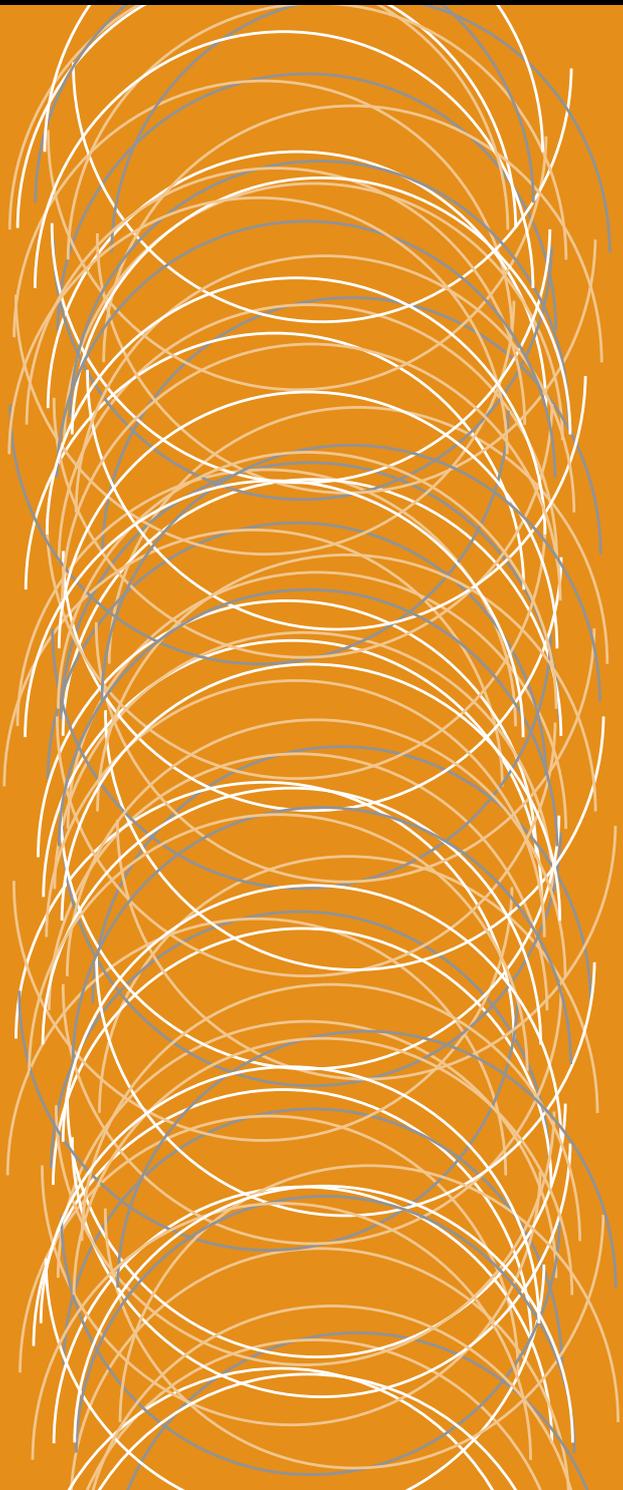


Australian Medical Council Limited

Accreditation of  
The Faculty of Medicine  
University of Otago

AMC



Medical School Accreditation Committee  
November 2008

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Australian Medical Council Limited

Australian Medical Council Limited  
PO Box 4810  
KINGSTON ACT 2604

Email: [amc@amc.org.au](mailto:amc@amc.org.au)  
Home page: [www.amc.org.au](http://www.amc.org.au)  
Telephone: 02 6270 9777  
Facsimile: 02 6270 9799

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## **Executive Summary 2008**

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An Australian Medical Council (AMC) assessment team visited the Faculty of Medicine, University of Otago, from 11 to 15 August 2008, to conduct a reaccreditation assessment.

The Faculty was last visited in August 2004 and, for the 2008 assessment, was given the option of undergoing a full reaccreditation or a smaller follow up visit. After discussion with the AMC, the Faculty requested a full assessment of the medical course with the view of obtaining the maximum available accreditation period.

The Team commented positively on the Faculty's progress and identified a number of areas of strength and a number of areas that will require consideration or development.

### **Areas of strength**

- i. The roles of Pro Vice-Chancellor for Health Sciences and Dean of the Faculty of Medicine have been combined providing direction and clarity, effective decision-making, better financial control and transparency.
- ii. Transparent funding based on EFT allocations.
- iii. Senior academic staff chair the Faculty Curriculum Committee and local curriculum development groups, providing important leadership and stability.
- iv. The educational expertise in undergraduate and postgraduate education and educational research, and Māori academia is impressive.
- v. The new curriculum in First Year Health Science, and the Early Learning in Medicine Programme with its good clinical relevance has had a positive impact on student learning and skills.
- vi. The new evidence based Hauora Māori program providing an experiential introduction to Indigenous health issues.
- vii. The well developed transition from Health Science Year 1, to Early Learning to Advanced Learning in Medicine to the Trainee Intern year and beyond.
- viii. The development and implementation of a broad range of learning methods, encouraging the development of attributes identified for graduates and including efficient ways to teach to large classes.
- ix. The innovative ways information technology is used to enhance learning.
- x. The clinical program, with its access to a wide geographical area providing students with a good number and range of patients.
- xi. The new facilities at all major sites are great assets for the delivery of the medical curriculum and are models for the whole Faculty.
- xii. The Medical Student Assessment Procedures Guide clearly setting out the assessment policy for staff and students.
- xiii. The ongoing development and implementation of monitoring and evaluation structures and processes.
- xiv. The development of the role of the Medical Education Adviser (MEA) in the evaluation of student experience.

- xv. The strong student support services, including counselling, and health and academic advice for students with social, cultural and personal needs. The Associate Dean Student Affairs at each campus is also an important contributor to student support.

### **Areas for improvement**

- i. The unclear relationship and reporting lines of MEGs (Medical Education Groups) to the MECs (Medical Education Committees) and the Faculty Curriculum Committee.
- ii. Although structure and content of domains and threads have been clearly defined, their impact on course design and assessment needs continuing promotion to ensure broad understanding by staff and better transparency for students.
- iii. The development of a common understanding and clear instructions on the role of the tutor.
- iv. The variation in commitment, and arrangements between clinicians and the University. A standard agreement between the University and the District Health Boards embedding teaching and supervision within contracts for all clinicians would be of benefit.
- v. Clinical titles and reliable access to University resources is encouraged for all clinical staff.
- vi. Vertical modules, formal teaching and attachment organisation need reviewing at some clinical placement sites to optimise student learning and immersion in the workplace.
- vii. Continuing expansion into peripheral urban and rural sites to retain optimal student numbers, and ensuring these adequately support learning, academic and administrative appointments.
- viii. The continuum of learning between the Trainee Intern year and the PGY1 and PGY2 years has been addressed by a working party of the Medical Training Board. The curriculum for PGY1 is being defined. The optimal organisation and length of training is being discussed by a number of groups including the Education Committee of the Medical Council of New Zealand and the Medical Training Board. More coordination will be necessary to ensure wide consultation.
- ix. The variable amount and quality of formative assessment in the clinical years. Assessments such as a one-station OSCE, the amount of assessment in Year 4 and process of awarding of distinction should be reconsidered.
- x. Monitoring and evaluation is being embedded in practice but mechanisms need to be in place for closing the loop, engaging external stakeholders effectively, and for sustaining an appropriate level of monitoring and feedback as the program expands.
- xi. Capital injection for IT and space for teaching and research is required, in part to attract and retain academic staff and researchers.

## **Recommendations 2008**

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### **Re-accreditation of established medical courses**

The AMC's *Assessment and Accreditation of Medical Schools: Standards and Procedures* provide the following options for the re-accreditation of established schools:

- (i) Accreditation for a period of 10 years subject to satisfactory periodic reports. Accreditation will be for six years in the first instance. In the year before the accreditation ends, the medical school will be required to submit a comprehensive progress report. 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 10 years subject to certain conditions being addressed within a specified period and to satisfactory periodic reports. Accreditation will be for six years in the first instance. In the year before the accreditation ends, the medical school will be required to submit a comprehensive progress report. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to a maximum of four years, before a new accreditation review.
- (iii) Accreditation for shorter periods of time. If significant deficiencies are identified or there is insufficient information to assess if development plans presented by school will result in a course that satisfies AMC Accreditation Standards, the AMC may award accreditation with conditions and for a period of less than six years. At the conclusion of this period, or sooner if the school considers that it has addressed its deficiencies, the AMC will conduct a review. The school may request either:
  - a full assessment of the school and the course, with a view to granting accreditation for a further maximum period; 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.
- (iv) Accreditation may be refused where the AMC considers that the deficiencies are so serious as to warrant that action or where the school has not satisfied the AMC that the complete medical course can be implemented and delivered at a level consistent with AMC Accreditation Standards.

### **Recommendations**

The Medical School Accreditation Committee recommends that the Australian Medical Council grant the Bachelor of Medicine Bachelor of Surgery of the Faculty of Medicine University of Otago accreditation for six years, that is until 31 December 2014, subject to the following conditions:

- i. that periodic reports to the Medical School Accreditation Committee demonstrate continuing progress against all areas which would benefit from further development, as per the Executive Summary, and areas for improvement as per the Preliminary Statement of Findings.
- ii. that subject to a satisfactory report from the Faculty in its fifth year of accreditation—that is, 2013—the AMC grant the Faculty a further period of accreditation, up to a maximum of four years, before the Faculty is revisited for accreditation.

## The AMC Accreditation Process

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The Australian Medical Council (AMC) is a national standards body for medical education and training. One of its principal functions is to advise and make recommendations to the State and Territory medical boards on the accreditation of Australian and New Zealand medical schools and medical courses. The link between AMC accreditation and registration is a statutory one: under the State/Territory Medical Practice Acts and/or statutes, graduates of AMC-accredited medical schools are eligible to apply for registration, subject to satisfying the medical boards' fitness to practise and character requirements.

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

The standards and procedures for accreditation are published in the AMC's *Assessment and Accreditation of Medical Schools: Standards and Procedures* (2002)<sup>1</sup>. The AMC lists the knowledge, skills and professional attributes expected on graduation, defines the curriculum in broad outline, and defines the educational framework, institutional processes, settings and resources necessary for successful medical education.

The AMC's Medical School Accreditation Committee, which includes members of the Council itself, and nominees of the Australian medical schools, the Medical Council of New Zealand, health consumers, medical students, the Confederation of Postgraduate Medical Education Councils and the specialist medical colleges, oversees the accreditation of medical schools.

In brief, the accreditation process is as follows: the AMC appoints a team (hereafter referred to as the Team), comprising a balance of members from several states and medical schools, from medical science and clinical disciplines, and from the health services. Members with other expertise may be part of the accreditation team, as considered appropriate. The medical school submits to the Team detailed documentation on the medical curriculum and the resources that underpin its delivery. The Team conducts a visit to the school and its clinical teaching sites. This visit normally takes a week.

Following an AMC visit, the Team prepares a detailed report for the Medical School Accreditation Committee (the 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, and its recommendation concerning accreditation to the Australian Medical Council.

The AMC Directors make the final decision concerning accreditation. In the case of major changes to accredited courses, accreditation may be granted until two years after the full course has been implemented, depending on satisfactory annual reports. Accreditation may be granted with or without conditions.

Once accredited by the AMC, all medical schools are required to report periodically to the Medical School Accreditation Committee on the ongoing evolution of the medical course, emerging issues

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<sup>1</sup> Following reviews in 2006 and 2007, new standards were approved by the Australian Medical Council at its meeting on 27 July 2006 and reviewed by the Medical School Accreditation Committee at its meeting on 23 October 2007. The new standards were used for the 2008 assessment.

that may affect the medical school's ability to deliver the medical curriculum, and the school's response to issues raised in its AMC accreditation report. Reports are required at least biennially.

## **Introduction: The Faculty of Medicine, University of Otago**

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The University of Otago was the first university to be established in New Zealand. It was also one of the first universities to be established in Australasia. It was founded in 1869 by ordinance of the Otago Provincial Council and within three decades of the establishment of the Province of Otago. The University opened in Dunedin in 1871 and, at that time, it was authorised to grant degrees in arts, medicine, law and music. A federal University of New Zealand was established by statute in 1870 and became the examining and degree-granting body for all New Zealand university institutions until 1961, when the University of New Zealand was disestablished, and the power to confer degrees was restored to the University of Otago by the University of Otago Amendment Act 1961.

The University has grown significantly since 1961, when enrolment numbers were approximately 3,000. There has been considerable growth in undergraduate and postgraduate enrolments, and in facilities and staff. In 2007, with enrolment numbers in excess of 18,000, the total number of full-time equivalent (FTE) staff was 3,453, with 2,028 FTE general staff and 1,425 FTE academic and research only staff.

Initially, the University of Otago had its campus solely in Dunedin. However, there was extension during the 20th century, due mainly to medical school activities, to significant campuses in Christchurch (in 1973) and Wellington (in 1977). There is also a smaller teaching facility of the University of Otago in Auckland and, with the recent amalgamation between the University of Otago and the Dunedin College of Education, there is a further campus in Invercargill in the South Island. Further teaching and associated activities take place at a range of geographic locations in the South Island of New Zealand and in the southern part of the North Island.

### **Governance and organisational structure of the University of Otago**

The University is governed by the University of Otago Council. The Council has been the governing body since the inception of the University, and operates in its present structure under the Education Amendment Act of 1990. The chair of the Council is the Chancellor, and the Council has staff and student representation amongst its membership, as well as positions appointed by the Minister of Education. There is also a position appointed by the Dunedin City Council.

The Executive Officer of the University is the Vice-Chancellor. The Executive includes the Deputy Vice-Chancellor (Academic) and the Deputy Vice-Chancellor (Research), the Chief Operating Officer, and the Secretary to the Council and the University Registrar. The current internal governance and organisational structure of the University was established in 1989, and is in the form of Divisions (Academic Divisions, and non-teaching [support and administrative] Divisions). The four Academic Divisions include Commerce, Health Sciences, Humanities and Science. The designation for the position of Head of each of the four Academic Divisions is Pro Vice-Chancellor.

### **The Division of Health Sciences**

The Division of Health Sciences is the largest academic division at the University of Otago. In 2007, the division had 5,122 EFTS and 1,459 FTE staff. The division consists of the following faculties and schools: dentistry, medicine, pharmacy and physiotherapy.

The mission of the Division of Health Sciences is to:

*Provide New Zealand society and other communities with a highly qualified workforce in the health*

*professions. The Division will promote health and health care through basic and applied research and academic and professional leadership. This will be achieved through research based undergraduate, postgraduate and professional programmes of international standard in the health sciences and related sciences.*

The strategic goals of the division reflect the six strategic imperatives of the University. These include:

- achieving research excellence
- achieving excellence in research informed teaching
- ensuring outstanding campus environments and student experience
- contributing to the national good and to international progress
- strengthening external engagement
- building and sustaining capacity

The campuses for the Division of Health Sciences are Dunedin, Christchurch (University of Otago, Christchurch), and Wellington (University of Otago, Wellington).

The Faculty of Medicine within the Division of Health Sciences comprises:

- Otago School of Medical Sciences
- University of Otago Christchurch
- Dunedin School of Medicine
- University of Otago Wellington

The deans of the faculties and schools in the Division of Health Sciences, in conjunction with the Business Manager and the Director of Policy and Programs for the Division, form the Executive of the Division of Health Sciences. The Divisional Executive oversees operational and strategic activities for the Division of Health Sciences. Academic program matters for the Division of Health Sciences are the responsibility of the Division of Health Sciences Board.

### **Assessment of the Medical course, the University of Otago**

The AMC first assessed the Faculty of Medicine, University of Otago in 1994. That assessment resulted in accreditation for a limited (five years) period with two conditions on the accreditation. The Medical Council of New Zealand also accredited the Faculty for five years and imposed conditions similar to those imposed by the AMC. In addition, the Medical Council of New Zealand highlighted general practice and behavioural science resourcing, and the adequacy of student counselling services as issues for attention.

In 1995, the Faculty reported to the Medical School Accreditation Committee (Accreditation Committee) of the Australian Medical Council (AMC) on its response to the conditions of its accreditation. On the basis of the 1995 assessment report, and the Accreditation Committee's advice that the Faculty had made good progress in dealing with the AMC concerns, the Faculty's accreditation until 1999 was confirmed.

During 1998, the Accreditation Committee and the Otago Faculty of Medicine discussed the arrangements for an AMC review before the Faculty's accreditation expired in December 1999.

When the AMC Team visited the Faculty in 1994, the Faculty had commenced a curriculum review. The revised curriculum was introduced in 1997. However, in 1999, when the AMC review was required, Years 5 and 6 of the revised course were still to be introduced. It was therefore agreed to conduct a limited AMC review visit in 1999 that would focus on the Faculty's response to the issues raised in the 1994 Accreditation Report, the revised curriculum for Years 2 to 4 of the medical course, and the current and proposed curriculum for Years 5 and 6.

The AMC visit took place in March 1999 and, following consideration of the report, the Accreditation Committee recommended that accreditation of the course be extended to 10 years; that is, until December 2004. Whilst there were no conditions on this accreditation, the Faculty was required to report annually to the Accreditation Committee on progress in implementing the new medical course and on its response to the issues raised as concerns in the Accreditation Report. These reports were assessed as satisfactory.

The principal task of the 2004 Assessment Team was to review the established curriculum in the light of AMC recommendations made on the previous visits, in 1994 and 1999. On the basis of the 2004 Report, the Accreditation Committee recommended that the Bachelor of Medicine Bachelor of Surgery course of the Faculty of Medicine University of Otago be granted accreditation until December 2008, subject to the following conditions:

- (i) In its report to the Medical School Accreditation Committee in September 2005, further details should be provided regarding:
  - strategic planning specifically to help address the budget deficits in the clinical schools
  - establishment of an overarching curriculum committee with responsibility for academic governance of the course
  - development of a modified course plan designed to take advantage of the work already done on the 'New Pathway'.
  
- (ii) In its report to the Medical School Accreditation Committee in September 2006, further details should be provided regarding:
  - re-establishment of a governance structure in which line management and budgetary control of the medical course reside with the Dean of the Faculty
  - establishment of Year 2/3, Year 4/5 and Year 6 committees reporting to the curriculum committee with responsibility for governance of each of these components across the whole course
  - establishment of common curricula in Years 4 to 6 across all sites
  - specific development of a clinical skills strand across the course to provide the basis for staged and horizontally integrated clinical skills teaching in Years 2 and 3 and vertical integration with Years 4-6
  - development of an overarching assessment policy for the Trainee Intern year.
  
- (iii) By September each year, the provision of annual reports to the Medical School Accreditation Committee demonstrating that continuing progress is being made in all of the 'Areas which would benefit from further development' noting the specific requests in (i) and (ii) above.

## **2005 Annual Report to MedSAC**

In its review of the 2005 report, the Accreditation Committee commented favourably on the report concluding:

- The Faculty had demonstrated significant progress toward addressing the areas nominated as ones which would benefit from further development.
- The issues of strategic planning to address budget deficits in the clinical schools, the establishment of an overarching curriculum committee with responsibility for academic governance of the course, and the development of a modified course plan designed to take advantage of the work already done on the 'New Pathway' were being broadly addressed in a constructive and appropriate manner.

In accepting the report, the Accreditation Committee requested the Faculty to provide clarifying details in its 2006 report on the areas of budget and expenditure management, and the activities of the Faculty Curriculum Committee.

## **2006 Annual Report to MedSAC**

In its review of the 2006 report, the Accreditation Committee noted that the matters raised in its review of the 2005 report had been addressed, including the main matters of budget and finance, and the activities of the Faculty Curriculum Committee. The report was accepted and the Faculty complimented on its good progress.

## **2007 Annual Report to MedSAC**

The 2007 annual report was reviewed by the Accreditation Committee in October 2007. It was agreed that the Faculty had addressed all issues raised in the 2004 report. The Committee also noted that significant renewal has occurred since the 2004 accreditation visit and that the Faculty had adequately addressed the AMC conditions and the nominated areas of concern.

The four-year accreditation of the Faculty of Medicine, University of Otago expired in December 2008. Under the accreditation guidelines, and as per the recommendations in the 2004 report, the Faculty was advised that it had the choice for either:

- a full assessment of the medical course with a view to obtaining the maximum available accreditation period; OR
- a more limited paper review, concentrating on the areas where deficiencies have been identified, with a view to obtaining an extension of the current accreditation.

The Faculty was further informed that the Australian Medical Council no longer grants accreditation for 10-year periods. For established medical courses, accreditation is for a maximum period of six years in the first instance, subject to satisfactory periodic reports. The AMC may then grant an additional period of accreditation, up to a maximum of four years, subject to a satisfactory report from the school in the fifth year of accreditation. If periodic reports are satisfactory, reaccreditation will be subject to an onsite assessment in the 10th year.

The Faculty requested a full assessment visit, with a view to obtaining the maximum available accreditation period. Prior to the visit, the University of Otago School of Medicine provided a comprehensive submission for reaccreditation of its medical course.

In accordance with AMC accreditation requirements, an AMC assessment team visited the School during 11 to 15 August 2008. The membership of the 2008 assessment team is provided at **Appendix One**. The groups met during the visit are provided at **Appendix Two**.

A copy of the Preliminary Statement of Findings presented to the School at the conclusion of the visit is at **Appendix Three**.

The following report details the findings of the 2008 assessment.

### **Appreciation**

The AMC Team wishes to express its appreciation to the University for the hospitality shown during the visit and the organisation that went into making the many meetings run efficiently. The Team recognises the hard work which goes into the preparation for an AMC accreditation visit, and the Dean and his staff are to be congratulated for their efforts.

## **1. The Context of the Medical School**

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### **1.1 Governance**

*The medical school's governance structures and functions are defined, including the school's relationships with its campuses and clinical schools and within the university.*

*The governance structures set out, for each committee, the composition, terms of reference, powers and reporting relationships, and ensure representation from all relevant groups in decision-making.*

*The school consults on key issues relating to its mission, the curriculum, graduate outcomes and governance with those groups that have a legitimate interest in the course*

The Faculty of Medicine has governance structures for its operational and academic activities to ensure oversight and interaction of strategic, financial, administrative, curriculum, and evaluation activities within the Faculty and its component Schools, as well as in its external relationships in the Division of Health Sciences and more widely within the University.

The governance structures, commencing with the place of the Faculty of Medicine in the context of the University and the Division of Health Sciences at the University of Otago, are set out below.

The University has four academic divisions: commerce, health sciences, humanities, and sciences. The Division of Health Sciences is the largest academic division at the University of Otago. It consists of:

- The Faculty of Medicine
- The Faculty of Dentistry
- The School of Pharmacy
- The School of Physiotherapy.

The Faculty of Medicine consists of:

- The Otago School of Medical Sciences (OSMS)
- The University of Otago, Christchurch, School of Medicine and Health Sciences (UOC)
- The Dunedin School of Medicine (DSM)
- The University of Otago, Wellington, School of Medicine and Health Sciences (UOW).

The academic and administrative responsibilities for each of the Schools are undertaken by the Dean of the respective School.

The changes in governance since the last visit, with combining the roles of Pro Vice-Chancellor for Health Sciences and Dean of the Faculty of Medicine, has given direction and clarity, effective decision-making, better financial control and transparency.

Each of the Faculty's governance committees and boards has terms of reference, membership, reporting relationships, and interactions with other governance committees, boards and groups. The overall governance structure and reporting relationships for the major governance committees and boards within the Faculty of Medicine were provided to the Team.

The Team recognises that in the first part of 2008 the Faculty Curriculum Committee (FCC), the Faculty Board and the Executive formally reviewed and updated the terms of reference for the Faculty committees. However, the Team noted that some needed further updating in line with current reporting lines and membership. For example, the terms of reference for the Medical Education Groups (MEGs) clearly indicate reporting to the Dean of the School of Medicine and the FCC, but do not indicate any reporting line to the Medical Education Committee (MEC) 4/5 or 4 to 6 committees. The terms of reference for MEC 4 do not clearly state that it receives reports from MEGs. The terms of reference for MEC6 indicate a reporting line to the Dean and FCC but do not describe a relationship with the MEGs. However, the TORs do clearly indicate a role in coordinating Year 6 activities across the schools. Further, the membership of this committee does not indicate representation from school based MEGs.

The School consults regularly with a number of external groups and consumers responsible for or involved in medical training or practice.

## **1.2 Leadership and autonomy**

*The medical school has sufficient autonomy to design and develop the medical course.*

*The responsibilities of the academic head of the medical school for the educational program are clearly stated.*

Overall control of the medical course (academic governance) vests in the Faculty of Medicine Board. Membership consists of the deans of the faculty and its four schools, an undergraduate student representative and a postgraduate student representative, as well as the Chair of the Faculty Curriculum Committee. The Faculty Manager also attends meetings of the faculty board.

The Faculty of Medicine Board meets monthly. The Chair of the Faculty of Medicine Board is the Dean of the Faculty of Medicine. The Faculty of Medicine Board receives reports and recommendations from the Boards for Examinations for Years 2 and 3, Years 4 and 5, and Year 6. The Board receives the minutes of the Faculty Curriculum Committee. The Faculty of Medicine Board also receives reports and recommendations for academic matters other than for the undergraduate medical curriculum within the Faculty of Medicine. The Faculty of Medicine Board reports to the Board of the Division of Health Sciences on academic matters within the Faculty of Medicine. Therefore, the Faculty of Medicine Board is responsible for the reporting of new course approvals, and course changes, to the Board of the Division of Health Sciences. The Board of the Division of Health Sciences considers and recommends new course approvals and course changes to the Board of Undergraduate Studies of the University and the Board of Graduate Studies of the University as appropriate. These Boards consider new course approvals and course changes, and make recommendations to the Senate of the University for final approval.

The Dean of the Faculty of Medicine has responsibility for ensuring the design, development and implementation of the educational program, including the provision of appropriate resources at all campuses. At present, the current Dean is also Chair of the Faculty Curriculum Committee. The Deans of the four schools within the Faculty of Medicine have further responsibilities for implementation and resourcing of the educational program within each of their Schools

The Team was impressed by the leadership group. The chairing of the Faculty Curriculum Committee (FCC) and local curriculum development groups by senior academic staff has provided important leadership and stability. The funding is transparent and based on EFT allocations. There

has been wide consultation with and involvement of the Faculty. The Chair of the FCC sits on the Faculty of Medicine Board which means education continues to be a core activity of the School.

### **1.3 Medical course management**

*The school has established 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 course.*

The Faculty of Medicine Curriculum Committee (referred to as the Faculty Curriculum Committee) has responsibility for oversight of the structure, content, assessment processes and evaluation of the undergraduate medical curriculum. The Faculty Curriculum Committee (FCC) has defined terms of reference and membership. This includes membership from each of the schools in the faculty, representation appropriate to Hauora Māori, student representation, and membership representing expertise within the Faculty appropriate to the needs of the curriculum. The Faculty Curriculum Committee has subcommittees and portfolios for particular activities. These include:

- Faculty Assessment Committee (which oversees assessment strategies, processes and assessment evaluations)
- Hauora Māori portfolio
- Medical Admissions Portfolio
- IT and Evidence Based Medicine portfolio
- Rural Health portfolio
- Educational Research and Quality portfolio
- Clinical Skills portfolio.

The FCC reports to the Faculty of Medicine Board, and also has a reporting relationship with the Faculty of Medicine Executive. The Committee meets monthly, with meetings held at the Dunedin, Christchurch and Wellington campuses on a rotating basis.

The Team agreed that the Faculty Curriculum Committee is effectively driving planned changes to the curriculum. The rotation of the meetings of the FCC across Schools has helped raise understanding of the curriculum and wide involvement in those changes. The committees that feed into the FCC and are responsible for the different phases of the program have been simplified within the program and across Schools and, in general, work very effectively planning and implementing the program. The FCC is developed to the point that a smooth transition to a new chair can occur.

There are three Medical Education Committees (MECs) within the Faculty curriculum structure. They cover Years 2 and 3, Years 4 and 5 and Year 6. They provide oversight of major components of the undergraduate medical curriculum. A further major function of these committees is to ensure and oversee linkages and continuity between major phases of the curriculum, and between the campuses of the Faculty.

The direct operational oversight of the various phases of the curriculum is provided by the MEC for the Early Learning in Medicine Programme (Years 2 and 3), and by the Medical Education Groups (MEGs) for each campus for the Advanced Learning in Medicine Programme (Years 4 to 6). In other words, the operational oversight structure is as follows:

- The Early Learning in Medicine (Years 2 and 3) programme, Dunedin campus: MEC Years 2 and 3
- The Advanced Learning in Medicine (Years 4 to 6) programme at each of the campuses (Dunedin, Christchurch, Wellington): MEG Dunedin, Christchurch, Wellington.

The MEGs report to the respective MEC, and to the Faculty of Medicine Curriculum Committee. The MEGs also have a reporting relationship to the governance and management structures within each School.

Clarity is still required around the relationship and reporting lines of Medical Education Groups (MEGs) with respect to the Medical Education Committees (MECs) and the Faculty Curriculum Committee. A single committee for Years 4, 5 and 6 could be considered and may help to ensure a continuum in learning, and may reduce staff work.

#### **1.4 Educational expertise**

*The school ensures appropriate use of educational expertise, including the educational expertise of Indigenous people, in the development and management of the medical course.*

The educational expertise across the Faculty is very impressive, with strengths in undergraduate and postgraduate education and educational research and Māori academia. The Faculty is well supported by its Educational Support and Development Unit. There are associate deans for medical education in each of the four schools. Each school is also well supported by its medical education unit consisting of the Associate Dean, Medical Education Adviser, Clinical Education Adviser and Clinical Skills Director.

The links between the Educational Support and Development Unit and the Medical Education Groups work well. They work together and provide support for each other. There is also a close relationship between these groups and various other committees including the Medical Education Committees. The input from the Medical Education Groups and the Medical Education Advisers (MEAs) is productive and their expertise utilised in the planning process. The Team commends the recent establishment of Clinical Education Advisers (CEAs) in all three campuses of the Faculty and is encouraged by stated intentions to increase these positions to 1 FTE.

The two Higher Education Development Centre (HEDC) funded positions appear to sit outside the planning and implementation groups. More constructive alignment with the educational groups at Christchurch and Wellington would make better use of these positions. As they sit externally to the Faculty, separated from those who run the program, the Team suggests the Faculty should consider enhancing the role of these two positions in evaluation.

#### **1.5 Educational budget and resource allocation**

*The medical school has a clear line of responsibility and authority for the curriculum and its resourcing, including a dedicated educational budget.*

*There is sufficient autonomy to direct resources in order to achieve the mission of the school and the objectives of the medical course.*

As noted, the change in combining the position of Pro-Vice Chancellor and Dean of the Faculty of Medicine, and providing this position with fiscal responsibility, has resulted in good financial control within the Otago Faculty of Medicine. The debts at Christchurch and Wellington have been cleared. A significant increase in funding per student for medical training was much needed and has had a demonstrable impact in terms of support for planning, staffing and physical resources. Cost centres are devolved to departmental levels but the full impact of this, in particular in Wellington, is yet to be realised on resources available for medical education.

It is clear however significant capital injection will be required in a number of areas. This is particularly so for IT, which needs development across geographically separated sites, and for research and academic staff space, which is limited.

### **1.6 Interaction with health sector**

*The medical school has constructive partnerships with relevant health departments and government, non-government and community health agencies to promote mutual interests in the education and training of medical graduates skilled in clinical care and professional practice.*

*The medical school recognises the unique challenges faced by the Indigenous health sector and has effective partnerships with relevant local communities, organisations and individuals.*

*The medical school works with its partners to ensure university staff in affiliated institutions are integrated into the service and administrative activities of the institution. In the same way, the university works with its partners to ensure that staff employed by the affiliated institutions can meet their teaching obligations and that peer review and professional development are a regular part of this interaction.*

Allowing for tight budget conditions, partnerships appear sound and productive with the Director-General of Health and with the District Health Boards. Regular meetings occur between the Deans and the Boards and both recognise the need to work together to ensure adequate clinical staffing. The University has had a longstanding working relationship with the Medical Council of New Zealand, and has recently developed a fitness to practice agreement. This should lead to better links supporting trainees. The University has excellent working relations with the newly formed Medical Training Board<sup>2</sup> and with the workforce strategy group of the District Health Boards, with expertise of academics being sought for major reviews. Indigenous partnerships at all centres are strong.

An overarching Memorandum of Understanding with the District Health Boards allowing additional specific agreements with individual boards is being negotiated. This will simplify and improve relationships and be very useful in confirming interdependence. This relationship could be taken further and the Team suggests the universities and the District Health Boards develop a standard agreement embedding teaching and supervision. This is needed because, although there is strong involvement and interest in teaching by clinical staff, the Team identified variation in commitment, and arrangements between clinicians and the University. Standardising expectations regarding junior and senior doctor involvement in teaching, along with support of teachers, should contribute to a culture supporting students and trainees. In recognition of their teaching, the Team encourages the University to award clinical titles for all clinical staff and to provide reliable access to University resources, in particular library and on-line resources.

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<sup>2</sup> The Medical Training Board was established by the New Zealand Minister of Health and the Minister for Tertiary Education. One of the Board's functions is to ensure effective oversight and coordination of the continuum of medical education and training in New Zealand from entry to medical school to registration in a vocational scope of practice, with a specific focus initially on the transition years and training in general practice.

With a range of established and new government and non-government agencies involved in health planning and implementation of educational programs, greater clarity and agreement is required about the roles of each, to ensure they can effectively achieve the changes needed in the continuum of health education.

### **1.7 The research context of the school**

*The medical course is set in the context of an active research program within the school.*

The Faculty of Medicine at the University of Otago is recognised as the most research active in the country and has performed well in the Performance Based Research Fund (PBRF) evaluation. There is a broad range of internationally recognised research programs across the Faculty and all sites are research active.

However, in an environment in New Zealand where research money is limited and not increasing, it is hard to compete with other countries. In addition, space for research is limited, making expansion difficult. These factors will continue to have a significant impact on staff recruitment and retention.

### **1.8 Staff resources**

*The medical school has a detailed staff plan that outlines the type, responsibilities and balance of academic staff required to deliver the curriculum adequately, including the balance between medical and non-medical academic staff, and between full-time and part-time staff.*

*The medical school has an appropriate profile of administrative and technical staff to support the implementation of the school's educational program and other activities, and to manage and deploy its resources.*

*Staff recruitment includes active recruitment by Australian schools of Aboriginal and Torres Strait Islander people and by New Zealand schools of Māori, together with appropriate training and support.*

*The school has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the medical course and the responsibilities of the school to these practitioners.*

The Team was impressed by the enthusiastic, widely engaged and committed staff of the Faculty of Medicine. Success in the performance based research fund and the current curriculum developments are indicative of the international standing of the staff of the Faculty of Medicine in both research and education. The Team commends the Māori staff and their commitment that has enabled development of the impressive Hauora Māori program. The Team encourages the Faculty to act on its intentions to continue to recruit staff and provide support to sustain and grow the development of the Hauora Māori program.

Overall the Faculty has adequate academic, administrative and technical staff in the majority of the disciplines and Schools to deliver and support the curriculum for the current student numbers. Staff strongly suggested that any further increases in student number would require substantial increases in physical and human resources.

The predominantly departmental based cost centres have responsibility for general, administrative and technical staffing required to meet the range of activities of the cost centre. This seems to be working well. However, as identified during the 2004 AMC visit, in Faculty strategic planning

documents, in the current self-study and during the current visit, one of the greatest challenges for the Faculty relates to insufficient academic staff in specific disciplinary areas.

The Team suggests that a Faculty-wide staffing plan that provides a process for identifying areas of shortage and a process for addressing the shortage be developed. The Team endorses suggestions from Faculty to commence exit interviews of staff in order to build a more complete picture of the requirements necessary to recruit and retain staff. The Team supports and encourages the continued communication between the Faculty and the District Health Boards to explore effective ways to share staff and staff costs. It is vitally important that Faculty, the DHBs and government find a sustainable way to address issues such as the salary shortfall for clinical academics and effective engagement of hospital and community based clinical staff in teaching, required to maintain the internationally competitive standard of medical training and service in New Zealand. The Team appreciates the international dimensions of this issue and is encouraged by the Faculty's awareness of the issue.

Hospital and community practitioners have a clear understanding of their direct roles in teaching. However, with variable access to the Faculty IT systems, they are less informed about broader matters, such as curriculum renewal.

The move to a more e-based learning format requires an increase in IT support staff and the Team urges the Faculty to review the requirements for IT staff at the three campuses.

The shift to small group based teaching requires substantially more tutors. A report entitled 'The Tutor in the Year 2 and 3 Curriculum: Acquisition, Training and Quality Assurance 2009' indicates that small group teaching in the Early Learning in Medicine Programme will require approximately 7099 tutor hours for 144 tutorial groups across the 2 years. Whilst the Team commends the shift to small group learning, the Faculty needs to ensure it is developing a sustainable program.

### ***1.9 Staff appointment, promotion and development***

*The university and the medical school have appointment and promotion policies for academic staff that address a balance of capacity for teaching, research and service functions, and recognise meritorious academic activities with appropriate emphasis on research and teaching.*

*The medical school has processes for development and appraisal of administrative, technical and academic staff, including clinical title holders and those who hold joint appointments between the university and other bodies.*

*The medical school's employment practices are gender-balanced and culturally inclusive.*

There is a clear well-constructed, gender-balanced and culturally inclusive HR policy for appointment and promotion. However the translation of the promotion policy into practice does not always occur, probably as a consequence of the PBRF (Performance-Based Research Fund), in that research performance appears to overwhelm criteria vital for development in and teaching of the medical curriculum. Education research is valued and counted towards a staff member's research profile. The Faculty has impressive education expertise and the Team encourages the Faculty to continue to value and grow education research and to ensure that excellence in education research and curriculum innovations are appropriately recognised.

The need for staff development for the renewal of the curriculum has been recognised; expertise and resources are available and programs have been delivered. However uptake of staff

development programs seems to be slow. The Team encourages Heads of Departments to be supportive of staff development initiatives. Important areas to focus on include self-directed learning and the roles of implementation of the PASAF (Professional Attitudes and Summary of Achievement Form) process. Specific support is likely to be necessary for the continued implementation of the electronic PASAF. The Team was impressed with the concept of a developmental learning process where increasing independence of the learner evolves over time. Changes to the culture of learning require dissemination of concepts and broad discussion, along with a consultative approach to developing a program inclusive of the local contexts of learning and teaching.

There is marked gender imbalance in the Professor and Associate Professor ranks. Despite success in attracting new professorial staff through the Leading Thinkers Initiative, the Faculty still faces issues regarding succession planning and gender balance. The Team appreciates that this is a sector wide problem and is encouraged by the level of recognition of the complexity of issues by the Faculty. Novel approaches to maintaining continuity of work and experience across genders will need to be determined.

### ***1.10 Staff indemnification***

*The university has arrangements for indemnification of teaching staff, with regard to their involvement in clinical research and the delivery of the teaching program.*

Indemnity and insurance is provided by the University for academic and general staff undertaking University responsibilities in teaching, research and professional service. The University also reimburses the cost of professional indemnity through recognised professional practice Indemnity organisations. The Accident Compensation Corporation (ACC) scheme in New Zealand provides cover for personal injury.

The University has been approved by ACC as a self-insuring employer under the Accident Insurance Act 1998 with entry to the program effective from 1 August 2000. This means that the University will receive and manage claims, calculate and pay entitlements and provide rehabilitation for work related accidents from 1 August 2000. The University will also pay for the portion of medical treatment costs that was previously paid by ACC or HIH WorkAble.

Cover is provided by the University for staff for travel (domestic and international) under its insurance arrangements. However, staff undertaking outside employment are not provided for in the University's indemnity policy.

## **2. The Outcomes of the Medical Course**

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### **2.1 Mission**

*The medical school has defined its mission, which includes teaching, research and social and community responsibilities.*

*The school's mission addresses Indigenous peoples and their health.*

*The school's mission has been defined in consultation with academic staff and students, the university, government agencies, the medical profession, health service providers, relevant Indigenous organisations, bodies involved with postgraduate medical training, health consumer organisations and the community.*

The Faculty's mission is clearly defined and available to all stakeholders via the Faculty website. The stated mission is as follows:

‘The Faculty of Medicine will have a central role in the New Zealand health care system through the provision of excellent undergraduate and postgraduate education in medicine and the biomedical sciences, through the expertise of its staff and through the maintenance of high clinical standards in its teaching hospitals and practices. The Faculty and its Schools will provide educational programs which will prepare graduates to meet the diverse health needs of New Zealand people. The staff and students of the Faculty of Medicine will contribute to knowledge and understanding in the health sciences and will promote health through high quality basic and applied research.’

“Ka noho tūāpapa mai ana te Kaupeka Whaiora i roto i te pūnaha hauora o Aotearoa mā te tuku whakaakoranga pai rawa atu ki ngā ākonga tohu paetahi, paerua, kairangi hoki e ako ana i ngā mātauranga whaiora me te pūtaiao hauora-ira, mā te mōhiotanga hōhonu o ngā kaimahi, ā, mā te tūtonutanga o ngā ōrite whaikiko o runga noa atu, i roto i ngā hōhipera me ngā whare makatea. Ka tuku te Kaupeka me ana Kura i ngā kaupapa akoranga e whakatakatū ai i ngā kauputa kia tūtakina ngā hapa hauora whānui o ngā iwi o Aotearoa. Ka toro atu ngā kaimahi me ngā ākonga o te Kaupeka ki te mātauranga me te mōhiotanga o ngā pūtaiao hauora, ā, ka hāpai i te hauora mā te rangahau taketake, ānuku hoki, e kaitā ana.”

From these, the Faculty of Medicine has derived the strategic goals of research excellence, excellence in research informed teaching, contributing to the national good and international progress, with strengthening of external engagement, and building and sustaining capacity. The Faculty's mission is clear and strong. It emphasises teaching in a strong research environment grounded in awareness of social obligations to the local communities and the wider national context. It appears to be the result of wide collaboration and buy-in, both within and outside the Faculty. The mission and goals are clearly set out and disseminated in publications such as student handbooks, and on the web site.

Hauora Māori is regarded as integral to the mission. However implementation in the three schools is unsymmetrical, with the program at the Christchurch School being more developed and leading the other schools. Hauora Māori is underrepresented at the deanery level and an appointment at Associate Dean level could be considered.

## **2.2 Medical course outcomes**

*The medical school has defined graduate outcomes and has related them to its mission.*

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

*The outcomes are consistent with development of the specific attributes incorporating knowledge, skills and professional attitudes of medical graduates endorsed by the Australian Medical Council.*

The Faculty produces graduate doctors well equipped with the knowledge, skills and attributes to become part of New Zealand's medical workforce. Graduates are benefiting from the Faculty's continuing emphasis on the continuum of medical learning through the integrating of early and advanced sections of the course, and into clinical practice. The selection is careful, with the aim of meeting graduate requirements. The attainment of the perspective and skills necessary for lifelong learning eases the transition of the graduates into their postgraduate training phase. The Rural Medical Immersion Programme is successfully introducing to a selected number of students the benefits of medical learning geared to rural practice, and exposing them to future career prospects.

### **3. The Medical Curriculum**

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#### **3.1 Curriculum framework**

*The medical school has a framework for the curriculum organised according to the overall outcomes which have, in turn, been broken down into more specific outcomes or objectives for each year or phase of the course.*

The University of Otago undergraduate medical curriculum has a range of outcome and objective statements from general to specific and from categorical to functional. Specifically, the broadest outcomes are the graduate profile and goals of the medical course. More detail is provided in the general and intermediate objectives. Functional grouping occurs through curriculum domains. The most specific level is for specific objectives within each vertical or block module.

The traditional classification of general and intermediate outcomes and objectives in the curriculum for the Faculty of Medicine has been under the headings: knowledge, skills and attitudes. These broad outcomes and objectives are partitioned under the Early Learning in Medicine Programme and the Advanced Learning in Medicine Programme.

The Team congratulates the Faculty on the new curriculum in First Year Health Science, and the Early Learning in Medicine Programme which have had a significant impact on student learning and skills. The students are extremely positive about the course and the changes that have occurred. Similarly the staff are happy with the direction the course has taken and were pleasantly surprised at the extent the changes have affected student engagement and learning. Staff have been responsive to student feedback.

The overall transition from Health Science Year 1, to Early Learning to Advanced Learning in Medicine to the Trainee Intern year and beyond is well developed. The use of these terms has helped reduce the traditional pre-clinical and clinical divide. The School has defined outcomes at the level of graduates, year of course and units, with revision in the later years occurring for the latter. The on-line curriculum database should link these outcomes to outcomes at the level of individual courses, making them useful for students and staff. Staff are being asked to contribute information to this database, which is a significant workload in addition to other duties and the Team urges the Faculty to provide feedback as to how it has been used, to keep that information flow occurring. The curriculum database is a dynamic project which the Team saw as having valuable potential.

The graduate profile and goals are clearly described within the knowledge, skills and attributes objectives. The presence of Hauora Māori as a program domain is commended. The curriculum domains are separated into program and practice domains and threads. The structure and content of domains and threads have been clearly defined, and documents explaining them produced, but they are still not evident in the current organisation of the course from a student or teacher perspective. Understanding of what they are, and their impact on course design or assessment, needs continuing promotion to ensure broad understanding by staff and better transparency for students. In addition, how threads are woven in across all years of the course needs to be addressed.

Curriculum mapping and the Curriculum Outcomes Database are in development. Observations on progress to date suggest that this will be a valuable search and analytical tool in future, supporting a continuum approach to the curriculum, as well as collegial communications. A potential to link

with the Medical Council and Colleges to plan vertical integration of the curriculum represents an exciting and valuable opportunity.

### **3.2 Curriculum structure, composition and duration**

*The medical school has developed descriptions of the content, extent and sequencing of the curriculum that guide staff and students on the level of knowledge and understanding, skills and attitudes expected at each stage of the course.*

*The course provides a comprehensive coverage of:*

- *basic biomedical sciences, sufficient to underpin clinical studies*
- *scientific method, inquiry skills, critical appraisal and evidence-based medicine*
- *clinical sciences relevant to the care of adults and children*
- *the pathological basis of disease*
- *clinical skills (medical history construction, physical and mental state examination, diagnostic reasoning skills, problem formulation and construction of patient management plans)*
- *management of common conditions, including pharmacological, physical, nutritional and psychological therapies*
- *acute care skills and procedures relevant to practice at the level of an intern*
- *communication skills*
- *population, social and community health*
- *an understanding of the culturally diverse nature of Australian or New Zealand society and the development of appropriate skills and attitudes for medical practice in a culturally diverse society*
- *Indigenous health (studies of the history, culture and health of the Indigenous peoples of Australia or New Zealand)*
- *personal and professional development*
- *law and ethics*
- *patient safety and quality of health care*
- *interprofessional education.*

As noted, significant changes have been implemented over the last few years, and these changes will continue through the latter part of early clinical learning through to Advanced Learning in Medicine. The changes in Health Science Year 1 are significant and highly successful with innovative delivery of large group sessions and emphasis on developing learning skills. The emphasis in the design of the changes was a greater relevance to human biology and human health, and improved interdigitation with the early health professional programs (Medicine, Dentistry, Pharmacy, Physiotherapy, and Medical and Laboratory Sciences) within the Division of Health Sciences. The impact of these changes has been seen in the subsequent Year 2 students. There were no major areas where staff or students felt there was deficient coverage of the basic biomedical sciences.

The changes in the Early Learning in Medicine Programme (Years 2 and 3) curriculum represent further evolution of the curricular directions implemented in 1997, and are in response to the educational directions of the newly developed HSFY Programme and contemporary directions in

medical education. The new program has an emphasis on clinically relevant and integrated learning from the day of entry to medical school.

The educational objectives of the newly developed Years 2 and 3 program are:

- Increased active and task-based learning
- Increased independent and group learning
- Enhanced skills in learning for life
- Less theoretical content and more application of concepts and principles
- Greater clinical relevance and a programmed progression of clinical skills
- Enhanced professional skills resulting from much greater patient contact
- Increased learning in context e.g. the community
- A curriculum structure which will build on HSFY learning and will provide a more functional educational platform for transition to the Year 4 component of the Advanced Learning in Medicine Programme
- A curriculum structure which will facilitate the vertical integration of biomedical sciences in the Advanced Learning in Medicine Programme (Years 4 to 6)
- Greater input by clinical academic staff into curriculum design and content
- Mapping of learning objectives which can be extended throughout the whole undergraduate curriculum
- A reduction in timetabled contact time.

Although there is strong support for basic science inclusion in Advanced Learning in Medicine, and capacity exists at each site to deliver it, how this will occur is not established. A working party, reporting to the Faculty Curriculum Committee, is being convened. The AMC looks forward to the report of the Working Party.

Discussions around Advanced Learning in Medicine (Year 4 and 5), the Trainee Intern Year and the continuum of learning clinical skills are well under way with wider engagement of staff at all sites gaining momentum. The philosophy and guiding principles are good. It has been agreed the same core objectives and assessment will be used for the Advanced Learning in Medicine Programme at the Schools at each of the three campuses. Beyond that, a strategic approach to diversity at each site will make best use of local expertise and environments, and minimise potential disadvantages for students and unintended impact on other schools. It is recognised more exposure to community practice should occur. The Trainee Intern year is well evaluated and a research project across New Zealand showed its importance for consolidating skills and confidence in preparation for PGY1.

Some clinical placements have limited immersion in the workplace. The Team considers that the impact of vertical modules, formal teaching and attachment organisation on student clinical learning should be reviewed. For instance, in Wellington, in particular in Medicine, alternate ways of aligning Year 4 and 5 students to clinical services, such as attaching them to a team rather than a ward, should be considered. Development of additional clinical sites will be required to keep the number of students at a clinical site down at an optimal level.

Opportunities for inter-professional learning are emerging but a significant amount of work needs to be done to make it meaningful. The rural immersion program may be able to introduce pilots because inter-professional models of care are more evident in routine practice in country areas.

Hauora Māori contributes to medical attachments, embedding it further into the curriculum. As recognised, Hauora Māori needs to be expanded across sites. Cultural diversity is introduced in Year 2, coordinated by the Hauora Māori team. However, the Team suggests that the Hauora Māori domain remain distinct and that responsibility for broader aspects of cultural diversity is dispersed more widely among Faculty so that the few Hauora Māori staff are not expected to take the lead role for cultural diversity as well as their own area of Hauora Māori.

### **3.3 Curriculum integration**

*The different components of the curriculum are appropriately integrated.*

The planning of the new curriculum has involved all components and so vertical and horizontal integration has been a focus. The cases in Early Learning demonstrate well the integration in the curriculum and how basic science relates to the clinical setting. The main concern in Years 2 and 3 relates to vertical modules (such as blood, genetics, cancer) which have been challenged by fragmentation. How they can be presented more coherently is being reviewed. The vertical integration from Early to Advanced Learning in Medicine, through to the Trainee Intern Year and beyond, is under development. The Medical Training Board and the Medical Council of New Zealand have worked on a Core Curriculum for PGY1 and PGY2 years, adapted from the Australian Junior Doctor Curriculum Framework. This should help identify who is responsible for learning at the different phases of training. As noted, joining the MEC 4 and 5 and MEC 6 into a single committee may help that development. Close links with the clinical skills working group and the Clinical Skills Directors, as well as the directors for postgraduate education, is required.

The Rural Medical Immersion Programme, with an integrated learning program across Year 5 works well and may work at additional sites. At rural centres and some peripheral sites in urban areas, academic appointments may help optimise the student experience, where availability of clinicians to give feedback and guidance is limited. Working with the District Health Boards may realise this.

### **3.4 Research in the curriculum**

*The medical course emphasises the importance of research in advancing knowledge of health and illness and encourages, prepares and supports student engagement in medical research.*

The University of Otago was the highest ranked university in New Zealand for research quality in the 2007 Performance Based Research Funding (PBRF) audit. The four schools which participate in the Medical Curriculum are highly ranked within the University and both biomedical and clinical medicine were ranked highest in their discipline. The average score for research quality in the Division of Health Sciences rose from 2.96 in 2003 to 4.10 in 2006. The number of staff ranked as A rated researchers also increased significantly.

The Team noted that there is clear interaction between teaching and research. This occurs in two ways: through the influence of research on the content of the medical curriculum, and through educational research, which has informed teaching and learning.

The culture of curriculum teaching is research-informed and integrated thoroughly in the early and advanced learning programs across the sites. Research-active faculty members reflect their relevant research in course content and motivate and stimulate students about research. This link is clearly understood and appreciated by the students. Students are required to read research papers and develop an analytical approach to such publications in terms of research methodology, results

analysis and discussion presentation. Tutorials discussing topical issues in journal publications in addition to follow up assessments are components of the course ensuring the students appreciation of the critical analysis necessary within the peer review process. The Team recognises the value of the New Zealand medical student journal in providing the opportunity for students to further develop their writing skills for publication in their field.

Students in their trainee intern level are provided with the chance to further investigate topical themes of practical interest in the form of therapeutic specialties. Through this they gain an appreciation of the specific components of research projects and will present a dissertation on their findings.

The Faculty of Medicine hosts a summer research studentship program each year in order to encourage the students to take up a research career. Participating students undertake a research project over the holiday period, in a field of research of interest to them (either clinical and/or laboratory-based). All four schools in the Faculty participate in this program and numbers of students are high (152 in 2004/5; 163 in 2005/6; 162 in 2006/7; 159 in 2007/8). The studentships are of 10 weeks' duration and students are paid an educational grant of \$3,000 to \$4,000.

Facilitation of intercalated research degrees for medical students or an integral research year as part of the medical program occurs at all four schools to encourage medical students to engage in such research programs. Since the 2004 AMC visit, 35 students have been enrolled on the intercalated BMedSc(Hons) degree. Eight have completed with first class honours and several have transferred to other full or part-time higher degrees (MMedSc or PhD).

The Team is confident that the University has a strong promotion of research careers following the course and that the significant research activity of the University acts as a suitable incentive for such. The University understands key issues contributing to graduate students pursuing research careers in countries other than New Zealand; however, how to overcome these barriers needs more planning.

In addition there have been significant research outputs in the medical education literature arising from members within the Faculty. These have informed curriculum development in areas of the course. This development is to be commended and it is hoped that the best available evidence continues to be used by the Faculty in course development and delivery.

### ***3.5 Opportunities for students to pursue choices***

There are number of opportunities at both Faculty and school levels within the course where students are given the chance to choose what they wish to undertake and where. These include a humanities paper in Health Science First Year, the Rural Medical Immersion Programme (RMIP), summer research studentships and the electives in Year 6, which can be taken overseas including in developing countries. This 12-week elective period during the trainee intern year encourages the students to look to their future and either take an opportunity to further explore an area of particular interest to them or broaden their scope of medical training by selecting an area not directly related to their future profession. These electives may also be an opportunity taken by the Faculty to direct a student to a particular area which is identified as one of weakness for them.

The electives of all interns are assessed via a written report. At the school level, the students undertake group research projects such as the part-time Dunedin public health six-week project. The University is looking to extend this period to further benefit the students. The Team suggests more choice be offered in the Advanced Learning in Medicine Programme and the Trainee Intern Year

with a range of equivalent placements but in different settings (e.g. ambulatory versus hospital based).

### **3.6 *The continuum of learning***

*There is articulation between the medical course and subsequent stages of training.*

The organisation of the trainee intern year is specifically designed to link learning to the clinical practise of its students. Positive feedback has been provided to the Faculty by the supervisors of the benefits of this time and the promotion of a learning continuum. Throughout the trainee intern year, the students work alongside registrars undertaking postgraduate training and trained physicians thus supporting the continuum between pre-registration training and post-graduate practice.

The undergraduate program also contains specific elements directed towards helping students prepare for postgraduate learning. These are the emphasis on information literacy and critical evaluation, the personal and professional development thread, the vertical integration of the biomedical sciences, and the introduction of early community and clinical experience.

The continuum of learning between the trainee intern year and the PGY1 and PGY2 years has been addressed by a working party of the Medical Training Board. The curriculum for PGY1 is being defined. The optimal organisation and length of training is being discussed by a number of groups including the Education Committee of the Medical Council of New Zealand and the Medical Training Board, both of which involve the two New Zealand Medical Schools. More coordination will be necessary to ensure wide consultation and input from all relevant groups.

## **4. The Curriculum – Teaching and Learning**

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### **4.1 Teaching and learning methods**

*The teaching and learning methods are appropriate for the content and outcomes of the course. They include those that are inquiry-orientated, encourage students to take responsibility for their learning process and prepare them for lifelong learning.*

The 2004 Accreditation Team was impressed by the range of modern education approaches to teaching and learning that were embedded as part of the planned New Pathway. The Faculty is to be commended on the implementation of many of these modern teaching and learning approaches into the current sustainable and evolutionary approach to development of the curriculum.

The First Year Health Sciences (FYHS) provides a broad introduction to the basic sciences and serves a range of health related degree programs. The student numbers are large and the Faculty is to be commended for its efforts to increase the clinical and health relevance of the year. The utilisation by staff of the multi-centred video conferencing in lectures has been well received by students. This also enables the Faculty to economically teach to the large cohort. Significant effort has gone into planning large group lectures which are educationally stimulating and include an increased emphasis on deep approaches to learning. The initiatives to enhance deep learning approaches are commendable but research conducted by staff suggests a lack of alignment between these initiatives and outcomes of assessment. The attention to detailed understanding of the impact of the changes gives the team confidence that these initiatives will continue to be observed and further developed.

The changes in FYHS lead into approaches for developing independent and self-directed learners in the Early Learning in Medicine Programme in Years 2 and 3. Importantly these approaches feature an increased use of small group teaching. How these attributes are to be further developed in the Advanced Learning in Medicine Programme has only recently begun to be debated amongst staff. The current changes in FYHS and Early Learning in Medicine Programme are designed in part to better prepare students for this transition. But it is important to note that students and staff have identified that the current transition into the Advanced Learning in Medicine Programme is a substantial learning challenge. Planning for the evolutionary changes in the Advanced Learning in Medicine Programme at the Schools at each of the three campuses to continue to support the development of students as self-directed and adult learners is therefore important.

Terminology and application of small group learning and ‘self-directed’ learning, as indicated by the self-study and feedback from staff and students during the visit, points to a need for further development to ensure consistent language, methodology and a planned approach. Current plans indicate that three of the four organisational components of the Early Learning in Medicine Programme (integrated case program, clinical skills program and the healthcare in the community program) involve or will involve significant small group learning. How the different small group learning contexts relate to each other and the more generic learning objectives such as developing self-directed learners needs to be clarified. Concern amongst staff and students regarding the role of expert and non-expert tutors in the various small group learning environments was noted.

The Team encourages the Faculty to develop a common understanding and clear instructions on the role of the tutor, which appears to be a facilitator rather than a content expert in many of the small group learning environments.

The Team commends the development of the clinical skills program embedded within the Early Learning in Medicine Programme and the consequent exposure of students to clinical skills early in their training. The focus of this program and its evolution into and through the Advanced Learning in Medicine Programme will be enhanced by continued collaboration between the Faculty and School Clinical Skills Directors, the CEAs and other staff in all Schools. There is no common understanding as to the role skills centres will play in training. The Team considers that this issue needs to be decided and resourced adequately in all sites if skills centres are to be established.

The planned and structured approach to Hauora Māori commencing in Year 2 is to be applauded. The Team was impressed by the health-based experiential learning experiences provided at this stage of the program. The commitment and the professionalism of all staff involved in the program are commended. This important initiative will require continued support from Faculty to maintain the impressive standard achieved to date.

Students across the program greatly value the Blackboard interface and efforts for best practice use of handouts and web based resources linked to lectures are clear. The Team encourages the Faculty to support and place more emphasis on the sophisticated use of IT for teaching and learning. Within the Advanced Learning in Medicine Programme, this is likely to further enhance sharing of teaching and learning resources and experiences between the schools at each of the three campuses. It will also provide a vehicle to effectively communicate an appropriate framework to support self-directed learning to students across dispersed learning environments such as the community based learning environments and the RMIP.

Whilst there is no planned approach to students learning in multi-professional teams there are some learning environments such as the RMIP where limited multi-professional learning occurs. Students stated that in the trainee intern year the importance of multi-professional learning becomes very clear to them, and they are supportive of a developmental approach to the area.

## **5. The Curriculum – Assessment of Student Learning**

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### **5.1 Assessment approach**

*The school has a defined and documented assessment policy which guides student learning towards attainment of the content and outcomes of the course.*

The assessment policy approach is set out very well for staff and students in the Medical Student Assessment Procedures Guide. There is evidence of good compliance with the assessment approach based on a review of the examination papers and student feedback. The Professional Attitudes & Summary of Achievement Form (PASAF) is an innovative and valuable assessment instrument that has overall acceptance by staff and students but in a number of instances comes under criticism for variation in its use, completion and application. The value of the PASAF is acknowledged in a number of areas that traditionally are difficult to assess in a meaningful way, for instance professional attitude related to social determinants of health.

### **5.2 Assessment methods**

*The school uses a range of assessment formats that are appropriately aligned to the components of the medical course.*

In general, there is adherence to the policy of using a range of assessment instruments for both within module formative assessment and end of year summative assessment. However, in some circumstances, within module assessments appear to be less than adequate: for instance, having only one OSCE station in some Year 4 and 5 modules and runs.

Throughout the program use is made of formative assessment results obtained during a module to decide whether a student is permitted to sit the end-of-year summative examination. Since the student will fail if not allowed to sit the end-of-year summative examination, the formative assessment on which that decision is based does not appear to be strictly formative; with information being provided to the Student Progress Committee for its decision about eligibility to sit summative assessment. This appears to be contrary to Principle 10 in the application document: ‘formative assessments are not part of the official student record of achievement’.

The renewal of Year 2 has provided the opportunity to introduce assessment instruments relevant to the new programs such as Clinical Skills and Health in the Community. The use of the PASAF at this stage in the course gives early emphasis on the importance of professional attitudes.

The examinations for each year are constructed by a group that includes module coordinators, and provides items that cover content across the curriculum. It is accepted that the development and use of terminology of domains, threads and vertical modules as a way of presenting content is at an early stage. When completed, such an approach should enhance the comprehensiveness of assessment and its transparency for students. It will also provide the opportunity for a longitudinal component to assessment throughout the years of the medical course.

### **5.3 Assessment rules and progression**

*The school has a clear statement of assessment and progression rules.*

*The school has clear and transparent mechanisms for informing students of assessment and progression requirements and rules.*

The University of Otago uses a standards based assessment system with results reported by pass, fail or distinction. Effort has also been put into refining the systems and procedures used, and aligning them across the four schools. The rules for assessment and progression are set out clearly in the Medical Student Assessment Procedures Guide. The guide is easy to read and informative for students and staff.

The PASAF has a pivotal role in the student progress system by virtue of its potential use to prevent a student sitting for an end-of-year summative examination for failure in components such as professional behaviour during the year. There are ongoing improvements in the way it is used, including around an electronic format.

Monitoring of student progress occurs through the Academic Progress Committee meetings and is augmented by the work of the Associate Deans for Undergraduate Student Affairs in each centre. There is ongoing work to extend the recording of student assessment results centrally on a web-based platform. Parts of this system are in place and steady progress is being made towards making this a comprehensive record for all students. The availability of a comprehensive electronic record has greatly enhanced discussion of under-performing students, particularly where this is of a recurring nature. The University has also developed a guideline on procedures and the nature of information to be conveyed to students who are having difficulties in progression.

The structure whereby there is a board of examiners separate to the curriculum delivery is valuable and used to good effect across the course. The linkage by blue-printing between the learning objectives in the curriculum and the assessment items is an important part of the assessment process that is reassuring for students and provides guidance for staff developing examination items. The boards of examination operate as the Student Progress Committee and in that role provide consistency across the assessment system.

### **5.4 Assessment quality**

*The reliability and validity of assessment methods are evaluated and new assessment methods are developed where required.*

*The school has processes for ensuring that the educational impact and utility of assessment items are regularly reviewed.*

*The school ensures that the scope of the assessment, and assessment standards and processes are consistent across its teaching sites.*

The Faculty's 2008 submission states:

*In general, we try to use established validated assessment tools. Our overview blueprint is one mechanism to ensure the overall mix of assessments has validity in relation to the curriculum goals.*

*Detailed and routine analyses of written exams and OSCEs are provided each year and have been the subject of more academic scrutiny through research and peer reviewed publications.*

The Team considers that overall the quality of assessments is very good with broad adherence to principles in the Medical Student Assessment Procedures Guide. The assessments have been evaluated formally to a varying degree with most effort in the new process, the PASAF. The Team considered the PASAF to be an excellent process, when used to its capacity, but noted a lack of consistency in the use and application of the PASAF.

The Team also noted that, with some forms of assessment such as the MCQ, there did not appear to be widespread use of conventional measures of quality such as discrimination index.

Formative assessment is variable in the Advanced Learning in Medicine years. Year 4 would benefit from a review of the balance between formative and summative assessment and from consistency across the Advanced Learning in Medicine Programme at the Schools at each of the three campuses. In the absence of end-of-year summative assessment for Year 4, the planning for the renewal of Years 4, 5 and 6 should consider an end of year assessment at the end of Year 4 or more comprehensive and consistent in-course assessment. Information from students supports such an approach.

The awarding of Distinction for modules or attachments, years and the overall medical degree is a source of concern for students and some staff. It is an area worthy of review in the planning process for the renewal of the curriculum in Years 4, 5 and 6.

## **6. The Curriculum – Monitoring and Evaluation**

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### **6.1 Ongoing monitoring**

*The school has ongoing monitoring procedures that review the curriculum content, quality of teaching, assessment and student progress, and identify and address concerns.*

*Teacher and student feedback is systematically sought, analysed and used as part of the monitoring process.*

*Teachers and students are actively involved in monitoring and in using the results for course development.*

The evaluation policy and procedures documentation sets out the evaluation policy of the Faculty of Medicine for the MBChB, the course monitoring process, and the informal routes for feedback on the curriculum. Staff, tutors and students have multiple opportunities for feedback which are used and valued. Students particularly value the staff-student committee structure, and early responses to how their feedback will be handled. The Faculty should embrace the staff-student committee structure as an efficient conduit for communication. Although it is important to maximise student involvement across Faculty committees, student time needs to be used judiciously so students stay well engaged. The deans of schools can play an important role in advising staff of evaluation responses. The Team considers that external stakeholders must be engaged effectively in monitoring and evaluation, particularly as the curriculum and placements become diverse.

The Team commends the Faculty for the ongoing development and implementation of its monitoring and evaluation structures and processes, and the development of the role of the Medical Education Adviser (MEA) in the evaluation of student experience. The Faculty needs to be aware that the role of the Medical Education Advisor, by virtue of involvement in both curriculum development and evaluation, may be a position of conflict of interest. The purposes of the Higher Education Development Centre and Faculty monitoring and evaluation need to be clearly differentiated and used in the most effective way. The former have the advantage of sitting outside the schools so can be impartial in the evaluation process and analysis of results.

The planning for Years 4 to 6 is receiving strong staff and student input across the schools. This is being led by the MEAs and also involves the Medical Education Groups.

The Team noted the invigorating engagement in addressing weaknesses within the current curriculum. This reflects the more cooperative style of working developed across sites, and the philosophy of reflective, well planned evolution. The Team suggests that heads of department need to be more fully engaged, as do District Health Boards, in the ongoing monitoring processes.

The outcome evaluation processes which the Hauora Māori group has been testing within years and modules are impressive. Participation in the international indigenous network is adding valuable impetus and credibility.

The Team is confident that monitoring and evaluation is being embedded in practice, but mechanisms need to be in place for closing the loop. Staff and students are keen to see the results of their input and this could ensure their ongoing participation. As the program expands, it should be a priority for the Faculty to sustain an appropriate level of monitoring and feedback.

## **6.2 Outcome evaluation**

*The performance of student cohorts is analysed in relation to the curriculum and the outcomes of the medical course.*

*Performance is analysed in relation to student background and entrance qualifications, and is used to provide feedback to the committees responsible for student selection, curriculum planning and student counselling.*

*The school evaluates the outcomes of the course in terms of postgraduate performance, career choice and career satisfaction.*

*Measures of, and information about, attributes of the graduates are used as feedback to course development.*

The Faculty acknowledges outcome evaluation as the most challenging aspect of evaluation. Currently, a number of outcome measures are considered including evaluation of assessments, student cohort performances, employer surveys, entrance and selection evaluation and graduate surveys. The Faculty has also joined the Medical Schools Outcomes Database and Longitudinal Tracking project (MSOD). This is a collaboration with all other Medical Schools in Australia and New Zealand, through the Medical Deans of Australia and New Zealand (MDANZ), to institute a national process to collect reliable data on medical students in prospective, longitudinal cohort surveys.

The Faculty believes the information gained from MSOD will be of major importance in further curriculum development and in developing more accurate information for future medical workforce planning. It is recognised that it will take some time for the results to be available, in particular the impact of the new program on outcomes.

## **6.3 Feedback and reporting**

*The results of outcome evaluation are reported through the governance and administration of the medical school and to academic staff and students.*

*The medical school provides access to evaluation results to the full range of groups with an interest in graduate outcomes. The school considers the views of these groups on the relevance and development of the curriculum.*

Key members of staff involved in the design and the delivery of the course are members of the committee structure of the Faculty and its schools. The key committees are the school MEGs curriculum committees. The MEGs meet regularly and the minutes feed into the Faculty Curriculum Committee. For Years 2 and 3, the equivalent committee is the Medical Education Committee (MEC).

Each MEG asks module convenors to report on how they have responded to the feedback received over the previous year. These reports are given in person or in writing. This feedback is recorded, a response made where applicable and minutes generated. Time is designated for two attachment convenors to present developments to a wide audience of heads of departments and other convenors. Regular heads of departments meetings in all four Schools allow staff to express areas of concern regarding the course. Areas of concern are often fed to the head of department by members of staff. The head of department can then raise issues and, if they are of sufficient

importance, they can be discussed by the Deans at Faculty Board and at the Faculty Executive and Faculty Committee. In this way a network of communication exists between and within the four schools.

There was clear evidence of reporting of entrance, selection and assessment evaluation and student cohort performance.

Outcome evaluation data are presented at heads of department meetings, curriculum conferences, school planning days and open forums such as school visits. Evaluation data are reported in Faculty and school based newsletters. Outcome of program evaluation is reported to MBChB stakeholders including students, employers (DHBs), government and colleges, local iwi, and the general public.

Where possible, outcome research is published in peer reviewed publications or special reports and disseminated to a wider audience. Outcome findings from the RMIP were provided recently to the Minister of Education and the Minister of Health. The input of the general public in the health in the community program and clinical skills program in Year 2/3 has been actively sought and outcome feedback will be given to this cohort when it is available.

Graduate surveys are undertaken, and appropriate linkages with the Medical Training Board and the NZ Medical Council are in place.

#### **6.4 Educational exchanges**

*The medical school collaborates with other educational institutions and compares its curriculum with other programs.*

The Team commends the breadth of relationships which enhance monitoring and evaluation of the curriculum including links with overseas groups and individuals. A number of academics with curriculum expertise have been invited to review different aspects of the course at different time points. In addition, a number of academics, who have medical education as their area of academic expertise, publish and present at international meetings regularly, and are recognised internationally for their work.

The Team also noted the positive relationships with the University of Auckland and with Australian schools and use of their staff to facilitate curriculum development meetings or review processes with external bodies.

## **7. Implementing the Curriculum – Students**

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### **7.1 Student intake**

*The size of the student intake, including the number of fee-paying students, has been defined and relates to the capacity of the medical school to adequately resource the course at all stages.*

*The school has clearly defined the nature of the student cohort, and quotas for students from under-represented groups, including Indigenous students and rural origin students.*

*The school has defined appropriate infrastructure and support to complement targeted access schemes for under-represented groups.*

The Faculty of Medicine currently has places for 210 domestic (New Zealand resident status) entrants annually. This is an increase of 20 places on the previous government decreed cap of 190 which was in place from 2004 until the end of 2007. Students taking up these domestic places receive funding support from the Tertiary Education Commission, and also have to pay a prescribed student component fee.

The Faculty of Medicine also provides places for some international fee paying students. The great majority of these students are sponsored by the home governments, after fulfilling strict minimum entry criteria by previous study. In 2008, 35 international students entered the medical curriculum at the Year 2 level. This is slightly over the preferred total number entering year of approximately 240 students: the increased number for 2008 was necessary because of previous international government Memoranda of Agreements being in place, with students consequently undertaking study to meet the entry criteria, while the announcement of the extra 20 domestic places for 2008 was made by the New Zealand government in mid-2007.

A further small cohort of students from the International Medical University, Kuala Lumpur, enters the Advanced Learning in Medicine Programme at University of Canterbury (UOC) and University of Wellington (UOW) annually. The maximum agreed number of students is six at each campus.

The current intake of 240 students per year is provided for with existing physical resources and staffing levels, although pressure is being felt in some areas, partially alleviated by recent capital works.

The Faculty has clear targets and a strategic vision for including underrepresented groups in the community in the medical intake. The initiative to increase rural origin student intake has succeeded in that their proportion now equals or exceeds that of the general New Zealand population.

### **7.2 Admission policy and selection**

*The medical school has a clearly defined selection policy and processes that can be implemented and sustained in practice, that are consistently applied and that are intended to minimise discrimination and bias, other than explicit affirmative action in favour of nominated under-represented groups.*

*The school publishes details of the process, including the mechanism for appeals.*

*The school has specific admission and recruitment policies for Australian Aboriginal and Torres Strait Islander or New Zealand Māori students.*

*The intended relationship between selection criteria, the objectives of the medical course and graduate outcomes is stated.*

The University calendar and student handbook clearly outline the admission policy and selection processes based on UMAT and grade point average. The selection policy and processes minimise discrimination and bias. Details of the process of selection and mechanism for appeals are published.

There is a Medical Admissions Committee and subcommittees responsible for Māori and Pasifika student admission. The process appears to be robust.

Although there are specific admission and recruitment policies for Māori students in place, the intake of Māori needs to increase incrementally to an appropriate level. The same applies to Pasifika students. Innovations such as the provision of a foundation year or bridging program for selected students are important, and are under way. Outreach visits to schools to encourage the study of science by Māori and Pasifika students at a more formative stage should be systematically undertaken.

### **7.3 Student support**

*The medical school offers appropriate student support, including counselling, health and academic advisory services, to cater for the needs of students including social, cultural and personal needs.*

*The school has procedures to detect and support students who are not performing well academically.*

*The school has policies on the admission of, and procedures for, the support of students with disabilities and students with infectious diseases, including blood-borne viruses.*

*The school has procedures for identifying and dealing with students with needs related to mental health or professional behaviour issues.*

*The school has appropriate support for students with special support needs including those coming from under-represented groups or admitted through widening-access schemes.*

The Faculty has strong student support services, including counselling, and health and academic advice for students with social, cultural and personal needs. The contribution of Associate Deans of Student Affairs to student support is particularly important.

The needs of Māori, Pacific, and rural students are accommodated at each site. Additional resources to support the current Hauora Māori staff are required.

The International Student Support Office and responsible Associate Dean were praised for their responsiveness to students across all sites.

Students also valued the Trainee Intern 4<sup>th</sup> Year Buddy system where that was available, and similarly the contributions House Surgeons and Registrars played in the development of professional confidence.

There is a formal code relating to Fitness to Practise which is made clear to all Year 2 students.

#### **7.4 Student representation**

*The medical school supports and encourages student representation in its governance and curriculum management.*

Students willingly, and meaningfully, contribute and have well defined structures across the years to do so. Students are well represented within the Faculty committee structure, although occurrence of regular meetings with deans of schools is variable across schools.

So that students are able to contribute efficiently, it is important that committees and relevant agenda items are scheduled to fit with the student timetable.

#### **7.5 Student indemnification**

*The school has adequately indemnified students for relevant activities.*

Appropriate policies and cover are in place for professional indemnity and the Faculty self-insures for ACC matters. Students are notified via the Handbook.

## **8. Implementing the Curriculum – Educational Resources**

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### **8.1 Physical facilities**

*The medical school has sufficient university-based physical facilities for staff and students to ensure that the curriculum can be delivered adequately.*

*The school has sufficient clinical teaching site physical facilities for staff and students to ensure that the curriculum can be delivered adequately.*

The Faculty has a range of new buildings which are a great asset for the delivery of the medical curriculum, and are models for the whole Faculty. The Team was impressed with the Hunter Centre in Dunedin which provides an excellent state of art resource for teaching in small and medium sized groups, including teaching basic clinical skills. Large lecture theatres are available for the projected increase in student numbers. The anatomy laboratory is well set up and available to students for self study. It has an excellent set of plastinated anatomical sections, along with a range of other models. A pathology laboratory is nearby and eventually a teaching resource linking both anatomy and pathology will be based at the Hunter Centre.

The new facilities at Wellington provide excellent small and large teaching spaces alongside the new library. For staff, the School office now co-locates leaders in the Faculty and in education and research, which offers important opportunities for planning and consolidating the program.

The central Christchurch facilities were upgraded some years ago but are good. The new co-located Women's Hospital at Christchurch has worked very well and provides a model for collaborative development of resources in the future.

Overall, the current facilities are adequate to cope with the current student load. However, the Team is aware the space available to the Faculty is at least 20 per cent below required when calculated by the University's space allocation method (SPAM). This relates to research and office space and is a problem at all centres. The lack of opportunity to grow space for academics and for research has serious implications regarding expansion of medical student numbers, recruitment of staff and research performance.

Given the proximity of the University and District Health Board facilities, there is logic in a partnership, including with other external bodies, to find solutions, such as where co-location of staff from the respective organisations can enhance clinical service, education and research. This is particularly important in small peripheral hospitals where access and space for student teaching is poorly developed, and where medical staff are part-time or visiting. This makes it challenging for staff to provide good supervision and guidance during clinical rotations, especially when the length of rotation is short.

### **8.2 Information technology**

*The school has sufficient information technology resources and expertise for the staff and student population to ensure the curriculum can be delivered adequately.*

*Library facilities available to staff and students include access to computer-based reference systems, supportive staff and a reference collection adequate to meet curriculum and research needs.*

Significant innovation has occurred in the ways information technology is used to enhance learning. Libraries contain more space for computer access and most buildings in the major sites have wireless connection available. Many small rooms used for problem based learning are equipped with computers. Students use e-lectures and, increasingly, bulletin boards for interacting with fellow students and staff. The on-line curriculum database will be a very useful for informing staff and planning programs.

In line with this greater use of the information technology for providing resources and guiding student learning, it is essential students, clinician teachers and academics, in particular in community and peripheral facilities, have reliable and high speed access to them. In some areas, better broadband/wireless access on campus and placements is required. It is important clinicians and students have access to IT systems within District Health Board facilities, including electronic health records which will allow them to integrate with and learn more from clinical teams.

Although face to face meetings between geographically separated staff has been invaluable and established good understanding, collaboration and trust across Schools, staff felt it would be appropriate to shift some meetings from face-to-face to video-linked. This would free up time for academics and reduce the carbon footprint of the schools. In addition, video-linked communication is essential for new peripheral sites, for supporting both students and staff.

### **8.3 Clinical teaching resources**

*The medical school ensures there are sufficient clinical teaching and learning resources, including sufficient patient contact, to achieve the outcomes of the course.*

*The school has sufficient clinical teaching facilities to provide a range of clinical experiences in all models of care (including primary care, general practice, private and public hospitals, rooms in rural, remote and metropolitan settings and Indigenous health settings).*

*The school provides all students with experience of the provision of health care to Indigenous people in a range of settings and locations.*

*The school actively engages with relevant institutions including other medical schools whose activities may impact on the delivery of the curriculum.*

*The school ensures that the outcomes of the programs delivered in the clinical facilities match those defined in the curriculum.*

With its population base of the whole of the South Island and southern areas of the North Island, the Faculty of Medicine has access to adequate numbers of patients in a range of clinical settings offering good clinical experiences. Rural and outer urban sites are becoming increasingly important. To ensure these sites adequately support learning means academic and administrative appointments need to be made. Working collaboratively with health boards to attract staff to joint academic and clinical appointments at these sites will help stabilise the workforce. In sites where there is a low staff student ratio, such as the Rural Medicine Immersion Programme, supervision is easier than in large hospitals where students are not clearly attached to a clinical team, or peripheral sites where clinical staff are visiting on a part-time basis. How those sites are used, such as where students are placed, who supervises them and in what fashion academic staff are employed to support learning needs careful planning, so students can make the most of the experience.

It has been agreed that, apart from outcomes and assessment which will be aligned, programs can be implemented in a flexible way and utilise local strengths. Programs for Years 4 to 6 should be flexible and encompass a range of innovative and feasible approaches to gaining required clinical experience. With the degree of communication within disciplines across schools, it seems likely programs will be equivalent. Planning of facilities needs to be site specific. The role of clinical skills laboratories and importantly, how experiences in these laboratories link to learning resulting from patient interaction needs definition, so appropriate centres can be built in time for the next phase of curriculum implementation. Although the current Dunedin skills facilities are old, the staff are enthusiastic, and the centre works well. It is hoped that a new centre in Dunedin can be planned to replace the current one. Facilities at other sites are minimal and how they are to be developed is under consideration.

Students value the patient contact which is now present from early in their learning. To provide appropriate clinical exposure with increased student numbers, and earlier patient exposure, patients are now seen in a wide range of settings besides the traditional inpatient wards, e.g. residential care, general practice, community providers and a pool of community volunteers. This reflects the strategic directions of the NZ Health sector and will produce doctors suited to practice in a more community oriented environment.

In obstetrics, variability in access at some sites for some students to witness normal deliveries needs review. In Christchurch, this variability in access has been obviated by co-locating academic staff with their DHB colleagues and with an academic appointment in midwifery. Consideration for at least the latter strategy in the other Schools ought to be explored.

The student experience in Indigenous health care is good and is expanding with a strong collaborative team approach across the sites. The Hauora Māori program receives support and funding through the Faculty. Further development of this support, possibly with providing the program with its own cost centre, and at a divisional level, should be considered.

The schools have good working relationships with the Auckland Medical School. An agreement on what geographical areas will be used exclusively by one school, which will be shared, and the process for planning in shared areas, is well established. Similarly, where crossover in student placements between schools in the Otago medical program occurs, such as with innovative rural placements, a transparent process for planning must occur.

## **Appendix One    Membership of the 2008 Assessment Team**

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**Associate Professor Fiona Lake** MBBS MD *W. Aust* FRACP (**Chair**)

Associate Professor of Medicine (respiratory), School of Medicine and Pharmacology  
Rural Perth Hospital Unit  
The University of Western Australia

**Ms Janice Donaldson** LLB Hons Dip Social Work *Cant* Dip Business Studies *Massey* M Pub Man  
*Vic*

Portfolio Manager, Service Improvement  
District Health Boards of New Zealand

**Dr Gary Hamlin** BSc *QLD* MSc *Mich* PhD *Kansas*

Lecturer in Physiology and Pharmacology  
James Cook University

**Professor Michael Hensley** MBBS Hons MRACP FRACP PhD *Syd* FAFPHM

Head, School of Medicine and Public Health  
The University of Newcastle Australia

**Professor Bryan Parry** MB ChB MD *Otago* Dip Obst *Auck* FRCS *Edin* FRACS

Professor and Head, Division of Surgery  
Faculty of Medical and Health Sciences  
The University of Auckland

**Professor Peter Soyer** MD FACD

Professor of Dermatology  
School of Medicine  
The University of Queensland

**Ms Karin Oldfield**

Manager Medical School Assessments  
Australian Medical Council

**Mr Peter Searles**

Accreditation Clerk  
Australian Medical Council

**Dr Ducksun Ahn** MB *Korea*

Observer  
Medical, Plastic and Reconstructive Surgery  
Korea University Anam Hospital

## **Appendix Two    Groups Met by the 2008 AMC Assessment Team**

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### **Executive Staff**

Vice-Chancellor  
Pro Vice-Chancellor and Dean of Faculty  
Deputy Vice-Chancellor (academic)  
Deans of Schools

### **Committees/Groups**

Curriculum Committee  
Assessment Committee  
Hauora Maori (Dunedin and Christchurch)  
Medical Education Committees  
Evaluation  
Rural Medical Immersion Program  
Year 2/3 Curriculum  
Educational Support and Development  
Educational Resources  
Medical Admissions  
Student Affairs (Dunedin, Christchurch and Wellington)  
Medical Education Group (Wellington)  
Tertiary Education Commission  
Research (Christchurch and Wellington)  
Management Group (Christchurch)  
Medical Education Unit (Christchurch)

### **Staff and Students**

Students from years 2-6 (Dunedin, Christchurch and Wellington)  
Recent graduates  
OSMS Heads of Departments  
Associate Deans Medical /Undergraduate Education  
Heads of Departments (Dunedin, Christchurch and Wellington)  
HSFY Paper Coordinators  
Year 2/3 Module Conveners and Tutors  
Years 4-6 Attachment Conveners and Clinical Teachers

### **Clinical Schools**

Mornington Health Centre  
Hunter Centre  
Lower Hutt General Practice  
Princess Margaret Hospital  
Hillmorton Hospital

### **External Bodies**

District Health Boards (Canterbury)  
Medical Training Board  
Medical Council of New Zealand

## **Appendix Three 2008 Preliminary Statement of Findings**

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### **Introduction**

This is a preliminary statement of findings of the accreditation visit to the Faculty of Medicine, University of Otago. The Team has been visiting the Faculty for the past five days as part of the re-accreditation process for an established medical program. This statement includes the Team's major findings following its assessment of the Faculty's documentation and the site visit. A full report will be completed over the next few weeks.

In presenting this preliminary statement, the Team expresses its thanks to the Faculty staff at all sites for their hospitality and cooperation during the assessment process. The Team recognises the large amount of thought and effort that has gone into preparing for this visit, and thanks the Faculty for the comprehensive documentation provided. The on-campus and offsite meetings have significantly assisted the Team's understanding of the Faculty's medical program.

This statement describes the Team's findings, indicating what it sees as areas of strength, and areas which it feels merit consideration by the Faculty in its future planning. These judgments are made in the context of the Standards for Basic Medical Education adopted by the AMC in July 2006 and further reviewed in 2007.

### **1. The Context of the Medical School**

#### ***1.1 Governance***

##### **Area of Strength**

Overall control of the medical course (academic governance) is vested in the Board of the Faculty. Combining the roles of Pro Vice-Chancellor for Health Sciences and Dean of the Faculty of Medicine has given direction and clarity, effective decision-making, better financial control and transparency.

#### ***1.2 Leadership and autonomy***

##### **Area of Strength**

The Team was impressed by the leadership group. The chairing of the Faculty Curriculum Committee and local curriculum development groups by senior academic staff has provided important leadership and stability. The funding is transparent and based on EFT allocations. There has been wide consultation with and involvement of the Faculty.

#### ***1.3 Medical course management***

##### **Area of Strength**

The Team was impressed that the Faculty Curriculum Committee is effectively driving planned changes to the curriculum. This is developed to the point that a smooth transition to a new chair can occur.

##### **Area for Improvement**

Clarity is required in some areas of governance, such as the relationship and reporting lines of clinical school MEGs (Medical Education Groups) with respect to the MECs (Medical Education

Committees) and the Faculty Curriculum Committee. A single 4, 5 and 6 MEC could be considered and may help ensuring a continuum in learning and reduce staff work.

#### ***1.4 Educational expertise***

##### **Area of Strength**

The educational expertise across the Faculty is very impressive, with strengths in undergraduate and postgraduate education and educational research and Māori academia.

##### **Area for Improvement**

More constructive alignment of the two Higher Education Development Centre (HEDC) funded positions, one each at Christchurch and Wellington, with the educational groups needs consideration.

#### ***1.5 Educational budget and resource allocation***

##### **Area of Strength**

The debts at Christchurch and Wellington have been cleared. The increased and greatly needed money available for medical education has had a demonstrable impact. Cost Centres are devolved to departmental levels but the full impact of this, in particular in Wellington, is yet to be realised on resources available for medical education.

##### **Area for Improvement**

Capital injection for IT and space will be required.

#### ***1.6 Interaction with health sector***

##### **Areas of Strength**

Allowing for tight budget conditions, partnerships appear sound and productive with the Director General of Health and District Health Boards. The University has had a longstanding working relationship with the New Zealand Medical Council and has recently developed a fitness to practice agreement. The University has excellent working relations with the new Medical Training Board and the workforce strategy group of the District Health Boards. Indigenous partnerships are strong.

An overarching Memorandum of Understanding with District Health Boards, allowing additional specific agreements with individual Boards is being negotiated and will be very useful in confirming interdependence.

##### **Areas for Improvement**

Although there is strong involvement and interest in teaching, by clinical staff, the Team identified variation in commitment, and arrangements between clinicians and the University. The Team suggests the Universities and the District Health Boards develop a standard agreement embedding teaching and supervision.

The Team encourages the awarding of a clinical title for all clinical staff and reliable access to University resources.

To effectively achieve the changes needed in the continuum of health education, greater clarity and agreement is required about the roles of the various government and non-government agencies involved in health planning and implementation of educational programs.

### ***1.7 The research context of the school***

#### **Area of Strength**

There are a broad range of internationally recognised research programs across the Faculty.

#### **Area for Improvement**

The limited amount of research funding available in New Zealand is having a significant impact on staff recruitment and retention.

### ***1.8 Staff resources***

#### **Areas of Strength**

The University of Otago has enthusiastic, widely engaged and committed staff.

The Team was impressed by the ability and commitment of Māori staff, but numbers need to increase.

#### **Areas for Improvement**

Staffing levels are adequate to deliver curriculum to the current student numbers. Any increase in numbers will require revision of staffing resources.

Staffing deficiencies were reported in some clinical departments and with information technology support.

There is no comprehensive plan for recruitment, retention and succession for academic staff, but could be developed in concert with the partner DHBs (District Health Boards).

The salary differential between academic and clinical staff and limited amount of research funding in New Zealand have specifically impacted on recruitment.

Hospital and community practitioners have a clear understanding of their direct roles in teaching but, with variable access to the Faculty IT systems, are less informed about broader matters, such as curriculum renewal.

### ***1.9 Staff appointment, promotion and development***

#### **Areas of Strength**

There is a clear well-constructed, gender-balanced and culturally inclusive HR policy for appointment and promotion.

The need for staff development for the renewal of the curriculum has been recognised; expertise and resources are available and programs have been delivered.

## **Areas for Improvement**

The translation of the promotion policy into practice does not always occur, probably as a consequence of the PBRF (Performance-Based Research Fund), in that research performance appears to overwhelm criteria vital for development in and teaching of the medical curriculum.

There is marked gender imbalance in the Professor and Associate Professor ranks.

Regarding staff development, to date buy-in appears slow and support from leaders, especially at the departmental level, should occur.

## **2. The Outcomes of the Medical Course**

### **Area of Strength**

The Faculty's mission is clear and strong. The outcomes are clearly defined and accessible from the student handbook and web site. There has been wide collaboration in their development. The developing medical outcomes database will be invaluable in promoting outcomes and determining how they contribute to the course.

## **3. The Medical Curriculum**

### **3.1 Curriculum framework**

#### **Areas of Strength**

The Team congratulates the Faculty on the new curriculum in First Year Health Science, and the Early Learning in Medicine Program which have had a significant impact on student learning and skills. The overall transition from Health Science Year 1, to Early Learning to Advanced Learning in Medicine to the Trainee Intern year and beyond is well developed.

#### **Areas for Improvement**

The structure and content of Domains and Threads have been clearly defined but are not evident in the current organisation of the course from a student or teacher perspective. Understanding of what they are, and their impact on course design or assessment, needs continuing promotion to ensure broad understanding by staff and better transparency for students. In addition, how threads are woven in needs to be addressed.

### **3.2 Curriculum structure, composition and duration**

#### **Areas of Strength**

The changes in Health Science Year 1 are significant and highly successful with innovative delivery of large group sessions and emphasis on developing learning skills. The impact of this has been seen in the subsequent Year 2 students. Staff have been responsive to student feedback.

The Trainee Intern year is well evaluated and a research project across New Zealand showed its importance for consolidating skills and confidence in preparation for PGY1. It is recognised more exposure to community practice should occur.

## **Areas for Improvement**

The vertical modules in Years 2 and 3 (such as blood, genetics, cancer) have been challenged by fragmentation and are being reviewed.

Discussion around Advanced Learning in Medicine (Year 4 and 5) and the Trainee Intern Year and the continuum of learning clinical skills are well under way. The philosophy and guiding principles are good. Wider engagement of staff at all sites will increase momentum.

It has been agreed the same core objectives and assessment will be used across Clinical Schools. Beyond that, a strategic approach to diversity at each site will make best use of local expertise and environments, and minimise potential disadvantages for students and unintended impact on other schools.

Some clinical placements have limited immersion in the workplace. The Team considers that the impact of vertical modules and formal teaching and attachment organisation on student clinical learning should be reviewed. For instance, in Wellington, in particular in Medicine, alternate ways of aligning Year 4 and 5 students to clinical service, such as attaching them to a team rather than a ward, should be considered. Development of additional clinical sites will be required to keep the number of students at a clinical site down at an optimal level.

Although there is strong support for basic science inclusion in Advanced Learning in Medicine, and capacity exists at each site to deliver it, how this will occur is not established. A working party, reporting to the Faculty Curriculum Committee, is being established. The AMC looks forward to the report of the Working Party.

Opportunities for inter-professional learning are emerging but a significant amount of work needs to be done to make it meaningful.

As recognised, Hauora Māori needs to be expanded across sites. Having Hauora Māori involved in the PASAF (Professional Attitudes and Summary of Achievement Form) in Years 4, 5 and 6 has strengthened the program.

### **3.3 Curriculum integration**

#### **Areas of Strength**

The cases in Early Learning demonstrate well the integration in the curriculum and how basic science relates to the clinical setting.

The Rural Medical Immersion Project, with an integrated learning program across Year 5 works well and may work at additional sites. At rural centres and some peripheral sites in urban areas, academic appointments may help optimise the student experience, where availability of clinicians to give feedback and guidance is limited. Working with the District Health Boards may realise this.

#### **Areas for Improvement**

The vertical integration from Early to Advanced Learning in Medicine, through to the Trainee Intern Year and beyond, is under development. As noted, joining the MEC 4 and 5 and MEC 6 into a single committee may help that development. Close links with the clinical skills working group and the Clinical Skills Directors is required.

### **3.4 *Research in the curriculum***

#### **Areas of Strength**

The culture of curriculum teaching is research-informed and integrated thoroughly in the Early and Advanced Learning programs across the sites. The scientific and the clinical staff motivate and stimulate students about research.

There are several options for intercalated research degrees for medical students including an integral research year as part of the medical program. There are numerous opportunities for scholarship supported summer research projects.

### **3.5 *Opportunities for students to pursue choices***

#### **Area of Strength**

The opportunities for pursuing choices include a Humanities paper in Health Science First Year, the Rural Medical Immersion Programme (RMIP), summer research studentships and the elective in Year 6, which can be taken overseas including in developing countries.

#### **Area for Improvement**

The Team suggests choice be offered in the Advanced Learning Program and the Trainee Intern Year with a range of equivalent placements but in different settings (e.g. ambulatory versus hospital based).

### **3.6 *The continuum of learning***

#### **Area for Improvement**

The continuum of learning between the Trainee Intern year and the PGY1 and PGY2 years has been addressed by a working party of the Medical Training Board. The curriculum for PGY1 is being defined. The optimal organisation and length of training is being discussed by a number of groups including the Education Committee of the Medical Council of New Zealand and the Medical Training Board. More coordination will be necessary to ensure wide consultation.

## **4. The Curriculum – Teaching and Learning**

#### **Areas of Strength**

The Faculty are to be commended on development and implementation of a broad range of learning methods that encourage the development of attributes identified for graduates. Important developments include an increased emphasis on small group teaching, and approaches to developing deep, independent and self directed learners.

The clinical and health relevance of the First Year Health Science (FYHS) and Early Learning in Medicine Program is excellent and the new evidence based Hauora Māori program provides an experiential introduction to Indigenous health issues.

The implementation of multi-centred video conferencing lectures in the FYHS has been well received by students and enables the Faculty to economically teach to large classes. Teachers at the Clinical Schools are exploring novel ways of delivering material to peripheral sites.

Students across the program greatly value the Blackboard interface and efforts for best practice use of handouts and web based resources linked to lectures are to be applauded.

The Faculty are to be commended on the successful immersion in rural practice program in Year 5, which is well planned and directed to national need.

### **Areas for Improvement**

The shift to 'self-directed' learning is applauded. However, student and staff development is needed to ensure consistent language, methodology and approach. A clear progression in independence of learning over the years of the program is important.

The Team identified concern amongst staff and students about the role of expert and non-expert tutors in small group learning environments. The Team encourages the Faculty to develop a common understanding and clear instructions on the role of the tutor, which appears to be a facilitator rather than a content expert.

Staff development in the use of Blackboard will improve use of the Faculty's IT resources.

## **5. The Curriculum – Assessment of Student Learning**

### **Areas of Strength**

The assessment policy is sound and set out very well for staff and students in the Medical Student Assessment Procedures Guide. There is evidence of good compliance with the policy, including the use of a range of assessment instruments in both formative and summative assessment. Assessments have been aligned to the new program in Year 2. A number of assessment instruments have been evaluated formally and results presented at meetings.

The examinations are constructed by a group to provide balance across curriculum content. Linkage by blue-printing between learning objectives in the curriculum and the assessment is an important part of ensuring the validity of the assessment process.

The separation of Boards of Examination, which also operate as the Academic Progress Committees, from those involved in curriculum delivery is valuable and functions well.

### **Areas for Improvement**

Some formative assessment is not strictly formative in that the results are fed into the Academic Progress Meetings and may be used to stop a student from sitting the end-of-year summative assessment. There should be consistency in the use of terms such as 'formative'.

The Professional Attitudes & Summary of Achievement Form (PASAF) is a valuable assessment tool that is accepted by students and staff but with some concerns about variability in its use, completion and application.

The amount and quality of formative assessment is variable in the clinical years. Assessments such as a one-station OSCE should be reconsidered.

Student feedback indicates consideration should be given to having more assessment at the end of Year 4. The Team suggests the Faculty give consideration to either end of year assessment or more formative assessments.

The process of awarding of distinction for modules/runs, years and the overall medical degree is a source of concern for students and some staff. The Faculty should review the awarding of distinctions.

## **6. The Curriculum – Monitoring and Evaluation**

### **Areas of Strength**

The Team commends the Faculty for the ongoing development and implementation of its monitoring and evaluation structures and processes and development of the role of the Medical Education Adviser (MEA) in the evaluation of student experience.

The outcome evaluation processes which the Hauora Māori group has been testing within years and modules are impressive.

The Team commends the breadth of relationships which enhance monitoring and evaluation of the curriculum including links with overseas groups and individuals, and presentation at international meetings.

### **Areas for Improvement**

The Team is confident that monitoring and evaluation is being embedded in practice, but mechanisms need to be in place for closing the loop. Staff and students are keen to see the results of their input and this could ensure their ongoing participation.

The Faculty should embrace the Staff Student Committee structure as a conduit for communication.

As the program expands, it should be a priority for the Faculty to sustain an appropriate level of monitoring and feedback.

It is important to maximise student involvement in Faculty committees by using their time judiciously so they stay well engaged.

The role of the Medical Education Advisor, by virtue of involvement in evaluation and curriculum development, may be in a position of conflict of interest.

External stakeholders must be engaged effectively in monitoring and evaluation, particularly as the curriculum and placements become diverse.

The purposes of the Higher Education Development Centre and Faculty monitoring and evaluation need to be clearly differentiated and used in the most effective way.

## **7. Implementing the Curriculum – Students**

### **7.1 Student intake**

#### **Areas of Strength**

The current intake level of 240 students per year is provided for with existing physical resources and staffing levels. The Faculty has clear targets and a strategic vision for including under-represented groups in the community in the medical intake. The initiative to increase rural origin student intake has succeeded in that their proportion now equals or exceeds that of the general New Zealand population.

There are clear selection policy and clear processes to minimise discrimination and bias. Details of the process of selection and mechanism for appeals are published.

The Faculty has strong student support services, including counselling, and health and academic advice for students with social, cultural and personal needs. The Associate Deans of Student Affairs contribute importantly to student support.

#### **Areas for Improvement**

Students are well represented within the Faculty committee structure, although occurrence of regular meetings with Deans of Schools is variable across Schools.

Specific admission and recruitment policies for Māori students are in place. The intake of Māori in particular but also Pasifika students needs to increase incrementally to an appropriate level. Innovations such as the provision of a Foundation year or bridging program for selected students are important, and are under way. Outreach visits to schools to encourage the study of science by Māori and Pasifika students at a more formative stage should be systematically undertaken.

## **8. Implementing the Curriculum – Educational Resources**

### **8.1 Physical facilities**

#### **Area of Strength**

The Team was impressed with the Hunter Centre, the anatomy laboratory, the new facilities at Wellington and the co-located Women's Hospital at Christchurch. These buildings are a great asset for the delivery of the medical curriculum, and are models for the whole Faculty.

#### **Areas for Improvement**

Current facilities are, in general, adequate. However, the Team is aware the space available to the Faculty is at least 20 per cent below required when calculated by the University's space allocation method (SPAM). This has serious implications regarding the expansion of medical student numbers, recruitment of staff and research performance.

Given the proximity of the University and District Health Board facilities, there is logic in a partnership to find solutions, such as where co-location of staff from the respective organisations can enhance clinical service, education and research. It is particularly important for a partnership approach with District Health Boards and external stakeholders where access and space for student teaching is poorly developed.

## **8.2 Information technology**

### **Area of Strength**

Significant innovation has occurred in the ways information technology is used to enhance learning.

### **Areas for Improvement**

The curriculum in certain areas increasingly relies on information technology and, to ensure students, clinician teachers and academics, in particular in community and peripheral facilities, have access, better broadband/wireless access on campus and placements is required. It is important clinicians and students have access to IT systems within District Health Board facilities, including electronic health records.

Although face to face meetings between geographically separated staff has been invaluable, better IT links allowing choice of face to face or video-linked meetings between Schools of the Faculty and with peripheral sites would free up time for academics and reduce the carbon footprint of the Schools.

## **8.3 Clinical teaching resources**

### **Areas of Strength**

With its population base of the whole of the South Island and southern areas of the North Island, the Faculty of Medicine has access to an adequate number of patients in a range of clinical settings offering good clinical experiences. The student experience in Indigenous health care is good and is expanding with a strong collaborative team approach across the sites.

### **Areas for Improvement**

The Hauora Māori program receives support and funding through the Faculty. Further development of this support, possibly its own cost centre, and at a divisional level, should be considered.

Continuing expansion into peripheral urban and rural sites is required but, to ensure these adequately support learning means academic and administrative appointments need to be made. The role of clinical skills laboratories and how experiences link to learning with patients needs definition. Although there are plans for a new centre in Dunedin to replace the current one, facilities at other sites are minimal. Programs for Years 4 to 6 should be flexible and encompass a range of innovative and feasible approaches to gaining required clinical experience.

### **Conclusion**

From the Team's perspective, this has been a very busy and professionally engaging week. The Team found the spirit of good humour and collegiality in which all meetings were conducted added to the enjoyment of the visit. It found members of the Faculty to be open and reflective, which is an excellent way to be.

The Team recognises the hard work which goes into the preparation for an AMC accreditation visit, and the Dean and his staff are to be congratulated for their efforts. The Team thanks the Faculty of Medicine for its cooperation in the prompt provision of preliminary information and documentation, its assistance in arranging the week's schedule; in particular, Kerry Galvin has quietly been a tower of strength and we thank her for her input. Bruce Smith, as usual, has provided excellent support. The Team would like to remind the Faculty all of the process of accreditation from here on. The Team will be involved with the preparation of the final report with recommendations, which will be

submitted to the Medical School Accreditation Committee in October. The Committee will consider the report and recommendations and will transmit it, together with its own specific recommendations regarding accreditation, to the next meeting of the Australian Medical Council. The Council will then make the final decision.

Those on the Team who know the program at Otago are impressed with the changes that have occurred over the last few years. The Team is impressed with the staff, with their engagement and their spirit of collaboration. The program fits together well and the AMC looks forward to the same approach to the latter years, which should result in a similarly excellent and innovative program. On behalf of the Team, thank you all.



