this requirement in a relatively crowded curriculum but, on balance, the Team formed the conclusion that the opportunity to pursue learners' wider interests would support the development of well-rounded practitioners with a better work-life balance.

The fourth year of the curriculum, with its requirement to undertake a research project, was also widely valued as a distinguishing aspect of the UNSW curriculum that supports meeting the workforce need for skilled clinician-researchers in our country. However, some stakeholders raised concerns about the interruption to clinical learning necessitated by the research project in the fourth year. There was also diverse opinion about the effectiveness of the Clinical Transition Course in mitigating this effect. There is an opportunity to look at enhancing the Clinical Transition Course with more simulated learning activities, as well as the possibility of enabling some level of regular clinical learning across the fourth year.

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 variety of teaching and learning methods aimed at fostering students' independence and reflection. Formal learning activities are documented in an online Curriculum Map, while informal clinical settings are not formally recorded. The curriculum integrates traditional teaching methods like lectures, small group tutorials, laboratory classes and clinical skills sessions. Blended learning is emphasised, with initiatives such as the Teaching Technology Toolkit and online simulated patient interviews.

Phase One

Phase 1 introduces scenario-based learning (SBL), encouraging collaborative and independent learning within medical contexts. SBL aims to develop skills in identifying learning needs, utilising resources and addressing outstanding issues. Students engage in discussions, supported by materials like journal articles. Assessment tasks include assignments and small group projects.

Phase 2

In Phase 2, as students are exposed to more clinical and practical settings there is an emphasis on practice-based learning. Small group tutorials are utilised in reflecting on clinical experiences and combining the acquisition of clinical skills with continued didactic learning on the social and scientific mechanisms of health and disease.

In Year 4, students undertake research in the form of either an Independent Learning Project or an Honours Degree. This research project, in particular, appears highly effective in ensuring student achievement of AMC graduate outcomes 1.4, 1.5 and 1.6.

Phase 3

Phase 3 expands on the clinical learning activities introduced in Phase 1 and 2 and provides students the opportunity for immersive clinical experiential work in hospital and primary care settings. This is facilitated by clinical supervisors and largely self-directed. Clinical learning experiences are sufficient and well organised across each of the sites.

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 UNSW medical program emphasises the graduate capabilities of 'Self-directed Learning and Critical Evaluation and Development as a Reflective Practitioner. Undergraduates undergo mandatory information skills training, such as the ELISE tutorial and quiz, to enhance their ability to source and use information resources. Foundations courses in Medicine introduce concepts of self-directed learning and reflective practice.

Throughout the program, assignments in all three phases include grades for 'Self-directed Learning and Critical Evaluation and Development as a Reflective Practitioner'. Assignments require a reflective piece where students discuss their insights into what they have learned and reflect on the assessment process.

The Portfolio requires students to provide evidence of their development in various capabilities. Students have the flexibility to choose assessment tasks that align with their learning needs, especially in Phases 1 and 2. In Phase 3, students set learning goals and present evidence of achievement. The Portfolio examinations at the end of each phase involve reflection on progress and plans for further development. The medical program's significant and progressive emphasis on self-directed learning was confirmed by the student report and multiple observations during

the visit. The portfolio assessment approach, in particular, encourages students to monitor and regulate their own learning and prepares them to be life-long learners in practice.

The Clinical Workplace Assessment App (CWAapp) streamlines workplace-based assessments (WBA) in the clinical setting. The app, developed with input from students replaces paper forms and facilitates a digital solution to WBA complexities. It provides immediate feedback to students for reflection, contributing to evidence in their portfolios and showcasing their development as Reflective Practitioners.

4.3 Clinical skill development

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

The Medicine program at UNSW focuses on developing core clinical skills, including communication, physical examination, procedural skills and clinical reasoning. Students progressively engage with clinical environments through the three Phases, starting with Phase 1 on their main campus and expanding to more extensive clinical exposure in Phases 2 and 3, including hospitals and general practices in both urban and rural settings. The program emphasises professionalism, and students are expected to demonstrate responsibility, punctuality and respect in clinical settings.

In Phase 1, the focus is on understanding the impact of illness on patients and developing information-gathering skills through medical history and physical examination. Generic communication skills, aligned with person-centred care, are emphasised. Simulated Patient Programs add authenticity to learning scenarios.

Phase 2 allows students to assess patients with common clinical problems, refining and extending their clinical skills. Phase 3 involves clinical clerkships, where students take on responsibilities in real healthcare settings as part of a team, under supervision.

The Clinical Skills program's objective is to ensure students develop competency in these skills and apply them within respectful patient relationships. The program adopts a staged approach to skill development, integrating knowledge, initial experience in a safe environment, supervised clinical application and ongoing independent practice. Effective communication, with a focus on self-awareness, is considered a key element, aligned with the capability of 'Development as a Reflective Practitioner.'

Clinical skills teaching involves lectures, practical classes, tutorials, and independent study, aligning the learning of skills with the relevant knowledge base. Simulated Patient (SP) sessions, including Online Simulated Patient Interaction and Assessment (OSPIA), enhance experiential learning. OSPIA, introduced in response to COVID-19, allows students to interact with simulated patients online, maintaining clinical experiences when access to physical sites is restricted.

The Clinical Skills element is well formulated to ensure that core capabilities are practised in simulated settings before being further developed in the real clinical environment under close supervision from early in the program. The Team noted some variation in the resourcing of simulation-based learning opportunities between sites, particularly in relation to students' ability to return to the simulation setting outside of scheduled learning sessions to practise clinical skills independently.

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.

In Phase 1, students participate in bedside tutorials at teaching hospitals in metropolitan clinical campuses and regional locations, enhancing their clinical skills through interactions with real patients and simulated patient sessions. The teaching is provided by clinical tutors, fostering small

group learning. There was some concern from stakeholders regarding the limited diversity of simulated patients that students were exposed to in Phase 1 teaching. The Faculty is encouraged to provide students with the opportunity to interact with a diverse group of simulated patients that align with the wide range of backgrounds they will encounter in their patients later in their studies and careers.

In Phase 2, students engage in clinical learning activities for three days a week or equivalent duration, attending general teaching hospitals and participating in clinical tutorials. Depending on the term, students may assess patients independently, present findings, or be involved in clinical units under supervision. Bedside tutorials further develop their clinical and communication skills.

In Phase 3, students undergo clinical clerkships in affiliated teaching hospitals, spending four weeks in various specialties. They actively participate in patient care under supervision, completing clinical assessments and engaging in ward rounds and multidisciplinary team meetings.

The Independent Learning Project (ILP) and BSc (Med) Honours program involve geographically diverse projects, facilitated through a fully online system using Microsoft Teams. The online platform serves various purposes, including supervisor support, examiner support and student support/mentorship. It includes online supervisor and examiner inductions, weekly mentorship programs, and mandatory tutorials covering key stages of the program, ensuring effective communication and support for all involved parties.

The Clinical Skills element enables learners to build on their learning from simulated settings through a progressive sequence of clinical experiences, culminating in deep integration into the provision of patient care in Phase 3. As noted previously, there was some concern about the impact of the interruption to clinical learning necessitated by the research project in the current structure of Year 4. The Faculty may wish to consider providing some additional access to learning in clinical settings in parallel with the research project to mitigate this concern.

4.5 Role modelling

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

The medical program at UNSW emphasises role modelling as a key learning method, particularly in clinical practice and research. Clinicians, including general practitioners and junior medical officers, serve as Phase 1 clinical teachers, engaging students in campus-based and hospital clinical skills tutorials. Phase 2 has clinical tutorials in which clinicians discuss cases presented by students, to demonstrate clinical reasoning approaches.

The Clinical Mentoring Scheme (CMS) supports students in developing clinical and professional skills from Years 3 to 6, with experienced clinicians serving as mentors. The CMS aims to enhance learning, career confidence, and employability by establishing mentee goals and providing support and advice. Additionally, a Professionalism and Quality & Safety module in Phase 2 involves online adaptive tutorials and team-based learning activities to address ethical and professional behaviour. Successful completion contributes to the Phase 2 portfolio under the graduate capabilities of patient assessment and management, ethics and legal responsibilities, and teamwork.

In Phase 3, students engage in clinical clerkships, witnessing and participating in real medical team activities. The Honors project and ILP provide opportunities for students to observe research practices, from project design to analysis, fostering direct interaction with research environments. The ILP experience often extends beyond the program, with ex-ILP students seeking professional advice from their supervisors.

The Faculty values and promotes role modelling as a learning method through extensive clinical exposure from the beginning to the end of the program. The team noted that the Faculty was also sensitive to the potential for 'negative role modelling' of sub-optimal practice and has integrated activities to sensitise students to this possibility, such as a mini-audit of medication chart compliance in Phase 2. Year 4 also provides the opportunity for students to learn from the effective research practice of the supervisors with whom they collaborate on their projects. The Team noted

that, as a result, UNSW medical graduates were viewed by stakeholders as being more likely to develop into doctors who readily apply scholarship to their practice.

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 Phase 1 Clinical Skills Guide emphasises patient-centred care and collaborative engagement in the learning and teaching methods within the clinical environment. The program focuses on understanding the impact of illness on patients and developing information-gathering skills through medical history and physical examination. The patient-centred clinical method is considered an essential element, encouraging students to appreciate the importance of understanding individual patient circumstances and experiences of illness in contributing to patient care.

In the Foundations course, students are introduced to the Calgary-Cambridge model, emphasising both the 'disease story' and the 'illness story' to comprehend the patient's experience. The student-patient observed communication assessment (SOCA) process reinforces patient-centred assessments early in Phase 1. Patient-centred care is further developed in the Clinical Transition course in Phase 2, revisiting the Calgary-Cambridge model with an emphasis on mutual decision-making and patient satisfaction.

The Primary Care course in Phase 3 expands on the patient-centred approach, requiring students to take the role of a GP in assessments, practising clinical assessment and negotiating management with a patient. In Phase 3 clinical attachments, bedside teaching becomes the primary learning environment, focusing on the patient for teaching clinical signs, management planning, communication and documentation. Professional engagement with multidisciplinary teams is facilitated through electronic communication tools such as WhatsApp groups that welcome Phase 3 students as team members during their PRINT term.

These learning activities are aimed at promoting the acquisition of capabilities for patient-centred care across all three phases of the program. However, the Team noted some variation in stakeholders' appraisal of the extent to which this was being achieved with some pointing to highly developed human capabilities among senior students and graduates, while others suggested that many were 'book-smart' but needed to develop their ability to practise in a patient-centred way, especially in the primary care domain.

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.

Interprofessional activities are integrated across all phases of the UNSW Medicine Program to develop teamwork skills and an understanding of how clinical teams function. In Phase 2, students explore the roles of different health professionals, evaluate clinical team effectiveness and engage with multidisciplinary clinical teams during terms such as Aged Care, Child Health and Oncology. Teamwork is a prominent aspect of Phase 3 clerkships, where students interact with various clinical team members and receive standard grades based on their teamwork performance.

In Phase 2, interdisciplinary experiences are embedded in programs such as Aged Care and Rehabilitation, Palliative Care, Society & Health, and Child Health. These experiences include home visits, lectures and tutorials involving various health professionals. Students also participate in workshops on working with interpreters in medical settings, enhancing cross-cultural communication skills.

The Clinical Transition Course in Phase 3 includes an interprofessional learning (IPL) activity with exercise physiology students. Clinical attachments involve attending multidisciplinary meetings, and in Primary Care placements, students develop team care plans for patients with chronic

diseases, emphasising the importance of a team approach. Quality Use of Medicine assignments involve case presentations with pharmacy involvement.

The team noted various interprofessional activities, such as the Building great health care teams program, have been developed, offering students exposure to nursing, medical and allied health perspectives. However, the ongoing use of these activities depends on availability and funding. Online platforms like the Interprofessional Collaboration in Health Care (ICH) program support interprofessional learning, but their utilisation varies. The Clinical Teaching Unit has explored different activities, including ward simulations and online courses. Despite some challenges and changes, interprofessional education remains an integral part of the UNSW Medicine Program.

Although UNSW medical students enjoy multiple opportunities to learn through working with practitioners from other health professions during clinical placement, they are currently provided with few opportunities to learn 'with, from and about' other health professional students. The Phase 2 and Phase 3 portfolios do allow students to reflect upon interprofessional encounters that occur in clinical settings in order to optimise the learning that might be derived from them. The program currently lacks access to a well-developed suite of interprofessional learning activities, guided by an overarching evidence-based framework. The Faculty acknowledges that this is an area in need of development and has recently appointed a new interprofessional learning coordinator.

5 The curriculum – assessment of student learning

5.1 Assessment approach

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

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

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

The medical program is supported by a well-developed and well-resourced approach to assessment. The approach is outlined in the Program Guide and on the medical program's website, available to both staff and students. Internal stakeholders were broadly aware of assessment requirements and the overall assessment philosophy. The assessment program is based around the principles of validity, reliability, efficiency and the concept that assessment is integral to the learning process. An example of supporting validity is the extensive use of assessor training, rubrics and information sessions, supported by analysis of inter-rater reliability, to minimise assessor variability. The Faculty achieves objectivity and fairness through rigorous and well-considered systems and characteristics of assessment.

The Faculty has significant autonomy in the approach to assessment in the medical program. The University has an *Assessment Policy* and related *Assessment Design and Implementation Procedures*. The medical program assessment approach and rules are compliant with this policy and procedures although there are some significant differences, such as the grading procedures. These differences in policy between the medical program and UNSW more broadly, including those outlined in *Medicine Rules of Progression*, have been approved through relevant University processes by the Academic Board.

The assessment and progression requirements are transparent and clearly documented in the Phase and Course Guides, but the Faculty could consider how to communicate assessment methodologies to enable students to better understand them. This may include, for example, the use of criterion referencing in the medical program and how this relates to University grading. Students within the Honours program, for example, expressed concerns about a lack of understanding of the metrics.

The Faculty reports that their system of assessment is based on programmatic assessment, with formative and summative approaches to mirror and support the curriculum. The assessment schedule is extensive, reflecting the Faculty's complex governance, as assessment is informed and shaped by multiple groups within the Faculty and across physical sites.

There is significant expertise in these various groups that oversee assessment such as the Curriculum Development Committee (CDC), the Faculty Assessment Development and Evaluation Group (FADE), the BMed MD Teaching Support Unit, the Clinical Learning and Assessment Committee (CLAC), the Advanced Study and MD Research Committee, each Phase committee and, for many specific pieces of assessment, subcommittees. It is clear that the CDC is the primary oversight body, FADE provides technical advice, and the Teaching Support Unit coordinates administrative and operational matters. However, the Faculty may wish to review the governance structures for overseeing assessments with so many groups, often with significant overlap of membership. They could look for opportunities to streamline governance alongside plans to streamline the assessment program.

With a possible review of the governance structure, the Faculty may consider refining assessment governance to provide oversight of formative assessment. This would enable evaluation and review of the balance between formative and summative assessments and the parity of assessment and feedback opportunities across sites. At present, there appear to be more opportunities for formative assessment at the Rural Clinical Campuses than at other sites.

The Team commends Faculty leadership for securing buy-in at the University level for programmatic assessment methodologies, which exemplifies the productive working relationship between Faculty and University leaders. This should allow greater adoption of a programmatic approach.

More work needs to be undertaken if the Faculty intends to move towards a research-informed programmatic approach.

Overall, the approach to the medical program is assessment dominant. The Faculty should consider how to reduce the burden of assessment on students. The 2021 'Streamlining Assessment' framework acknowledged this burden, but changes have not yet been enacted. There is a risk, with discussions around the possible introduction of EPAs, that the burden of assessment may further increase.

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 Faculty uses a range of fit-for-purpose assessment methods in the medical program which align with assessment of the application of knowledge, skills and behaviours. These assessment methods include written assessments (such as short-answer questions and multiple-choice questions (MCQs)), practical exams (such as Vivas, OSCEs and – particularly later in the program – types of workplace-based assessments) and oral assessment (such as the portfolio interview). The Team notes the potential of the longitudinal reflective portfolio, which includes various assessment tasks, extending throughout the program and driving learning.

The Team received mixed stakeholder views of the Year 5 Biomedical Science Viva. Stakeholders, both staff and students, perceive the timing and content of the Viva as being disjointed from the broader clinical aims of the medical program in Year 5. While there was recognition by some that revisiting basic science comes with some advantages in the mainly clinical phase of the program, most stakeholders expressed concern that the examination distracted students from learning on the wards, feeling compelled to return to their books to revise. The main stated driver for the Biomedical Science Viva was to reinforce and integrate learning in the biomedical sciences and clinical disciplines. Some stakeholders felt that, after the year gap in clinical training in Year 4 where students either undertake a BSc (Med) Honours year or Independent Learning Project, going back to studying for this Viva and integrating clinical learning was challenging. With the implementation of the Health 25 Strategy and planning for the redesign of the medical program underway, there is an opportunity to revisit clinical exposure in Year 4 and therefore perhaps the need for and timing of the Biomedical Science Viva.

Assessment development and blueprinting is devolved to various groups under the CDC including the Phase Committees, CLAC and their subcommittees. Resources for clinical examinations such as supervisor and examiner guidelines, calibrating stations, blueprinting of examinations and reviewing evaluations of clinical examinations is the responsibility of CLAC, which meets every two months. Subcommittees of CLAC develop clinical examinations. The CDC oversees work done to correlates assessment items to the amount of time teaching each specialty and the graduate capabilities by medical program Phase. The Faculty also records the alignment of all individual items featured in assessments and in the program's assessment item bank to the curriculum map within the eMed curriculum management system. In this way, the Faculty ensures that assessments both address course/phase learning objectives and are directly linked to the achievement of graduate capabilities.

The 'Streamlining Assessment' framework has identified that assessment is currently disaggregated across the medical program. This is problematic for sampling both to achieve validity

and reliability for each examination event, but also for overall blueprinting of the assessment program to the curriculum. The development of a principles framework for assessment is welcomed, but more will need to be undertaken to ensure consistency, moderation and understanding at a whole-of-program level to account for student progress across phases and years. In particular, with the move to a programmatic assessment approach, the reliance on assessment at the end of each Year and Phase will need to be reviewed.

Further disaggregation between the clinical and pre-clinical years would also make blueprinting across the whole Medicine program challenging.

The recently described and implemented objective borderline method and standard-setting methods based on Rasch modelling as well as the new 'EZ method' will require exploration of their utility over time. This includes the wider role, if any, of high-stakes barrier examinations in a wider suite of assessment methods that all contribute to a programmatic approach and decision-making pathway for students.

The Team identified examples of a deficit model when describing Indigenous Health scenarios in assessment questions across all years of the program, that appears to persist despite feedback from students indicating that they need to be addressed. This content contributes to culturally unsafe spaces for Aboriginal and/or Torres Strait Islander students and staff and promotes negative stereotyping and understanding of Aboriginal and/or Torres Strait Islander people. This requires urgent attention.

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.

Feedback on assessment and examination performance is provided to all students. Student understanding of scoring and feedback opportunities is not always consistent and appears to vary across sites, particularly with some students at Rural Clinical Campuses sites receiving more formative assessment and feedback opportunities. The Faculty acknowledges that it faces continuing challenges in ensuring that written assessments are graded reliably and feedback provided in a timely manner, particularly in Phase 2, though it has taken steps to improve this. The level of feedback depends on the type of assessment, ranging from only an overall grade through to more detailed feedback provided for the portfolio assessment in each Phase. Much of this variability is to be expected.

There is a recognition that some students are at higher risk of underperformance and there are some strategies to try to deal with this. Some cohorts of students, namely those on the Gateway Admission Pathway and Indigenous Entry Program, are recognised as being at higher risk of requiring remediation and monitoring by staff. Much of this focus is on baseline data from student selection or underperformance and exam failure early in the program. Prior failure as a risk factor for subsequent failure in knowledge-based examinations may not hold true with the move to more programmatic assessment and this will need to be monitored carefully.

The Team noted that the early identification of an underperforming student was often through a network of staff members and clinical supervisors flagging attendance issues and other poorly documented and understood processes. The Team acknowledges that early identification of underperformance is challenging, and reliance on relational ties between staff, supervisors and students, rather than on more established policies and procedures, is a risk.

There is an overreliance on supplementary examinations to support student progression. Students are allowed to sit multiple supplementary examinations in the hope that they will subsequently

pass. While all failing students are eligible to sit a supplementary examination, irrespective of their result in the initial examination, there is no additive (additional sampling) methodology applied. The supplementary examination is taken as a new examination, rather than as an extension of the original examination. With the move to programmatic assessment planned, this aspect of further sampling may need to be conceptualised and explored in the context of the medical program.

Other remediation mechanisms are robust. Students who fail an examination are given the opportunity to meet with an academic advisor to discuss their performance, feedback and plans for remediation. Students whose academic standing is suboptimal according to Academic Risk levels are required to see an academic advisor. Underperforming students are also referred to portfolio advisors and the UNSW Academic Skills Support team to be provided with further performance improvement support. Individualised Study Programs provide structured opportunities for students to remediate assessments and progress through the program.

Supervisors and teachers are provided feedback on student cohort performance through governance review and distribution of cohort performance reports. The Assessment Review Group reviews cohort results at an individualised level, and the CDC and Phase Committees have access to detailed exam performance and item analysis data. The groups include many key academic staff. Cohort performance data, including the distribution of results, are made available to teaching staff, and data on aggregate student performance for each clinical site are provided to site staff.

5.4 Assessment quality

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

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

The CDC oversees the review of assessment in the medical program, supported by FADE and the Phase Committees. FADE provides important technical advice. Together, these groups provide quality assurance over the complex assessment ecosystem in the medical program.

The UNSW Medicine Program is actively involved in the Australian Medical Schools Assessment Collaboration (AMSAC) and the MDANZ Medical Education Collaboration Committee – Assessment Benchmarking project.

As previously described, blueprinting across such a complex medical program is challenging. While the blueprinting process is approved by the CDC, the process of content blueprinting is carried out and outcomes approved by the relevant subcommittee. The blueprinting is based on the expectations of the course/Phase. Generally, the proportion of items by discipline is expected to correlate with the amount of teaching in the discipline in the course/Phase. Blueprinting questions based on quantity of teaching content in the course, rather than mapped to learning outcomes, is not best practice. With eight graduate capabilities, the latter approach would be challenging for the medical program. However, the Team considers that this approach may be worth reviewing given the changes linked to the Health 25 Strategy and medical program redesign, in line with plans for an overall assessment program that better reflects what students need to know, rather than what they have been taught (measured in time).

The Faculty acknowledged that there is some variation in the assessment practices between the urban and rural sites, but it had taken appropriate steps to reduce this variability, such as through assessor calibration and simultaneous cross-site assessment events. The Team sees the Faculty as appropriately managing any associated risk, and this variation appeared to reflect alignment with the way the curriculum was delivered, although in the absence of a whole-of-program assessment blueprint aligned with a curriculum map, formal examination of this was not possible.

There was no evidence that different standards were applied to the detriment of the decisions about student progress, although concerns were raised about the validity of some unit assessments, as reflected in the standard setting decisions. The procurement of an enterprise solution for

assessment data management – noting the Faculty's previous use of Questionmark, OnDemand and the current transition to Inspera, a University-wide online assessment platform – might be of benefit for quality assurance of assessment across the Medicine Program.

The Faculty has conducted significant research in assessment, publishing extensively in this area. This established approach leans heavily on the contribution of the dedicated current chair of FADE. While the current chair is to be acknowledged for his significant contribution to not just the medical program but also the wider literature, this dependence also presents a potential key person risk to the program's capacity to review assessment.

6 The curriculum – monitoring

6.1 Monitoring

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

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

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

The medical program has some monitoring and review mechanisms in place including central University processes, contributions to national surveys, a biannual survey of medical students, and some ad hoc evaluation activities. The Faculty has an appropriate focus on gathering student feedback and understanding course outcomes and experiences of the program.

There are two key evaluation tools administered at a University level. The first is a systematic review of programs by the Academic Board at least every seven years. Because UNSW is externally accredited by the AMC, the Board's review of the medical program is undertaken as a desktop, paper-based review. The second is the myExperience student survey. This survey is completed at the end of individual courses. Similar to the experience of other medical programs, this central University mechanism does not always meet the needs of the UNSW medical program. In particular, the timing and focus of myExperience surveys does not align well with the quality assurance needs around clinical placements.

The Faculty considers the results of national surveys, including the Quality Indicators for Learning and Teaching Student Experience Survey (QILT SES) and the joint AMC/Medical Board of Australia National Preparedness for Internship Survey. While the Faculty indicated that the internship survey, which has not run since 2019, was a component of its quality assurance framework, the Team noted there was not much indication that QILT SES results are used widely.

In order to meet the medical program's unique evaluation needs, the Faculty designs and employs the Medicine Student Experience Questionnaire (MedSEQ). MedSEQ has been developed to capture medical students' perceptions of their learning experience and is completed by students every two years. Response rates have varied each year from 36.9% in 2017 to 34.2% in 2021. The data from this survey provide the Faculty with opportunities to analyse trends in the student experience and inform the medical program redesign.

In relation to the student experience in the clinical environment, the Faculty has promoted the use of the Perceived Effectiveness of Clinical Teaching Scale (PECTS) for use as an evaluation tool by clinical teachers. This has recently been operationalised via a mobile-enabled system that uses a QR code to allow clinical teachers to request anonymised feedback from students. The Team found that there is currently limited awareness of, and engagement with, the PECTS tool among clinicians and therefore limited evidence of it feeding back to an improved student learning experience. With the systems in place, the Team encourages the Faculty to work to improve the uptake of this promising tool.

Staff feedback is primarily obtained through representation on committees and working groups. Specific evaluation projects often include the targeted collection of teacher feedback obtained by either surveys or focus groups. The Faculty also sees performance appraisal processes and the annual planning day with the Senior Leadership Team as further opportunities to solicit and receive staff feedback. The Team consistently heard that staff feel they are able to contribute feedback and that their ideas are seriously considered.

At a University level, the monitoring and evaluation approach is focused on continuous improvement in accordance with UNSW's Scientia Educational Experience (SEE) framework, as

outlined in the UNSW 2025 Strategy. The framework sets the expectations of a holistic and flexible educational approach, quality teaching and student experience against which programs are evaluated and continuously improved. Though the SEE framework sets a clear expectation about what drives the quality of UNSW and how this will be further built upon, the Team did not see that it establishes clear mechanisms to quickly and effectively manage concerns about quality nor set a clear threshold for what success looks like.

The approach to integrating the consideration of these tools into the medical program quality assurance process is clearer than the University-wide SEE framework, but falls short of a holistic approach which can consistently manage concerns around risk and enable consistent continuous improvement. Data from surveys and other sources are discussed at the Program Evaluation and Improvement Group (PEIG), which is the main medical program evaluation working group. The PEIG is the body that administers the MedSEQ. PEIG follows a high-level evaluation framework to continuously monitor, support and improve the medical program through four aspects: the formal curriculum and resources, student experience, quality of staff and teaching, and student and graduate outcomes. Performance in each of these aspects is tracked through a set of key quality indicators. PEIG makes strategic decisions on which parts of the medical program to focus on for improvement. Discussions from and decisions made at PEIG are fed back to the CDC and the respective Phase Committees or Course Convenors. The structure and function of PEIG was described to the Team as and shown through the Terms of Reference to be fairly informal.

At an individual course level, each course has a Design and Implementation Group (DIG), comprised of a variety of teachers, content and educational experts who contribute to the course. The DIGs meet every six months to discuss the outcomes of the course, including by reviewing evaluation tools such as myExperience. The outcomes of the various DIGs for each course come through the Phase Committee to the CDC.

As mentioned earlier, FADE is the working group that looks specifically at evaluation of assessment. The assessment evaluation process follows similar steps to the broader medical program quality assurance process, but also involves the assessment-related subcommittees such as the Phase Examination Committees and CLAC.

The Faculty also sometimes employs more targeted ad hoc evaluation activities, such as the review of Phase 2 in 2018. This initiative was in response to 2017 data from the MedSEQ suggesting that students in Phase 2 were less satisfied than students in other Phases. This review took the form of a workshop which led to some recommendations and subsequent changes.

For the medical program redesign which is currently underway, the Faculty is undertaking a broad and well-resourced evaluation and consultation approach. The Team was impressed by the comprehensive and open process to consultation which the Faculty is engaging in.

With respect to collaborations with other education providers, the Faculty uses comparative data from the QILT SES and participates in AMSAC and other assessment collaboration initiatives to further monitor the medical program.

The PEIG is responsible for both considering evaluation data and making and implementing change recommendations. There is no separate place in the current governance structure to consider overall evaluation data, including outcome data and trends, without a focus on the impact of any recommendations. It would be helpful to have specific evaluation expertise on the PEIG and for clear alignment with the evaluation work on assessment, through FADE. The Faculty could also consider formalising the PEIG, with a clearer remit around summarising and systematically disseminating evaluation data and ensuring accountability for change.

In general, the Faculty ensures timely responses and student-centred approaches to the many sources of student feedback across metropolitan and rural sites, but there is evidence that some important feedback from students is not acted on in a timely fashion. The team heard from students and staff at Wagga Wagga that their requests for flexibility regarding timing of integrated online tutorials to align with clinical hours were declined, as were requests to have these sessions recorded. There was evidence of continued use of negative stereotyping in case studies of Aboriginal and/or Torres Strait Islander people despite student concerns of its contribution to a culturally unsafe environment for Indigenous students, and a lack of purpose in the use of these

negative framings. The student society, MedSoc, is clearly a positive, empowered and valued contributor to the evaluation of the medical program. MedSoc's contribution and leadership is an important and complementary part of evaluation approaches.

Given the planned medical program redesign, and implementation of end-to-end pathways in the Rural Clinical Campuses, it will be important for the Faculty to prioritise and resource a whole-of-program evaluation strategy that has some independence from current structures and which solicits and utilises feedback to the range of key stakeholders.

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 University and Faculty take part in the QILT SES and the joint internship survey (last run in 2019), and the Faculty administers MedSEQ. These surveys show that students have good experiences and outcomes in line with other medical programs in Australia. In the case of the SES, there was a noticeable dip during 2020 and 2021 which the Faculty attributes to the impact of COVID-19 on the student experience.

Although there were no regular, formal avenues for feedback on outcomes from external stakeholders, the Team gained a general sense from stakeholders that there is a range of opportunities to be heard and to share perceptions of graduate work readiness. The Faculty does not run its own exit or graduate survey and makes limited use of other sources of data such as the Medical Deans Australia and New Zealand Medical Schools Outcomes Database. Data such as these would assist the Faculty to better understand student intentions and outcomes to inform the ambitious medical program redesign and, for example, to ensure the success of the strategic focus on primary care.

Comprehensive work is undertaken to examine student performance in the medical program, including in relation to student characteristics. This work clearly takes a broad approach, is well resourced, and demonstrates its value in informing development of admission and selection processes. The current process for performance evaluation within and across cohorts will continue to be important with increased diversity of cohorts, and as changes are made to the program. The work being done to analyse assessment data across cohorts is key to ongoing monitoring and provides insights to the types of student support needed.

The Faculty should, within its broader evaluation approach, use specific tools and have processes to collect and review outcome evaluation data. These outcome data should focus on graduates and students in the latter stages of the medical program to inform priorities for the medical program. For example, the Faculty may consider reviewing the outcomes of the COVID-19 initiative that saw later-year students acting in Assistant in Medicine roles during the pandemic, an initiative that was considered a valuable learning experience. The Faculty should consider more systematically collecting the feedback from key stakeholders such as NSW Health and the NSW Health Education and Training Institute (HETI).

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.

Academic staff and students are aware of evaluation data, mainly through inclusive participation on the myriad committees and working groups that regularly consider evaluation data. Reports generated from evaluation and monitoring tools, particularly myExperience, are provided directly to relevant teachers, Course Convenors, the DIGs and Phase Committees, the Program Authority, and the Senior Vice Dean (Education). These reports are also considered by the CDC and the Faculty Education Committee. The Academic Board receives and discusses reports on the student experience – both external (SES) and internal (myExperience). Student representatives from MedSoc have membership on PEIG, CDC and other relevant committees where evaluation data is shared and discussed in depth. A 'Closing the Loop' intranet site provides students and staff with an overview of evaluation findings from myExperience and MedSEQ, and resultant change plans by course.

Processes for formal reporting on changes as a result of evaluation are limited. The Faculty could enhance its processes for communicating its responsiveness to issues raised through various stakeholder channels.

There is limited distribution of data on graduate outcomes to external stakeholders. The clinical schools are responsible for distributing results to clinical teachers who are not staff of the medical program, though there is no central process to support this. The Faculty does not have processes for distributing evaluation results to community stakeholders or health service partners. Although the Faculty is undertaking substantial internal consultation to inform its medical program redesign process, the needs and input of external stakeholders have been less well considered.

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 a quota of 198 domestic commencing students, set by the Australian government. The Faculty has agreed to a quota of 100 international students. Recruiting is done within these limits. UNSW is predominantly an undergraduate entry program with 90% of the commencing cohort being school leavers. The remainder of the places form the graduate entry pathway, accepting students from the UNSW BMedSc program and transferring students from the International Medical University and the Universiti of Brunei Darussalam. The Faculty has the resources to support this number of students, though it acknowledges some challenges in clinical teaching capacity in some clinical disciplines in Phases 2 and 3.

In addition to the standard entry pathway, the medical program has a number of targeted special entry schemes available for people from rural backgrounds, Aboriginal and/or Torres Strait Islander students, and people from equity groups particularly those from low socioeconomic backgrounds.

Students applying through the Rural Student Entry Scheme (RSES) compete for a separate entry quota of at least 28% of UNSW's yearly domestic intake. RSES is well supported and includes active outreach to and recruitment of people with rural backgrounds, primarily through extensive rural high school outreach events.

The medical program has a well-supported Indigenous Entry Scheme, complementing a strong strategic focus on recruiting and admitting Aboriginal and/or Torres Strait Islander students. To provide potential Aboriginal and/or Torres Strait Islander applicants with an experience of University life, Nura Gili, the UNSW Aboriginal and/or Torres Strait Islander educational unit, runs a week-long Winter School program for Aboriginal and/or Torres Strait Islander students in Years 10–12, which the Faculty enthusiastically participates in. Aboriginal and/or Torres Strait Islander students who are successful in their initial application through the Pathway, which does not consider ATAR or University Clinical Aptitude Test (UCAT) results, attend a three and a half-week Pre-Medicine Program (PMP). PMP is an intensive residential preparatory course, jointly managed by Nura Gili and the Faculty. The Program is highly regarded by stakeholders. For the Faculty's Aboriginal and/or Torres Strait Islander student support and academic team, PMP allows an understanding of applicant performance and provides pathways for students who need additional bridging courses or who may not be suited for medicine. For Aboriginal and/or Torres Strait Islander applicants and students, PMP is highly supportive and allows them to build a community before entering the Medicine Program.

There are no set targets relating to Aboriginal and/or Torres Strait Islander student cohort numbers but the Faculty states that it aims to recruit as many students as possible. Data provided shows that since 2016, the medical program has enrolled around 10 Aboriginal and/or Torres Strait Islander medical students annually. The program currently has 58 Aboriginal and/or Torres Strait Islander student enrolments. While the numbers of Aboriginal and/or Torres Strait Islander students entering and progressing through the program has been steadily increasing, recruitment and admission activities would be better supported if the Faculty had concrete targets to measure success against.

The ACCESS scheme awards applicants who have experienced longstanding hardship bonus ATAR points to support their application into the various UNSW programs including the medical program. This scheme supports people from culturally and linguistically diverse backgrounds, people with disabilities and people with caring responsibilities.

The Gateway Entry Scheme into the medical program fits within the goals of UNSW 2025 Strategy and Health 25 Strategy to increase the accessibility of the medical program for students identified as being from low socioeconomic backgrounds. The Scheme allows up to 10 students from low socioeconomic backgrounds to enter the Program in Year 1, without competing against other domestic entry cohorts. Potential applicants are engaged through the Gateway Admissions Pathway and Programs initiative, which includes experience days delivered by the Faculty. Students admitted through the Scheme are supported by the Gateway Mentoring Program, receive targeted transition support and are prioritised for UNSW Equity Scholarships, among other financial and community-building supports. At present, domestic entry students from lower socioeconomic status represent 6–10% of the cohort. The Faculty aspires to increase this to 13% by 2025.

The Team was impressed by the Faculty's dedication to promoting diversity within the student body. However, the Team noted that the demand for services continues to rise as more students from equity groups are recruited and enrolled through targeted access initiatives, and yet the supply of these services has not consistently kept pace. Students and staff told the Team about their concerns regarding the level of support for students gaining admission through targeted entry schemes once they are enrolled in the course.

This was particularly true in relation to support for retaining Aboriginal and/or Torres Strait Islander students. While PMP is seen as very well supported, the Team heard that, once enrolled in the medical program, Aboriginal and/or Torres Strait Islander students disproportionately struggle academically and are not adequately scaffolded with academic and pastoral support. This leads to a perception among some stakeholders that these students are being set up to fail. The Student Experience Officer (Indigenous), who recently rejoined the Faculty, is held in high regard, but their role is mainly to triage student needs, and the mainstream support services that students are referred to often do not meet the needs of Aboriginal and/or Torres Strait Islander students. Concerningly, stakeholders described numerous incidents which add up to a learning environment that is deemed to be culturally unsafe for Aboriginal and/or Torres Strait Islander students and staff. A lack of accountability for culturally unsafe behaviour, reporting pathways and support exacerbates these issues.

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 Faculty has a clear and well-evidenced selection policy and process which aims to increase the diversity of students and ensure that students are academically prepared to succeed in the medical program. The responsibility for designing, implementing and evaluating the selection policies lies with the Admission and Re-enrolment Committee. The Committee is chaired by a recognised expert in admissions policy and includes key Faculty and medical program leadership, as well as

representatives for all admissions streams and the Student Experience Team, which coordinates and administers the admissions process.

Entry into the UNSW Medical Program through the mainstream and international pathways and RSES relies on a combination of criteria, which includes academic merit demonstrated through the Higher School Certificate (HSC) or an equivalent qualification or results from a university degree, performance in the UCAT or International Student Admission Test (ISAT) and an interview. Applicants are first ranked and selected for an interview based on their ATAR or equivalent and UCAT/ISAT score. They also attend a structured interview with two interviewers. Where possible, the interviewers are mixed by gender, faculty/community member and clinician/non-clinician. Based on the interview, interviewers are required to classify applicants as highly suitable, suitable, maybe suitable and not suitable. Applicants are then ranked according to their ATAR or equivalent, UCAT/ISAT and interview score and offers are made to the applicants, proceeding down the ranking order until the quota is filled. Interviewers are trained thoroughly prior to participating in interviews.

Entry through the Lateral Entry Scheme from the UNSW BMedSc is also possible. The process is the same as described above, except that the academic merit criteria is based on BMedSc results. Approximately 10 students enter the medical program through this Scheme annually.

Gateway Entry Scheme candidates are also required to demonstrate academic merit, sit the UCAT or ISAT and attend an interview. However, only applicants who live in or attend school in a low socioeconomic area are eligible to be considered under this pathway. Their applications also include a personal statement, and applicants compete only with each other for the 10 available places.

Selection into the PMP to determine eligibility for enrolment through the Indigenous Entry Scheme is based on confirmation of Aboriginality, evidence of academic capability, motivation and knowledge of Aboriginal and/or Torres Strait Islander health issues. Selection does not consider ATAR or equivalent results and does not require students to sit the UCAT. The Faculty and University central services work together to select, monitor and support eligible Indigenous Entry students.

Since the medical program offers end-to-end pathways at some Rural Clinical Campuses, applicants select their preferred campus – Port Macquarie, Wagga Wagga or Kensington – and are assigned based on their preferences and rank. RSES students are generally allocated to and expected to remain at a Rural Clinical Campus.

The latest review of the admission process took place in 2016 by a specially formed Selection Working Party and was first applied to the 2018 student cohort. During this review, modifications were introduced to the interview questions, placing a greater emphasis on evaluating the behaviours, thoughts and attitudes of applicants in response to various scenarios. Additionally, the scoring scale for the interview was revised to enable interviewers to assess an applicant's response in conjunction with their application. A non-compensatory algorithm was introduced, as each tool measures a unique set of attributes, and selection is primarily based on applicants providing adequate evidence of suitability, while avoiding any indications of their unsuitability for the program. These changes have led to a higher academic level of successful applicants while also increasing the proportion of students from low socioeconomic backgrounds, in line with the Faculty's broader strategic aims.

The medical program has no specific policies that address the admission of students with disabilities, though the Faculty does not prohibit the admission of any students on these grounds and states that it encourages applications from students with disabilities. The Faculty affirms its dedication to supporting students with disabilities to successfully complete the program, striving to make reasonable accommodations in line with UNSW policy whenever feasible. While the Faculty does not have a policy on the inherent requirements for studying medicine, it has recently developed a guide for prospective students that outlines expectations of the program.

The Faculty has an Immunisation and Blood-Borne Viruses Policy that aligns with NSW Health policies.

Whilst there is a proactive and robust approach to recruiting Aboriginal and Torres Strait Islander students, there is no dedicated Aboriginal and/or Torres Strait Islander student retention strategy to support recruited students. The Team appreciates the Faculty's ambition to revise and review processes regarding Aboriginal and/or Torres Strait Islander student recruitment and retention. The revision and review processes are appropriately being guided by Aboriginal and/or Torres Strait Islander staff and experts, who should be properly resourced and supported by non-Indigenous staff and leaders. The Team looks forward to the implementation and evaluation of these strategies.

The Faculty has made its selection process, including the various entry pathways and details about the appeal process, easily accessible to the public through the UNSW website. In addition, a promotional booklet with targeted information for mainstream, RSES, international and other students is available. UNSW has information evenings for prospective students and proactively reaches out to Aboriginal and/or Torres Strait Islander communities and equity groups, in part to share information about selection processes.

7.3 Student support

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

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

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

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

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

Students enrolled in the medical program can access assistance through various channels, spanning from program-specific support to Faculty-level guidance and University-wide resources. Available services include mental health support ranging from on-campus counselling services to 24/7 mental health support lines that are accessible by call or text, study and academic advice, assistance with navigating personal issues, resources to aid safety and wellbeing and GP services.

Strategic planning to guide and inform initiatives and activities related to student health and wellbeing is undertaken by the Student Wellbeing Action Group, co-chaired by the Senior Vice Dean (Education) and a MedSoc representative. The Group reports to the CDC.

Student wellbeing is appropriately prioritised by the Faculty. Within the medical program, learning activities on the topic of self-care and stress management are embedded in each Phase of the course. In addition to this, clinical students have access to the Employee Assistance Program at all NSW Health hospitals. Students at rural campuses are encouraged to utilise University central services. However, it is evident that academic and professional staff at remote sites frequently deliver personalised support for students, driven by a strong sense of community. This is reflected in the high levels of satisfaction regarding wellbeing support amongst students at rural locations.

Support for Aboriginal and/or Torres Strait Islander students is a coordinated effort among University- and Faculty-level supports. However, as mentioned, while these support staff take great efforts to uplift students, the resourcing for these efforts and connection into mainstream support

services falls short of the medical program's needs. Nura Gili is the University-wide centre for Aboriginal and/or Torres Strait Islander students. Nura Gilli offers all Aboriginal and/or Torres Strait Islander students support through advocacy, tutoring, workshops, events and safe study spaces. Services provided through Nura Gili are highly regarded and appreciated by students. The Faculty Student Experience Officer (Indigenous) is the primary touch point for all Aboriginal and/or Torres Strait Islander students and provides much needed services. Aboriginal and/or Torres Strait Islander students also have a range of scholarships available to them.

Students entering the Program through the Gateway Entry Scheme are supported through workshops, opportunities to meet other students from the admission pathway and support staff, the Faculty Academic Mentor program, and financial scholarships and bursaries. The Team notes that the success of the Faculty Academic Mentor Program is varied and is under review.

RSES students are mainly supported through the active Rural and Allied Health Medical Society, which is funded by, and collaborates extensively with, the Faculty. Students from a rural background also have a range of tailored scholarships available to them.

The Wellbeing and Student Support Staff within the Faculty work in conjunction with University Central Services to maintain an impressively high level of service for a large, diverse, and widely distributed student cohort. The Faculty Wellbeing Officer and the Faculty Student Experience Officer (Indigenous) act as primary points of contact for issues related to student wellbeing. The Team noted that at present these roles have a workload of everyday service provision that is not sustainable and restricts the ability of the role holders to strategically contribute to wellbeing initiatives within the Faculty. Moreover, due to the University and Faculty's shared aspiration to diversify the student cohort through targeted admission schemes the need for specialised student support will continue to increase, highlighting the need for a review into the accessibility, efficacy and sustainability of the current wellbeing processes.

The mechanisms for identifying and supporting students with additional health and academic support needs rely on a small group of key teaching and administrative staff to detect struggling students and refer them on to support service. In particular, the Faculty describes that Course and Phase Convenors have knowledge of support services, and they are approached by teachers in small group activities, placement supervisors and administrative staff, who have more direct contact with individual students. Many students and staff members that the Team spoke to indicated that they would not know what to do if they became aware of a peer being at risk. Formalised processes in this area would ensure that students and staff were aware of how to identify issues and, importantly, the key contact people to speak to in the medical program.

The Faculty does not proactively identify students with blood-borne viruses in line with University policy.

Efforts to maintain a separation between providers of student support and academic progression decision-making is evident through delegated roles for student support. There is a commitment to maintaining confidentiality regarding the reasons that students access support services. This is achieved through processes for establishing and actioning Equitable Learning Plans, strengthen the separation between student support and academic progression decision-making.

While students and staff are broadly aware of the Faculty Wellbeing Officer, there was little awareness – even among student support staff and coordinating academics – of the senior officer for grievances. This is consistent with a broader trend of students feeling complaints are not taken seriously by the Faculty or even that they may be subject to retaliation for raising a concern, particularly around cultural safety. The Faculty should consider reviewing its complaints process to ensure that students have confidence that concerns will be handled fairly, consistently and appropriately.

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.

There are a handful of relevant policies that form the basis for expectations and grievance processes related to professionalism, impairment and fitness to practise medicine. The Faculty's *Fitness to Practise Policy* and *NSW Health Code of Conduct* are key documents related to student conduct in clinical environments and patient safety. The *UNSW Student Code of Conduct* outlines the general professional and ethical expectations of students in the academic environment and outlines the policies and processes for managing student misconduct. Medical student expectations regarding professionalism are further outlined in *Professionalism in Medicine: A Student Code of Conduct*, which is available on the Medicine program website. Content from this document is integrated into the Foundations Course. Furthermore, aspects of professionalism are integrated into all Graduate Capabilities.

Significant breaches of professionalism expectations are escalated to the Senior Vice Dean (Education) who then works through the case with the UNSW Conduct and Integrity Office. Faculty policies and procedures can allow for exclusion of students on the grounds of unprofessional behaviour if required, as has happened in a small number of cases.

The Faculty adopts an educative approach to professionalism wherever possible through requiring students to reflect on minor instances of unprofessional behaviour in portfolio assessment.

While this educative approach in principle provides an opportunity for students to learn through reflection, the Team was told of cases where the students who raised concerns about issues, particularly Aboriginal and/or Torres Strait Islander students speaking out in response to alleged cultural safety issues and instances of racism, were then told their behaviour in raising the concern was unprofessional. Some students were made to reflect on concern-raising behaviour in their portfolio where it was recorded as unprofessional behaviour and felt this was ultimately inappropriate as a response to a perceived lack of cultural safety or racism. They felt unsupported in having to recount their 'unprofessional' role in a situation where they had been the ones subject to unacceptable behaviour.

Plagiarism is systemically monitored through Turnitin, a similarity detection program. Students are made aware of this process via course guides and the Medicine Program website. Cases of plagiarism are addressed in compliance with the guidelines set by the University.

7.5 Student representation

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

The Faculty maintains a robust and effective partnership with UNSW MedSoc, including by ensuring that students are appropriately represented on all Faculty committees. Student representatives acknowledge the Faculty's leadership for their commitment to inclusivity and responsiveness to student input. The student cohorts at Port Macquarie, Wagga Wagga and the rural clinical campuses are represented on key committees, including the Student Wellbeing Action Group (SWAG). The Team appreciates the functional nature of this relationship and applauds the initiatives of MedSoc.

MedSoc representatives uphold the organisation's mission to advocate equally and effectively for all medical students, however the Team was concerned that in the absence of a widely understood and effective formalised complaints process, students overly rely on MedSoc as the point of escalation for all student concerns.

7.6 Student indemnification and insurance

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

The Medical Program provides comprehensive indemnity insurance coverage for students on approved clinical placements. Students on approved international placements with an approved Overseas Risk Assessment are covered under UNSW travel insurance. Details regarding insurance cover are communicated to students via the Program Guide.

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.

Physical facilities in the Faculty's teaching and learning sites meet the needs of the student body and staff and help ensure the outcomes of the medical program can be achieved. Facilities are spread across various campuses and learning sites.

The Kensington Campus facilities are particularly well resourced, with much of the teaching space directly managed by the Faculty. Large central lecture theatres, used for Phase 1 teaching and live streaming to other sites, are managed through a central University booking system. Teaching spaces are located in the Wallace Wurth Building and accommodate a variety of fit-for-purpose learning and teaching methods. These include lectures, student-led study, clinical skills simulation, small group teaching, large active learning and laboratory-based learning, with both physiology wet teaching laboratories and biotechnology & biomolecular sciences teaching laboratories. The Samuels Building has teaching spaces used in Phase 2 and 3 and a pathology museum. There are staff offices in both buildings. The campus hosts a safe space for Aboriginal and/or Torres Strait Islander students and staff in the Faculty, and for students in the Nura Gili Centre.

The four metropolitan clinical campuses affiliated with the School of Clinical Medicine (SoCM) are physically located in buildings owned and co-occupied by the hospitals where they are based. At each campus, UNSW has adequate, clearly identifiable spaces for teaching, student facilities and offices for both academic and professional staff. This includes space for the Clinical Teaching Units which host the Teaching Support staff. The SoCM manages designated teaching space, which typically accommodates small group teaching, at all these campuses. Other teaching facilities such as lecture theatres and clinical skills centres are owned by the hospitals but are available for teaching medical students.

The Rural Clinical Campuses have designated buildings including small group teaching rooms, computer labs and a clinical skills training delivery capability. Each campus has offices for the Directors of Medical Education, professional staff and some academic staff, as well as student facilities.

More modern and fit-for-purpose spaces are planned in conjunction with capital works at some of these sites. In particular, the UNSW Biomedical Sciences Centre near the Wagga Wagga Base Hospital, slated for completion by the end of 2024, will include a suite of high-quality learning facilities including a state-of-the-art simulation suite.

The Team was satisfied that professional, academic and non-academic clinical staff have access to sufficient facilities to achieve the outcomes of the medical program. Metropolitan teaching sites generally identify more closely with UNSW as a direct resource for information. At rural sites, staff rely on local staff supports, identifying visits from central UNSW more for endorsement of what has been developed locally.

The Team heard that limited availability of accommodation for students placed across some Rural Clinical Campuses is a concern for the Faculty, and stakeholders and was pleased to hear that the Faculty has established a working group to address this issue.

The Team heard from students that access to common rooms and clinical teaching units at the hospital sites to facilitate clinical tutorials was appreciated. Liverpool Hospital was particularly highlighted for providing opportunities for students to access supervised simulation labs.

Students were also positive about clinical learning spaces at the Rural Clinical Campuses, praising the implementation of simulation labs across clinical schools such as Wagga Wagga and Albury.

8.2 Information resources and library services

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

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

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

The Faculty and University employ a range of high-quality and modern information technology infrastructure, systems and applications that help achieve learning objectives. This is supported by access to high-speed wi-fi on campuses and at clinical sites. The Team identified that the internet availability in key student spaces on the Sutherland campus is not sufficiently reliable to consistently meet the educational needs of the staff and students, though the Faculty has taken steps to remedy this.

The Faculty uses Moodle as its learning management system. Applications integrate with Moodle to allow for blended learning. For example, students are able to interact with lectures remotely through Moodle with the UNSW Lecture Recordings+ system, supported by the Echo360 platform. There is also support for and extensive use of Microsoft Teams and Zoom.

A key IT system is eMed, a bespoke curriculum management system developed within the Faculty, which includes as a centrepiece a detailed, holistic and interactive curriculum map. eMed contains further applications, such as the student directory and timetable, which provide key functionality to both students and staff.

While the exact scope of plans is not clear yet, the Faculty advised that discussions with the University indicate that eMed is likely to be retired and replaced with a central University system as part of a broader move to modern IT enterprise solutions over the next several years. The Faculty has the support of the University to transition to a new system at a pace that does not compromise the usability and functionality of existing systems.

Students placed at clinical sites have access to both central Faculty learning resources through internet on their personal devices and computers at Clinical Teaching Units and hospital libraries. Students can access the health technology, including electronic medical records, and other clinical technology within their scope of practice.

The breadth and variety of library resources available is appropriate and meets the learning needs of the students. Students made particularly positive mention of the recent acquisition of licences for 3D educational platform Complete Anatomy. Students told the Team that access to further external resources through the University, such as Osmosis and AMBOSS, would be useful study tools to complement lectures.

Stakeholders told the Team that, in some instances, resources which are not centralised or compatible with the existing IT solutions are not easily accessible. For example, in Year 3, the eMed timetable is not always linked with hospital timetables at certain hospitals (e.g. Randwick campus), which potentially causes some confusion amongst students. Some students described receiving class timetables from the clinical school on the day they are expected to start their clinical placements.

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 amalgamation of the seven clinical and discipline Schools into the SoCM in 2022 has enabled a more coordinated and better calibrated approach to education across all the clinical campuses and disciplines. The medical program uses a graded approach to skill building, entrustability and time spent in clinical settings. Over the six years of the medical program, students gain a wide range of clinical experiences, with major discipline coverage guaranteed through the design of the clinical learning component of the program. Students undertake at least the minimum government-required 4-week clinical placement in a rural setting, with 30% of the cohort completing a year-long rural placement and increasing numbers participating in the end-to-end rural programs offered in Port Macquarie and Wagga Wagga. Students undertake short placements in community facilities in Phase 2, and 8-week placements in general practices in Phase 3.

The Faculty has acknowledged that there are two exceptions to the varied opportunities for clinical experiences across a range of models of care. The first is in more in-depth, longitudinal primary care placements. These types of placements are more available in the Rural Clinical Campuses, but the available opportunities do not yet match the Faculty's stated commitment to primary care.

The second area, which has a greater gap for the Faculty to bridge, is placements which provide structured clinical experience in Aboriginal and/or Torres Strait Islander health. All students participate in an immersion activity in Year 1, and all students visit an Aboriginal Community Controlled Health Organisation (ACCHO) as part of the Phase 3 Primary Care course. Students at Rural Clinical Campuses get additional immersion opportunities. A small number of students undertake placements at a handful of ACCHOs and community health services that serve Aboriginal and/or Torres Strait Islander communities.

The development of clinical learning opportunities in both areas will require greater engagement with a range of community health services. The Faculty should ensure that its Aboriginal and/or Torres Strait Islander staff are resourced to be able to guide the building of relationships with community health services, and continue to work with mainstream health services to secure structural opportunities to allow more students to have experience with Aboriginal and/or Torres Strait Islander health in these services.

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

8.4 Clinical supervision

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

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

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

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

The Faculty draws upon a large number of clinical academics, conjoint appointees, junior medical officers, GPs, and other practitioner supervisors to support the student placements in a variety of clinical environments. Clinical clerkship supervision arrangements in hospitals, many of which are UNSW-affiliated teaching hospitals, are effective and well supported by academic and professional staff. The General Practice Unit ensures that supervision arrangements in primary care placements are safe and effective. All those who contributed to clinical supervision that the Team met were committed to the medical program and expressed a strong desire to see the medical program succeed and ensure that students' learning needs are met.

Orientation and training opportunities are reasonable for hospital-based clinicians commencing student supervision. However, the lack of formal orientation left some supervisors uncertain of the requirements they were expected to meet. Clinical supervisors in hospitals receive written guides which outline the objectives of clinical clerkships. These supervisors are also offered, and many take up, the C-MED online modules, which explain the high-level expectations of supervisors. Conjoint supervisors are also required to sit the C-MED modules. Even greater uptake of these well-regarded modules would help with shared Faculty-supervisor understanding. Much of the mismatch of expectations hinges on the fact that clinicians are often teaching across different levels and for numerous educational and training providers. Key academics at the SoCM have established communities of practice in clinical disciplines to connect supervisors across sites and provide more opportunities for input into the medical program.

The system for primary care supervisor orientation and training, run by the General Practice Unit, is robust. These supervisors are subject to screening for eligibility, and orientation is more formalised.

All supervisors have access to C-MED modules and detailed written guides and handbooks. There are further opportunities to undertake more in-depth training in key competencies related to learning and teaching. The SoCM hosts an annual workshop and releases monthly webinars, and regularly updates a clinical teachers' website.

The Faculty monitors clinical supervisors effectively. Academic staff undertake periodic professional development with clinical supervisors and managers. Clinical academics are separately appraised by their hospital employer and the Head of their respective clinical departments. Conjoint appointees are formally reviewed by the Faculty's Director of Conferrals at either the time of appointment renewal or when applying for progression. The Team found that many of the conjoint appointees were unaware of the processes around opportunities for progression. The PECTS tool has promise to contribute to monitoring through more systematic collection of student feedback on supervisor quality; however, it remains underutilised.

Directors of Medical Education and Heads of Clinical Campuses are effectively able to monitor and assess teaching load and service requirements to ensure that individual clinical academics and conjoint appointees are meeting teaching obligations, and there is sufficient supervision capacity generally.

The Faculty appropriately defines responsibilities for clinical supervisors. Clinical placements in the NSW public health system are governed by an agreement (through HETI) such that each institution is 'responsible for the oversight of the education of its students.' Written agreements with primary care supervisors clearly establish reciprocal responsibilities.

Appendix One Membership of the 2023 AMC Assessment Team

Professor Alison Jones (Chair), Dean (Education), College of Medicine and Public Health, Flinders University

Professor Gary Rogers, Dean of Medicine and Professor of Medical Education, Faculty of Health, Deakin University

Professor Julian Archer, Head of School, School of Medicine and Dentistry, Griffith University

Ms Petah Atkinson, Lecturer and PhD Candidate, Gukwonderuk Indigenous Engagement Unit, Faculty of Medicine, Nursing and Health Sciences, Monash University

Professor Kirsty Forrest, Dean of Medicine and Professor of Medical Education, Faculty of Health Sciences & Medicine, Bond University & Senior Staff Specialist in Anaesthetics, Gold Coast University Hospital

Professor Jeff Hamdorf AM, Director, Clinical Training and Evaluation Centre, Head, Discipline of Surgery & Professor of Surgical Education, University of Western Australia

Ms Tisshapaa Sivagnanan, Medical Student, James Cook University & President, Australian Medical Students Association

Mr Daan Verhoeven, Manager, Medical School Assessments, Australian Medical Council

Ms Juliana Simon, Manager, Specialist Medical Program Assessment, Australian Medical Council

Ms Esther Jurkowicz, Program Support Officer, Australian Medical Council

Mr Simon Roche, Program Support Officer, Australian Medical Council

Appendix Two Groups met by the 2023 Assessment Team

Meeting	Attendees
Monday, 25 September 2023	
University of New South Wales, Kensington	
Welcome to Country and Smoking Ceremony	Aboriginal Elder Deputy Vice-Chancellor (Academic Quality) Interim Dean, Medicine & Health Senior Vice Dean Education, Medicine & Health Senior Vice Dean Research and Operations, Medicine & Health Faculty Executive Director, Medicine & Health Deputy Faculty Executive Director, Medicine & Health Director, Strategy & Precincts Head, School of Population Health Director, Centre for Big Data Research in Health Program Authority, BMed MD
Acknowledgment of Country and Welcome	Deputy Vice-Chancellor (Academic Quality) Interim Dean, Medicine & Health Senior Vice Dean Education, Medicine & Health Senior Vice Dean Research and Operations, Medicine & Health Faculty Executive Director, Medicine & Health Deputy Faculty Executive Director, Medicine & Health Director, Strategy & Precincts Head, School of Population Health Director, Centre for Big Data Research in Health Program Authority, BMed MD
UNSW Medicine and Health Executive	Interim Dean, Medicine & Health Director of Teaching, School of Clinical Medicine Senior Vice Dean Education, Medicine & Health Faculty Executive Director, Medicine & Health Head Rural Clinical Campuses & Associate Dean Rural Health Program Authority, BMed MD IT Business Partner, Medicine & Health Clinical Lead, Medicine Program Redesign Associate Dean Indigenous, Medicine & Health Phase 3 Convener
Indigenous Strategy – Faculty Perspective	Interim Dean, Medicine & Health Associate Dean Indigenous, Medicine & Health Head, Rural Clinical Campuses & Associate Dean Rural Health Director of Medical Education, Wagga Wagga campus Student Experience Officer (Indigenous) Senior Vice Dean Education, Medicine & Health Coordinator, Pre-Medicine Program Head, School of Population Health

Meeting	Attendees
	Director of Indigenous Health Education Lecturer, Aboriginal and Torres Strait Islander Health
Academic Leaders – Curriculum	Program Authority, BMed MD Senior Vice Dean Education, Medicine & Health Director of Teaching, School of Clinical Medicine Head, Rural Clinical Campuses & Associate Dean Rural Health Academic Consultant, Coffs Harbour campus Director of Medical Education, Albury campus Director of Medical Education, Port Macquarie campus Director of Medical Education, Wagga Wagga campus Phase 1 Convenors ILP/BSc (Med) Hons Convenor Phase 3 Convenors Clinical Skills Convenor Clinical Teaching Support Manager, Medicine & Health Discipline Manager President, UNSW MedSoc Vice President Advocacy, UNSW MedSoc Vice President Inclusivity, UNSW MedSoc Director of Indigenous Health Education Director of Simulation, School of Clinical Medicine Senior Lecturer, South Western Sydney Campus
Interim Dean	Interim Dean, Medicine and Health
UNSW Aboriginal and/or Torres Strait Islander	Director of Indigenous Health Education Associate Dean Indigenous, Medicine & Health Lecturer, Aboriginal and Torres Strait Islander Health Student Experience Officer (Indigenous) Lecturer, School of Population Health
Assessment Strategy	Senior Vice Dean Education, Medicine & Health Chair, Faculty Assessment Development and Evaluation Group Chair, Clinical Learning and Assessment Committee Medicine Portfolio Assessment Convenor & Written Assessment Lead Director of Teaching, School of Clinical Medicine Program Authority, BMed MD Director of Indigenous Health Education
Assessment in Practice	Senior Vice Dean Education, Medicine & Health Chair of Faculty Assessment Development and Evaluation Group Chair, Clinical Learning and Assessment Committee Medicine Portfolio Assessment Convenor & Written Assessment Lead Program Authority, BMed MD Phase 1 Convenors ILP/BSc (Med) Hons Convenor

Meeting	Attendees
	Phase 3 Convenors
Information Technology	IT Business Partner, Medicine & Health Teaching Support Team Lead, BMed MD Manager, Medicine & Health Education Development Unit Chair, Technology Enhanced Learning and Teaching Senior Technical Support Officer, Rural Clinical Campus, Port Macquarie
Professional Staff	Faculty Executive Director, Medicine & Health Deputy Faculty Executive Director, Medicine & Health Education & Student Experience Manager, Medicine & Health Teaching Support Manager, Medicine & Health Academic Programs and WIL Manager, Medicine & Health Clinical Teaching Support Manager, Medicine & Health Manager, Rural Clinical Campuses Student Experience Officer (Indigenous)
Indigenous Students	Students
Debrief with Dean	Interim Dean, Medicine & Health Senior Vice Dean Education, Medicine & Health
Tuesday, 26 September 2023	
University of New South Wales, Kensington	
Teaching and Learning Overview	Senior Vice Dean Education, Medicine & Health Head, School of Clinical Medicine Director of Teaching, School of Clinical Medicine Program Authority, BMed MD Academic Consultant, Prince of Wales Hospital, Randwick Head of Discipline of General Practice Phase 1 Convenors Phase 2 Convenor ILP/BSc (Med) Hons Convenor Phase 3 Convenor Element Convenor - Clinical Skill Element Convenor - Ethics Element Convenor - Quality of Medical Practice Director of Simulation, School of Clinical Medicine Director of Indigenous Health Education Lecturer, Aboriginal and Torres Strait Islander Director of Medical Education (UNSW Wagga Wagga)
President of Academic Board	President of Academic Board
Faculty Executive	Interim Dean, Medicine & Health Senior Vice Dean Education, Medicine & Health Faculty Executive Director, Medicine & Health Deputy Faculty Executive Director, Medicine & Health Director Strategy & Precincts

Meeting	Attendees
	Head, School of Population Health Director, Centre for Big Data Research in Health Program Authority, BMed MD Associate Dean Indigenous, Medicine & Health
Vice Chancellor, President and Provost	Vice Chancellor and President Provost
Student Services	Student Services Business Partner Clinical Teaching Support Manager, Medicine & Health Teaching Support Manager, Medicine & Health Teaching Support Officers, BMed MD Work Integrated Learning Officer, BMed MD Education Developer, Education Development Unit Learning Resources Officer, BMed MD Admin Officer, Rural Campus Coordinator, Port Macquarie Student Experience Officer (Indigenous)
Admissions and Selection	Chair of Medicine Selection and Re-admission Committee Senior Vice Dean Education, Medicine & Health Student Experience Team Lead Education & Student Experience Manager Representing Manager, Rural Clinical Campuses Director of Indigenous Health Education Future Students Lead Student Experience Officer (Indigenous)
Student Support	Faculty Wellbeing Officer, Medicine & Health Student Experience Officer (Indigenous) Student Experience Officer, Medicine & Health Graduate Entry Bridging Course Convenor Clinical Mentoring Scheme Rural Campuses Coordinator Phase 1 Convenor Phase 2 Convenor Current Students Lead, Nura Gili Indigenous Program Student Success Officers, Nura Gili Academic Lead for Peer Assisted Study Support, Rural Clinical Campuses Education & Student Experience Manager
Student Experience	President, UNSW MedSoc Vice President Advocacy, UNSW MedSoc Vice President Inclusivity, UNSW MedSoc Albury Medical Society President St Vincent Hospital Year 3 Representative, UNSW MedSoc St George Hospital Year 3 Representative, UNSW MedSoc Sutherland Hospital Year 3 Representative, UNSW MedSoc

Meeting	Attendees
	Liverpool Hospital Year 3 Representative, UNSW MedSoc POW Hospital Year 3 Representative, UNSW MedSoc Coffs Harbour Year 3 Representative, UNSW MedSoc Port Macquarie Year 3 Representative, UNSW MedSoc Wagga Wagga Year 3 Representative, UNSW MedSoc
Interprofessional Learning	Head, School of Clinical Medicine Director of Simulation, School of Clinical Medicine Head, School of Health Sciences Professional Practice Development Lead, School of Health Sciences Senior Vice Dean Education, Medicine & Health Convenor, Clinical Transition Course Director of Indigenous Health Education Phase 3 Convener
Research Learning	ILP/BSc (Med) Hons Convenor Co-Convenor Phase 2 Head, Environmental determinants of obesity group Senior Hospital Scientist ILP Research Coordinator Lead, Medical Education Research Group Teaching Support Officer, BMed MD Associate Dean Indigenous, Medicine & Health Director of Indigenous Health Education Lecturer, Aboriginal and Torres Strait Islander Health Associate Professor, Obstetrics and Gynaecology
Simulation	Director of Simulation, School of Clinical Medicine Program Director, Simulation and Research, Ingham Institute Clinical Skills and Simulation Centre Director of Teaching, School of Clinical Medicine Element Convenor - Clinical Skills Lecturer, Clinical Skills and Simulator Educator, Port Macquarie Simulation Educator, Simulation and Research, Ingham Institute Clinical Skills and Simulation Centre Student Representatives
Meeting with Notre Dame Sydney	Head, St Vincent's and Mater Clinical School
Biomedicine Learning	Director of Teaching, School of Biotechnology and Biomolecular Sciences, Faculty of Science Phase 1 Convenors A/Professor, School of Biotechnology and Biomolecular Sciences, Faculty of Science Lecturers, School of Biotechnology and Biomolecular Sciences, Faculty of Science Director of Teaching, School of Biomedical Sciences Director of Medical Education, Port Macquarie
General Practice Clinical Unit	Head of Discipline of General Practice

Meeting	Attendees
	Senior Lecturer in Primary Care and Phase 2 Society and Health coordinator, and Phase 2 convenor Director of Medical Education Development, School of Population Health Lecturer, Phase 2 Society and Health coordinator Co-convenors of Phase 3 Primary Care (GP) course Clinical Teaching Support Officers, General Practice Lecturer Primary Care (Port Macquarie) Lecturer, Primary Care (Wagga Wagga) Lecturer, Primary Care (Coffs Harbour) Director of Indigenous Health Education
Debrief with Dean	Senior Vice Dean Education, Medicine & Health
Wednesday, 27 September 2023	
Liverpool Hospital	
Clinical Site – Liverpool Executives	General Manager, Liverpool Hospital General Manager, Bankstown Hospital Clinical Dean, Liverpool Clinical School, WSU Head of Clinical Campus, SWS
Clinical Training Site – Liverpool Hospital/South West Sydney Clinical Campuses Leadership	Head of Clinical Campus, SWS Director of Medical Education, SWS Clinical Campus Manager, SWS Research Director, SWS
Clinical Training Site – Liverpool Hospital/South West Sydney Clinical Campuses Placement Coordinators/Supervisors	Director of Medical Education, SWS Clinical Campus Manager, SWS Clinical Teaching Unit staff members
Clinical Site – Liverpool and SWS Students on Placement	Students
Clinical Training Site – Liverpool and SWS Academic Staff and Clinical Titleholders	Year 5 students Director of Medical Education, SWS Year 4 Research Coordinator Emergency Medicine Physician Medical Oncologist Haematologist Haematologist Professor Orthopaedic Surgery Associate Professor Neurology Head of Campus Lecturers – Simulation, SWS
Clinical Training Site – Liverpool and SWS Junior Medical Staff	Junior Medical Officers
Clinical Training Site – Liverpool and SWS Tour of Facilities	Clinical Campus Manager, SWS Lecturer – Simulation, SWS
Clinical Training Site – St George Hospital Leadership and Clinical Teaching (Virtual)	Head of Campus Director of Medical Services (St George Hospital) Campus manager Clinical Teaching Unit staff

Meeting	Attendees
	Academic (Teaching) Academic (Research)
Clinical Training Site – St George Hospital clinical Titleholders and Students (virtual)	Conjoint Academics Student Representatives
Wagga Wagga	
Clinical Training Site – Wagga Wagga Base Hospital Executives	Acting General Manager WWBH Clinical Operations Director Aboriginal Health Strategy, Policy and Performance Dean & Head of School of Clinical Medicine (Rural) Director of Medical Education (UNSW Wagga Wagga)
Clinical Training Site – Wagga Wagga Clinical School Leadership	Associate Dean Rural Health & Head, Rural Clinical Campuses Director of Medical Education (Wagga Wagga campus)
Clinical Training Site – Wagga Wagga Placement Coordinators/Leads	Director of Medical Education, Wagga campus Phase 1 Coordinator Phase 2 Coordinator Phase 3 Coordinator & Orthopaedic Lead Obstetrics & Gynaecology Coordinator Paediatrics Lead Emergency Medicine Lead Emergency Medicine Co-Lead Medicine Leads Primary Care Coordinator
Clinical Training Site – Wagga Wagga Students on Placement	Students, Years 1-6
Clinical Training Site – Wagga Wagga Academic Staff and Clinical Titleholders	Phase 1 Program Coordinator Senior Lecturer (Clinical Teaching) Phase 1 Lecturer Primary Care Lecturer Phase 1 Clinical Skills Coordinator Associate Lecturer, Communication Skills & Simulation Conjoint Professor Conjoint Senior Lecturer Anaesthesiology Lead Psychiatry Lead Administrator (Curriculum RCC) – Phase 1 Administrator (Curriculum RCC) – Phase 2 Administrator (Curriculum RCC) – Phase 3
Clinical Training Site – Wagga Wagga Junior Medical Officers	Junior Medical Officers
Clinical Training Site – Port Macquarie Clinical Campus (Virtual)	Director of Medical Education Academic Phase Coordinator Regional Training Hub Director Clinical/Discipline Lead

Meeting	Attendees
	Lecturer Indigenous Health and Culture Admin Officer, Rural Campus Coordinator Admin Teaching Support (curriculum) School Support Student representatives Director of Medical Services Deputy Director of Medical Services
Prince of Wales	
Clinical Training Site – Randwick Clinical Campus Executive	Chief Executive, Sydney Children's Hospital, Randwick General Manager, Prince of Wales Hospital General Manager, Royal Hospital for Women Head, Randwick Clinical Campus & Head, Discipline of Paediatrics & Child Health Director of Education, RaCC
Clinical Training Site – Randwick Clinical School, Clinical School Leadership	Head, School of Clinical Medicine Head, Randwick Clinical Campus + Discipline of Paediatrics & Child Health Head, Discipline of Women's Health Deputy Head, Randwick Clinical Campus, Discipline of Medicine Lead Head, Discipline of Surgery Head, Discipline of Critical Care Director of Teaching, School of Clinical Medicine Director of Education, RaCC Clinical Campus Manager, Randwick
Clinical Training Site – Randwick Clinical Campus Placement Coordinators/Leads	Director of Teaching, School of Clinical Medicine Senior Lecturer, Discipline of Paediatrics & Child Health Senior Lecturers, Discipline of Women's Health Clinical Teaching Unit Staff
Clinical Training Site – Randwick Clinical Campus, Students on Placement	Students
Clinical Training Site – Randwick Clinical Campus Academic Staff and Clinical Titleholders	Senior Lecturer, Prince of Wales Hospital, Randwick Professor, Sydney Children's Hospital, Randwick Associate Professor, Sydney Children's Hospital, Randwick Consultant, Sydney Children's Hospital, Randwick Conjoint Associate Professor, Sydney Children's Hospital, Randwick Conjoint Consultant, Sydney Children's Hospital, Randwick Professor, Royal Hospital for Women, Randwick Consultant, Royal Hospital for Women, Randwick Conjoint Professor, Royal Hospital for Women, Randwick Conjoint Consultant, Royal Hospital for Women, Randwick

Meeting	Attendees
	Conjoint Consultant, Royal Hospital for Women, Randwick
Clinical Training Site – Randwick Clinical Campus Junior Medical Staff	JMOs from POWH, RHW, SCH
Clinical Training Site – St Vincents Clinical Campus Leadership and Staff	Head of Clinical Campus Clinical Campus Manager Clinical Academics Professor of Clinical Pharmacology, Phase 3 BPS Prescribing Skills Assessment Lead Director of Medical Education Postgraduate Coordinator Clinical Teaching Support Unit Clinical Teaching Support Manager, Medicine & Health Clinical Teaching Support Administrator for St Vincent's Conjoints
Clinical Training Site – Randwick Clinical Campus Tour of Facilities	Head, School of Clinical Medicine Head, Randwick Clinical Campus + Discipline of Paediatrics & Child Health Director of Teaching, School of Clinical Medicine Director of Education, RaCC Clinical Campus Manager
Thursday, 28 September 2023	
NSW Health	A/Director, Workforce Governance Deputy Director, Clinical Governance and Medical Services, SESLHD Chief Executive Officer, SESLHD
Indigenous Strategy – University Perspective	Vice Chancellor and President (Online) Deputy Vice-Chancellor Education & Student Experience Acting Director Nura Gili (Online) Provost Associate Dean Indigenous, Faculty of Medicine & Health
Program Authority	Program Authority, BMed MD
Clinical Training Site – Coffs Harbour Clinical Campus (Virtual)	Director of Medical Education Academic Phase Coordinator Clinical/Discipline Lead Admin Officer, Rural Campus Coordinator Admin Teaching Support (curriculum) Student representatives LHD/Hospital representatives
Clinical Training Site – Albany Rural Clinical Campus (Virtual)	Director of Medical Education Academic Phase Coordinator Regional Training Hub Director representing Director Clinical/Discipline Lead Admin Officer, Rural Campus Coordinator Admin Teaching Support (curriculum)

Meeting	Attendees
	Students LHD/Hospital representatives
Friday, 29 September 2023	
University of New South Wales, Kensington	
Meeting with Dean	Interim Dean, Medicine & Health Senior Vice Dean Education, Medicine & Health
AMC Team presents preliminary statement of findings to Faculty representatives	Interim Dean, Medicine & Health Senior Vice Dean Education, Medicine & Health Faculty Executive Director, Medicine & Health Deputy Faculty Executive Director, Medicine & Health Director, Strategy & Precincts Program Authority, BMed MD Director of Indigenous Health Education