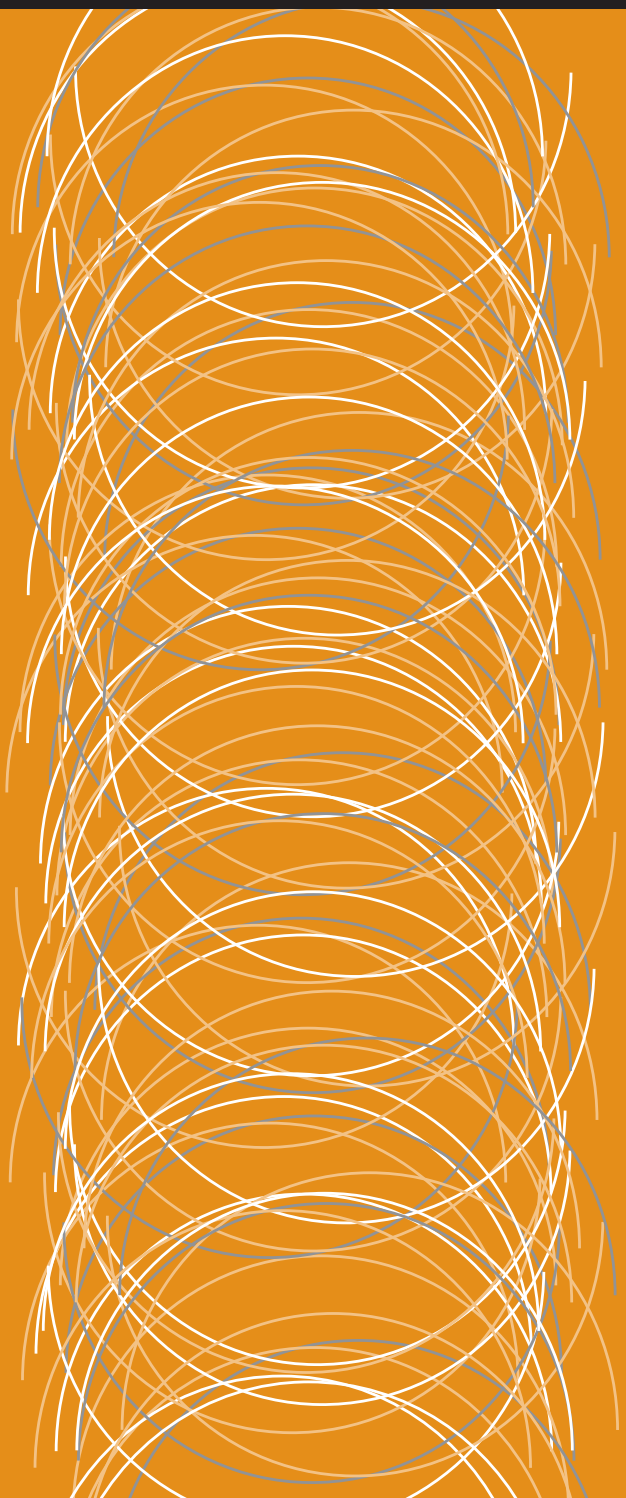
Australian Medical Council Limited

Accreditation of Australian National University ANU Medical School

AMC



Medical School Accreditation Committee
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Australian Medical Council Limited
PO Box 4810
KINGSTON ACT 2604

Email: amc@amc.org.au
Home page: www.amc.org.au
Telephone: 02 6270 9777
Facsimile: 02 6270 9799

Contents

Executive Summary 2013

The AMC's *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2011* provides for accredited medical education providers to seek reaccreditation when a period of accreditation expires. Accreditation is based on the medical program demonstrating that it satisfies the accreditation standards for basic medical education. The provider prepares a submission for reaccreditation. An AMC Team assesses the submission and visits the provider and its clinical teaching sites.

The Australian National University Medical School is seeking reaccreditation of its medical program. The four-year graduate-entry program was first accredited in 2003 for six years to 2009, subject to a number of reporting conditions and follow up visits. The last AMC visit occurred in 2005 to review the implementation of the first two years of the program and detailed plans for Years 3 and 4. Accreditation was confirmed after the second follow-up assessment. The School submitted a comprehensive report for extension of accreditation in 2008. On the basis of this report accreditation was extended for a maximum of four years to 31 December 2013

The School notified the AMC in its 2012 progress report of its plans to move the MBBS degree to a Doctor of Medicine and Surgery (MChD) program, delivered as a Masters degree (Extended), from 2014. The last cohort of MBBS students, commencing in 2013, will graduate in 2016 and the MBBS program will be replaced with the MChD.

The AMC applies one set of accreditation standards for programs of study that lead to professional registration. It recognises that there are additional academic expectations of programs at Masters degree level, and the University has structured its program to take account of these expectations. The AMC notes that separate processes exist to audit and assess whether the University's academic programs are in line with national qualification framework guidelines.

An AMC Team reviewed the School's submission and visited the School and associated clinical teaching sites in the week of 19 August 2013. This report presents the Team's findings against the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council* 2012.

The AMC Directors considered the draft report of the assessment and recommendations on accreditation within the accreditation options described in *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2011*. This report presents the detailed findings against the approved accreditation standards.

Decision on Accreditation

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

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

Reaccreditation of established education providers and programs of study

The accreditation options are:

(i) Accreditation for a period of six years subject to satisfactory progress reports. In the year the accreditation ends, the education provider will submit a comprehensive report for extension of accreditation. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to a maximum of four years, before a new accreditation review.

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

(iii) Accreditation for shorter periods of time. If significant deficiencies are identified or there is insufficient information to determine that the program satisfies the accreditation standards, the AMC may award accreditation with conditions and for a period of less than six years. At the conclusion of this period, or sooner if the education provider requests, the AMC will conduct a review. The provider may request either:

- full accreditation assessment, with a view to granting accreditation for a further period of six years; or
- more limited review, concentrating on the areas where deficiencies were identified, with a view to extending the current accreditation to the maximum period (six years since the original accreditation assessment).

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

The 21 November 2013 meeting of the AMC Directors found that the medical programs of the Australian National University Medical School meet the approved accreditation standards.

The AMC Directors agreed:

(i) That the four-year graduate-entry program Bachelor of Medicine/Bachelor of Surgery (MBBS) medical program of the Australian National University Medical School be granted accreditation to 31 December 2018 subject to satisfactory progress reports;

(ii) That the four-year graduate-entry Doctor of Medicine and Surgery (MChD) medical program of the Australian National University Medical School be granted accreditation for a period of six years to 31 December 2019.

(iii) That accreditation is subject to the following conditions:

(a) In the School's 2014 progress report:

- Provide evidence the School has communicated to students the instructional objectives and outcome statements expected at each stage of the program. (3.4)

- Provide evidence that the assessment methods and formats are fit for purpose in assessing learning outcomes. (5.2.1)

(b) In the School's 2015 progress report:

- Provide evidence that the program achieves comparable outcomes through comparable education experience and equivalent methods of assessment across all instructional sites. (2.2.3)
- Provide evidence that students have opportunities for interprofessional learning across the curriculum. (4.7)
- Develop an assessment plan which aligns with learning outcomes, clearly documents the assessment and progression requirements, and makes those requirements available to students. (5.1.2)
- Develop a detailed assessment plan which includes details of the assessment blueprint, formats and standard setting. (5.2.2)
- Provide evidence of improved feedback to students following assessments. (5.3.2)
- Provide evidence that clinical supervisors in Phase 2 are provided with aggregated assessment performance data regarding cohort performance. (5.3.3)
- Provide evidence of mechanisms for regular review of its assessment program which ensure the quality of assessment items. (5.4)
- Provide evidence that all feedback is analysed and evaluated at a program level to inform monitoring and program development. (6.1.2)
- Provide evidence of systematic collection and evaluation of data on outcomes. (6.2.2)
- Provide results of its evaluations to examine student performance in relation to student characteristics and evidence that evaluation results are provided to committees responsible for student selection, curriculum and student support. (6.2.3)
- Provide evidence that the School has clearly defined and communicated the responsibilities of clinical supervisors who contribute to the delivery of the medical program. (8.4.4)

(c) In the School's 2016 progress report:

- Provide evidence that the results of outcome evaluations are reported through the governance and administration of the medical program. (6.3)

Key Findings Table

The table below summarises the findings of the 2013 AMC assessment against the accreditation standards, which includes conditions on accreditation, commendations and quality improvement recommendations.

The right column of the table notes conditions on accreditation. If requirements are 'not met' or 'substantially met' the AMC imposes conditions to ensure that the medical education provider does meet the standard in a reasonable timeframe[1].

The left column notes commendations and quality improvement recommendations. The quality improvement recommendations are suggestions by the AMC Team on areas for improvement. These are not conditions.

Accreditation standard with commendations and quality improvement recommendations.	**Ratings and conditions.**
1. The Context of the Medical Program	**Met**
<u>Commendations</u> The strong leadership and expertise in the Medical Education Unit. The Medical School has a close and collaborative relationship with the ACT Health Directorate. <u>Quality Improvement Recommendations</u> The Medical School may wish to consult relevant groups beyond ACT Health, including Indigenous groups, on key issues related to its purpose, curriculum, graduate outcomes and governance. (1.1.3) The Team encourages the School to consider additional e-learning expertise and support in order to develop and manage the medical program. (1.4)	
2. The Outcomes of the Medical Program	**Met**
<u>Commendations</u> The excellent resources and experiential opportunities provided for students in Indigenous Health.	<u>Condition on Accreditation 2015:</u> Provide evidence that the program achieves comparable outcomes through comparable education experience and equivalent methods of assessment across all instructional sites. (2.2.3)

[1] Section 48 Health Practitioner Regulation National Law

3. The Medical Curriculum	Met
Commendations The significant improvements in the pharmacology and anatomy curriculum content. The program provides students with the opportunity to work with an array of high quality researchers and supervisors. The considerable progress in aligning both overarching and lower level outcomes to the curriculum, with particular reference to assessment across the program. The introduction of an Indigenous Health stream.	Condition on Accreditation 2014: Provide evidence the School has communicated to students the instructional objectives and outcome statements expected at each stage of the program. (3.4)
4. Teaching and Learning	**Met**
Commendations The impressive range of teaching and learning methods align to the learning needs of students at different stages of the program. The use of actors and volunteers in teaching basic clinical skills. Role modelling appears to be integral to teaching and learning within the medical program. The School encourages teaching at all levels, from medical student to expert clinician. The early introduction of patient-centred care in the curriculum. The concepts of patient safety and patient autonomy are strongly emphasised in Phase 1 and cultural competence is a taught and assessed skill. Quality Improvement Recommendations The Team encourages the School to communicate to students which learning objectives are formally taught and those which require self-directed learning. (4.2)	Condition on Accreditation 2015: Provide evidence that students have opportunities for interprofessional learning across the curriculum. (4.7)
5. The Curriculum – Assessment of Student Learning	**Substantially Met** **5.1 Substantially Met** **5.2 Substantially Met** **5.3 Substantially Met** **5.4 Substantially Met**
Commendations The development of an Assessment Committee and individual Year-based sub-committees to administer implementation of the assessment policies and	Condition on Accreditation 2015: Develop an assessment plan which aligns with learning outcomes, clearly documents the assessment and progression requirements, and

procedures. The commitment of staff and policies relevant to the identification of students at risk and the additional support and remediation that is subsequently provided. The comprehensive nature of assessment item performance and psychometric analysis that is available for examinations. <u>Quality Improvement Recommendations</u> The School may wish to consider providing students with examination papers with structured answer guides. This would provide students with a tangible outline of the overall blueprinting schema and marking allocations. (5.1) The School may wish to undertake comparisons of assessment performance for students having differential experiences at the Calvary and the Canberra Hospitals during in Phase 2. (5.4)	makes those requirements available to students. (5.1.2) <u>Condition on Accreditation 2014:</u> Provide evidence that the assessment methods and formats are fit for purpose in assessing learning outcomes. (5.2.1) <u>Conditions on Accreditation 2015:</u> Develop a detailed assessment plan which includes details of the assessment blueprint, formats and standard setting. (5.2.2) Provide evidence of improved feedback to students following assessments. (5.3.2) Provide evidence that clinical supervisors in Phase 2 are provided with aggregated assessment performance data regarding cohort performance. (5.3.3) Provide evidence of mechanisms for regular review of its assessment program which ensure the quality of assessment items. (5.4)
6. The Curriculum - Monitoring	**Substantially Met** **6.1 Met** **6.2 Substantially Met** **6.3 Not Met**
<u>Commendations</u> The School's response to student feedback which resulted in major revisions of Phase 1, Blocks 1 and 7. The School's overall low attrition rates attest to the high quality of teaching and remediation that is evident throughout the program. Clinicians and health services executives report substantial enhancements to local health services as a result of the medical school's existence and engagement. This includes vastly improved success rates with the recruitment of junior doctors, a more academic culture, improved infrastructure, and for some clinicians, a refreshed outlook on professional practice.	<u>Conditions on Accreditation 2015:</u> Provide evidence that all feedback is analysed and evaluated at a program level to inform monitoring and program development (6.1.2) Provide evidence of systematic collection and evaluation of data on outcomes. (6.2.2) Provide results of its evaluations to examine student performance in relation to student characteristics and evidence that evaluation results are provided to committees

	responsible for student selection, curriculum and student support. (6.2.3) <u>Condition on Accreditation 2016:</u> Provide evidence that the results of outcome evaluations are reported through the governance and administration of the medical program. (6.3)
7. Implementing the Curriculum - Students	**Met**
<u>Commendations</u> The Medical School's Indigenous Entry Scheme and the support provided to Indigenous students in the program. ACT Health provides internship places for all ANU medical graduates, including international students. The high quality of both academic and pastoral support provided the Year Coordinators, and the role they play in the identification and remediation of students at risk. The Rural Clinical School provides excellent support for students on both short and long term rotations. Students are strongly represented on committees and in the decision-making processes of the School.	
8. Implementing the Curriculum- Learning Environment	**Met**
<u>Commendations</u> The Medical School has excellent physical facilities, many of which were purpose built for the medical program. Students have access to a wide variety of clinical teaching facilities providing a range of models of care. All students gain experience with Indigenous patients. The enthusiasm and commitment of clinical supervisors.	<u>Condition on Accreditation 2015:</u> Provide evidence that the School has clearly defined and communicated the responsibilities of clinical supervisors who contribute to the delivery of the medical program. (8.4.4)

Introduction: The AMC Accreditation Process

The AMC is a national standards body for medical education and training. Its principal functions include assessing Australian and New Zealand medical schools and medical courses, and granting accreditation to those that meet accreditation standards.

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

The standards and procedures for accreditation are published in the AMC's *Assessment and Accreditation of Medical Schools: Standards and Procedures.* The AMC lists the knowledge, skills and professional attributes expected upon 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 oversees the AMC process of assessment and accreditation of medical schools, and reports to the AMC Directors. The Committee includes members of the Council itself and nominees of the Australian and New Zealand medical schools, the Medical Council of New Zealand, health consumers, medical students, the Confederation of Postgraduate Medical Education Councils, and the Committee of Presidents of Medical Colleges.

To assess a medical school, the Committee selects an expert team (the Team). The Team composition is balanced, with assessors from different states, medical schools, the basic and the clinical disciplines, hospital and community-based teachers, experienced academic managers, health service managers, and community interests.

The school's accreditation submission forms the basis of the assessment. Following a review of the submission, the Team conducts a visit to the school and its clinical teaching sites. This visit may take a week. Following the visit, the Team prepares a detailed report for the Medical School Accreditation Committee, providing opportunities for the medical school to comment on successive drafts. The Committee considers the Team's report and then submits the report, amended as necessary, to the AMC Directors. The Directors make the final accreditation decision. In the case of new medical courses, accreditation may be granted for a period up to two years after the full course has been implemented, subject to satisfactory annual reports. The granting of accreditation may also be subject to other conditions, such as a requirement for follow-up assessments.

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 that may affect the medical school's ability to deliver the medical curriculum, and issues raised in the AMC accreditation report. The AMC requires new medical schools and those that have made major course changes to report annually.

The Australian National University School of Medicine

The Australian National University is organised into seven academic colleges. The Medical School resides in the College of Medicine, Biology and Environment (CMBE). The Dean of Medicine and Health Sciences (the Dean of the Medical School) is the academic head of the medical program, with responsibility for the delivery of the medical program.

The School's main campus in Canberra is the Acton Campus, with additional locations at The Canberra Hospital, the major teaching hospital for the medical school, and The Calvary

Hospital which is also in Canberra. The Rural Clinical School operates in South East New South Wales with major teaching locations in the main regional centres.

The University made a determination to reclassify the medical program from an Australian Qualifications Framework (AQF) Level 7 Bachelors program to an AQF Level 9 (Masters Extended). Commencing in 2014 the Medical School will offer a Medicinae ac Chirurgiae Doctoranda (MChD). This process was guided by the Medical School Curriculum Committee in conjunction with the University's Education Committee.

This report details the 2013 assessment findings. Each report section begins with the relevant approved accreditation standards.

The approved accreditation Standards were revised in 2012 and the program was assessed against the revised standards.

Appreciation

The AMC thanks the University and the School staff for the detailed planning and hard work involved in the site visits. The AMC also acknowledges and thanks the staff, clinicians, students and others who met the AMC Team for their hospitality, cooperation and assistance during the assessment process.

The members of the 2013 AMC Team is at **Appendix One**.

The groups met by the AMC in 2013 is at **Appendix Two**.

1 The context of the medical program

1.1 Governance

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

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

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

2013 Team findings

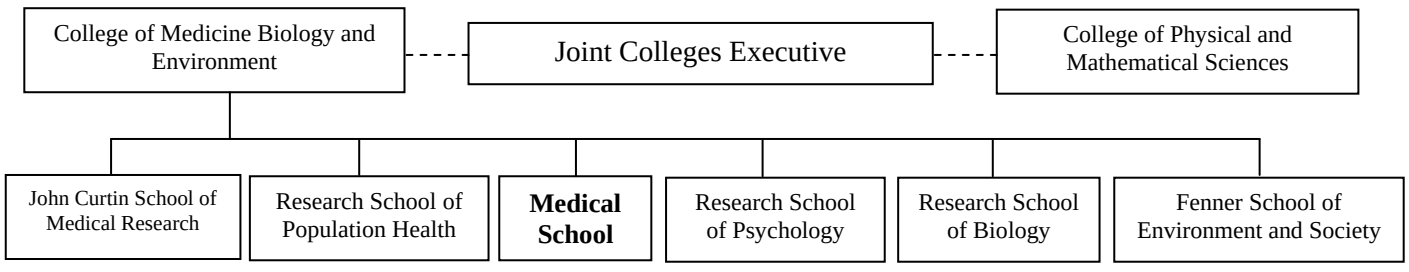
Since the last AMC assessment in 2005, the Australian National University has implemented significant changes to the executive management team and governance structure. The University appointed a new Vice-Chancellor and Deputy Vice-Chancellor (Research) in 2012, with a new Deputy Vice-Chancellor (Academic) appointed in 2011. The University has implemented a college structure of governance, which was foreshadowed by the University during the AMC's 2005 assessment.

The University is organised into seven academic colleges, structured around core disciplines and themes. The Medical School is one of six schools located in the College of Medicine, Biology and Environment (CMBE). The Head of each College reports to the Vice-Chancellor and is a member of the University's Senior Management Group.

Although the Dean of Medicine and Health Sciences (the Dean of the Medical School) is not a College Head, the Dean also reports directly to the Vice-Chancellor. This reporting relationship preceded the formalisation of the role of College Head. The Dean is also a member of the Senior Management Group, along with the seven College Heads and members of the University executive. The Vice-Chancellor determined the Dean of Medicine should sit as a member on the Senior Management Group because of the nature of the role, particularly due to the strategic relationships with the health sector.

These arrangements appear to function well and enable both strategic medical leadership of the School and collaborative participation in the College structure of the University.

Joint Colleges of Science Organisational Structure



The College of Medicine, Biology and Environment (CMBE) and the College of Physical and Mathematical Sciences (CPMS) have a joint administrative support structure and the two Colleges share a Joint Colleges Executive Committee (JCEC). The Committee is chaired on a rotational basis, and is currently held by the Head of the College of Medicine, Biology and Environment. School Directors report to College Heads, and are delegated budgetary responsibility for their schools that relate to physical infrastructure, recruitment, and other related functions. The Dean of the Medical School, as the School Director, holds these delegations.

The Medical School remains a relatively new entity within the university, with its first cohort commencing in 2004. The first 72 students graduated from the medical program in 2007. The School is well supported by the Vice-Chancellor, the Joint Colleges Executive Committee, and the College Head. The changes to the university's decision-making structures have had little impact on the ability of the Dean to make decisions within approved delegations.

The Team noted a change in nomenclature of its organisational units for teaching and research since the last AMC assessment. The change was made in order to avoid confusion arising from the references to schools within schools. For example, the School of Clinical Medicine (as The Canberra Hospital based group was then called) had the potential to be confused with the ANU Medical School.

The Medical School determined the most useful way of representing its sub-units was based on geographical descriptors. There are three Campuses and two Domains in which the Medical School sub-units are contained:

Campuses

Acton Campus is the main ANU Campus and is also the main location of administration and delivery for Years 1 and 2 (Phase 1) of the curriculum.

The Canberra Hospital Campus (TCH) is the major teaching hospital for the Medical School.

Calvary Hospital Campus provides both public and private health services. The Calvary Campus is aligned predominately with the public component of Calvary Healthcare.

Domains

The Rural Clinical School (RCS) operates predominately in South East New South Wales with major teaching locations in the main regional centres (Goulburn, Bega, Cooma, Young/Cowra and Batemans Bay/Moruya). These five nodes, in a hub and spoke model, have teaching and student accommodation infrastructure, and local academic and administration staff. There are also teaching facilities at Queanbeyan, and student and supervisor accommodation at Yuendumu in the Northern Territory.

General Practice: The Medical School has widespread support for its teaching program among the ACT general practice community.

The Medical School Advisory Board, chaired by the Dean, meets annually and includes wide representation from external bodies including government, public hospitals, private hospitals and general practice organisations. This body meets annually but evidence that the Advisory Board contributes significantly to program development is lacking.

The Dean regularly consults (both informally and through committee representation) with medical students. The submission from the ANU Medical Student Society confirms the approachability and level of access students have to the Dean to discuss key issues.

The Vice-Chancellor indicated to the Team the University serves the entire nation. The Team identified an opportunity for the Medical School to define the community it serves, and articulate a clearer regional focus.

The School has a high level of engagement with and support from the ACT Health Directorate, a critical stakeholder in the medical program. The School may wish to consult relevant groups, including Indigenous groups, beyond ACT Health on key issues related to its purpose, curriculum, graduate outcomes and governance.

1.2 Leadership and autonomy

1.2.1 The medical education provider has autonomy to design and develop the medical program.

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

2013 Team findings

The Medical School has sufficient autonomy to design and deliver its medical program.

The Dean is the academic head of the medical program, with responsibility for the delivery of the medical program. The role and responsibilities of the Dean are clearly defined and the Team concluded that the Dean retained appropriate autonomy and had sufficient resources to administer the Medical School program effectively.

1.3 Medical program management

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

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

2013 Team findings

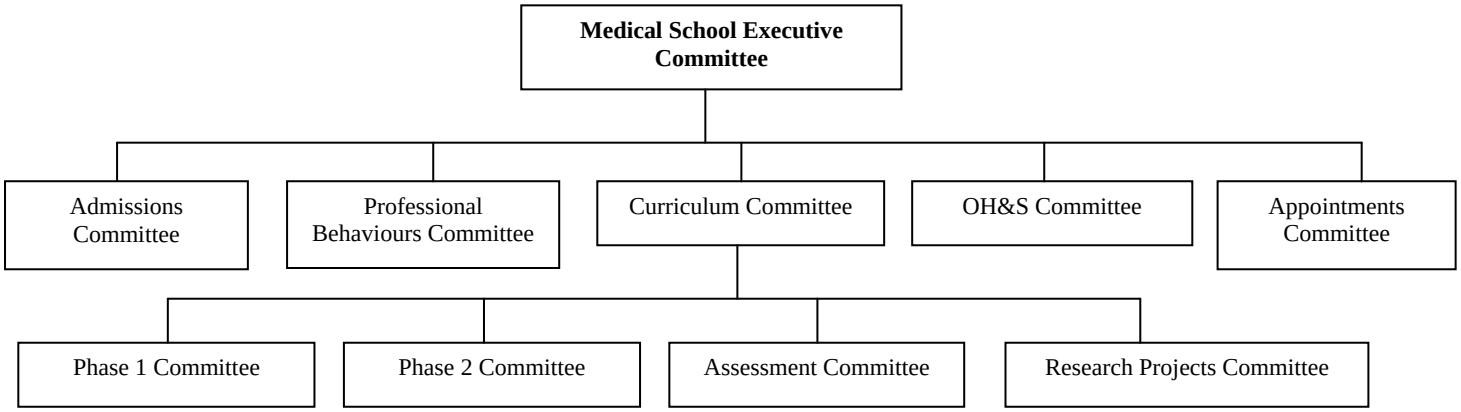
The Medical School Executive Committee (MSEC) is the principal committee within the Medical School. This Committee considers all high level strategic matters relevant to the program's operations; makes decisions, and oversees the processes of implementing those decisions. The Dean is Chair, with membership drawn from the three campuses and key areas and committees in the Medical School. The Head of the College of Medicine, Biology and Environment is also a member of the MSEC.

The relatively small size of the Medical School enables many of those who chair committees to sit on the MSEC, and this facilitates communication and decision-making. However, the small size of the school necessarily leads to the committee work load being shared by a relatively small number of members, many of whom serve on multiple committees. Overlapping membership of different committees has created difficulties, particularly due to workload on staff. The School reports that recruitment of new committee members to some committees has been difficult.

Reporting to the MSEC are the Admissions Committee, Professional Behaviours Committee, Curriculum Committee, Occupational Health and Safety Committee, and the Appointments Committee. The terms of reference of the Medical School committees clearly set out the purpose, composition, reporting lines, terms of appointment, meeting schedule and quorum

requirements for each committee.

Medical Program Governance Structure
Medical School Executive Committee with Major Committees



Planning, implementation and review of the medical program rests principally with the Medical School Curriculum Committee. The Committee's principal role is to maintain an overview of the curriculum across all four years of the program, to ensure that it is relevant, up-to-date, and appropriate to the needs of our students. The Medical School Curriculum Committee has status as a "College level" Committee providing for its decisions to go directly to the University level Education Committee, and then to the Academic Board.

The following key committees report to the Curriculum Committee:

- Phase 1 Committee
- Phase 2 Committee
- Assessment Committee
- Research Project Committee.

The University made a determination to reclassify the medical program from an Australian Qualifications Framework (AQF) Level 7 Bachelors program to an AQF Level 9 (Masters Extended). Commencing in 2014 the Medical School will offer a Medicinae ac Chirurgiae Doctoranda (MChD). This process was guided by the Medical School Curriculum Committee in conjunction with the University's Education Committee.

The University has assessed the level of the proposed qualification against the AQF and confirmed that it will meet the criteria for Level 9 (Masters Extended).

1.4 Educational expertise

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

2013 Team findings

The Medical School has been successful in recruiting leaders and scholars with published records of achievement in education. The School engenders a culture of education and research within the medical program through promoting and rewarding achievement in medical education.

The Team was impressed with the strong leadership and expertise in the Medical Education Unit. The Unit provides a variety of services, including administration of the Phase 1 program on campus, support of problem-based learning, faculty development related specifically to the medical program, assessment, quality assurance and mapping of curriculum to outcomes and standards. The Team considered that there is currently insufficient e-learning expertise and support in the School and encourages the School to adequately resource this area.

The students who spoke to the Team appreciated the fact that all classes in the medical program are delivered almost exclusively to medical students (with the exception of MEDI 1001 where there may be a small number of Bachelor of Philosophy (Honours students) on the PhB/MBBS pathway). The students also expressed appreciation for the educational expertise evident in the clinical skills and population health themes.

There are two Indigenous staff members who form the core of the School's Indigenous Health Unit. Other Indigenous staff, doctors and health practitioners also teach into the program at all year levels.

1.5 Educational budget & resource allocation

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

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

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

2013 Team findings

The Dean has delegations relevant to program resources, to the utilisation of space, to staff recruitment, and travel. The Dean confirmed that the current delegations provide sufficient autonomy for the Medical School to conduct its own business.

The Medical School receives funding from four sources:

- An operating grant from the University based on student load. Domestic student enrolment, capped since 2009 at 360 students across all four years of the program, is the principal determinant of funding. The University charges a levy for the Medical School student load at 13.9% and distributes the rest to the CMBE. The Medical School pays its share of the costs borne by CMBE from this post-levied amount. The levy for the Medical School is the lowest in the University, recognising the unique resource needs of the Medical School.
- Funding from the Commonwealth Department of Health and Ageing (DoHA) under the Rural Clinical Training and Support (RCTS) program is the source of income for the operation of the Rural Clinical School and the rural health curriculum.
- Research Grants which support the research activity within the School. The University and the College charge a levy on this line of income before distributing to the Medical School. The levy changes year to year and reflects changes in Government policy and the University's budget model.
- Consultancy/Services fees income derived from the provision of non-research consultancy services.

The Team considered that funding arrangements were transparent and provided for considerable autonomy to direct resources. The Dean consults with the Medical School Executive Committee on funding allocations and the Executive Officer of the MSEC is responsible for developing, monitoring and reporting on budgets.

The Medical School is aware of the potential to increase revenue by increasing the number of international fee-paying students. However, the Medical School, with the support of the ACT Health Directorate, aims to have a maximum of 40 international students across the four years of the program. Since the last AMC accreditation, the School has formalised an agreement with the International Medical University of Malaysia (IMU) to take up to six IMU students each year into Year 3 of the Medical School program.

The Vice-Chancellor, Head of the College, Dean, senior clinicians, and academic staff expressed support-in-principle for a modest increase in fee-paying students. However, the placement of additional fee-paying international students in intern positions was a major consideration in determining whether this could be realistically pursued and this would need to be agreed in conjunction with ACT Health.

1.6 Interaction with health sector and society

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

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

2013 Team findings

The Team commended the Medical School for its close and collaborative relationship with the ACT Health Directorate. The School views the Directorate as a primary stakeholder, particularly as now over 70% of graduates are employed by the Directorate.

The Directorate is well represented on the School's Advisory Board and Executive Committee. The Medical School/Health Directorate Liaison Committee has executive membership from both the medical program and the Health Directorate. The Team was impressed by the Directorate's strong support of the Medical School, and a new ten-year deed of agreement between the two organisations was executed in June 2013.

One of the many benefits of this relationship is guaranteed employment for all of the School's medical graduates at ACT Health, at least for the intern year. Prior to the founding of the Medical School, ACT Health relied upon a mainly locum medical workforce. Health service representatives highlighted the positive impact for ACT Health resulting from educating a local medical workforce. This positive impact on workforce was also confirmed by health service managers in the regional areas outside of ACT where the Rural Clinical School had a presence.

The Medical School also has partnerships with a range of agencies where, for the most part, there are formal agreements in place. Partnerships are established with public and private hospitals and with various government departments and agencies. The majority of clinical teaching takes place in public sector settings.

The Medical School engages with Indigenous health services in the ACT, in South East New South Wales and in the Northern Territory.

The Team met with several health service organisations who commented on the positive impact of their relationship with the Medical School. The CEO of Katungul Aboriginal Corporation Community and Medical Services, a clinical placement site for short term rural placements and the Executive Manager of the Southern NSW Medicare Local were enthusiastic about the partnership with the School and the benefits which resulted to their organisations.

1.7 Research and scholarship

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

2013 Team findings

The ANU is a research-intensive university and this is reflected in the Medical School's outcomes statement. Research performance in the Medical School since 2008 is consistent, with steady grant success and Higher Education Research Data Collection (HERDC) eligible publications increasing.

The Team considered there was an excellent opportunity to enhance "bench to bedside" research collaboration between the Medical School, the John Curtin School for Medical Research, the Canberra Hospital, Calvary Hospital, and ACT Health.

Such collaboration would enhance the cohesion and mutual understanding between basic science and clinical academic staff and has the potential to provide significant benefits to each group. The impending co-location of additional space for the medical program with the John Curtin School for Medical Research (JCSMR) presents a major opportunity for the Medical School and the JCSMR to share expertise and resources.

The Research Strategy Committee of ACT Health provides high level advice about research related matters within the ACT Health Directorate, and the Medical School has strong representation on this Committee. The Director of Research for Canberra Hospital and ACT Health Services is also Sub Dean Research for the Medical School and a member of the Medical School Executive Committee. This linkage is purposefully designed to build a strong research connection between the School and ACT Health public hospital services, including Calvary Hospital public services.

The Medical School is also a major supporter and sponsor of the Canberra Health Annual Research Meeting, and works with the ACT Health Research Office in the coordination of research in publically funded hospital and health services. The School is encouraged to build on this activity in order to strengthen its contribution to translational research at the hospital level.

Research activities are embedded in the curriculum and engage other schools and colleges within the University. Medical students are exposed to students and staff pursuing research degrees through Phase 1 tutoring and laboratory demonstration.

Phase 1 students undertake a research project which requires 120 hours of student work and which contributes significantly to the School's estimate that approximately 5% of the curriculum is directly related to research. Some students informed the Team that they found it difficult to obtain help with certain aspects of their research projects, such as how to write a manuscript or to prepare a grant submission.

Generally, students indicate the focus on research is a strength of the program and noted the School provides considerable support and encouragement for students to become involved in research.

There is opportunity for the Medical Education Unit to make a more substantial contribution to the international body of medical educational research.

1.8 Staff resources

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

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

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

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

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

2013 Team findings

The Medical School has the appropriate academic, professional and administrative staff to support the program. There are approximately 220 academic staff who contribute to the program, with 60 staff employed by the university, and 160 staff employed by the ACT Health Directorate. There are many visiting medical officers in the hospitals and in community practices, some of whom have academic appointments in the University.

However, staffing presents constant challenges and recruitment of academic staff is increasingly competitive.

The process of recruitment to the vacant positions of Professor of General Practice and Professor of Obstetrics and Gynaecology was underway at the time of the assessment visit. The position of Professor of Surgery, also vacant at the time of the site visit, was recently filled, with the successful candidate scheduled to commence duties in early 2014. The Team noted that the appointee is an international medical graduate and will be required to undergo assessment of comparability of specialist qualifications and will in all likelihood be required to undergo a period of supervised practice before being eligible for unrestricted specialist registration. The School is aware of this and does not anticipate that such arrangements would interfere with the capacity of the new appointee to provide academic and clinical leadership.

The Team commended the University on its appointment of an Associate Dean (Medical Education) at the end of 2012 to head the Medical Education Unit. The Associate Dean brings strong leadership and educational expertise to this important role.

The appointment of a Manager to the Medical Education Unit, who commenced the position shortly before the assessment visit, is also a positive development, particularly in the current setting of a relative freeze on new professional staff appointments across the University.

The Medical School is actively recruiting, training and supporting Indigenous staff and has established an Indigenous Health Unit.

The School uses Community Volunteer Patients (CVP) and Real Patients (RP), the latter mostly coming from outpatient clinics. CVPs are recruited, trained and supported by the school. RPs are recruited via hospital clinicians or through support groups. The students appreciate the valuable contribution that both CVPs and RPs make to medical student education.

The Team noted that all curriculum-related activities are covered through appropriate indemnity and insurance policies which are reviewed through a broker annually.

1.9 Staff appointment, promotion & development

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

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

2013 Team findings

The Medical School follows the ANU's policies and procedures relating to academic appointment and promotion and ensures a balanced capacity for teaching, research and service functions. Medical School appointments for academic status from Level A through to Level D are determined by the Appointments committee, which is chaired by the Dean of the Medical School. Appointments at Professorial Level E are taken by the Dean to the Vice Chancellor.

The Team noted the limited relevance of University-wide evaluation mechanisms for staff applying for promotion, particularly clinical academics. The Team was informed that the Medical School has good input into plans to review the evaluations, and supports this work. The promotion committee processes for clinical academics are conducted separately from university promotion committee processes for academic staff, which reflects the university's insight into the differing demands on time faced by clinicians.

All ANU staff participate in a mandatory staff development and review program and have an agreed Statement of Expectations. Opportunities for professional and personal development can be identified as part of this process. However, there is no formal development program in place.

The ANU Centre for Higher Education, Learning and Teaching provides a wide range of staff development options. All new appointees undergo mandatory training in higher education teaching.

The Team discussed opportunities for promotion with both basic science staff and with clinicians. It was evident that opportunities for promotion are not universally known to staff, particularly in the clinical sphere, notwithstanding efforts made by the School to communicate this.

Supervisors and teachers at both The Canberra Hospital and Calvary Hospital highlighted the value placed on a formal university appointment. Clinical teachers suggested that appointments at clinical tutor level could be considered for junior medical staff, such as registrars with a regular teaching load and a demonstrated commitment.

Many of the dedicated supervisors at The Canberra Hospital took advantage of a university-

sponsored certificate in medical education and the Team commended the University on its initiative. However the Team considered that the School could provide additional pathways to facilitate academic promotion for its clinical staff.

The Medical School may wish to consider complementary processes to develop and appraise the Indigenous knowledge of staff in administrative, technical and academic areas, including clinical title holders.

2 The outcomes of the medical program

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

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

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

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

2 Clinical Practice: the medical graduate as practitioner

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

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

2.1 Purpose

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

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

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

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

2013 Team findings

The Medical School has clearly articulated its purpose, which covers the domains of learning, teaching, research and societal and community responsibilities.

The School's Purpose is to undertake to create and maintain an educational environment that encourages their students to:

1 Practise medicine with compassion, conscience and professional excellence.

2 Demonstrate knowledge of Aboriginal and Torres Strait Islander health and societies.

3 Understand the health problems and strive to alleviate the suffering of people in rural Australia; and

4 Extend the boundaries of medical knowledge through research and share this knowledge with patients and colleagues, locally, nationally and internationally.

The School's purpose addresses Aboriginal and Torres Strait Islander Health, and the leadership demonstrated by the Dean in this area is immensely important. The Team commended the excellent resources and experiential opportunities provided for students in this field. It is clear that this is one of the communities that provides context to the School's

stated purpose and it would seem appropriate to highlight this community partnership at a strategic level. The School may wish to build on their engagement of local Aboriginal leaders to facilitate curriculum development.

Development of the purpose and outcomes of the medical program has been undertaken and continually adapted in consultation with the ACT Health Directorate and other local and rural health care providers. The ability for the Medical School and partner health care providers to respond to changing workforce requirements and pressures is seen as a significant strength. The Medical School/Health Directorate Liaison Committee clearly has an important role in both informing the design and outcomes of the medical program, and in planning for the future workforce needs of the region. The Team was impressed by the depth of Medical School and health care provider representation in strategically important positions on both sides of the education/service provision nexus.

The Medical School is able to define its clinical community, and is clearly integrated within the spectrum of health care service provision at multiple levels and multiple sites in the region. The Medical School has not clearly defined its sphere of influence outside the clinical realm and has only peripheral evidence of consultation with health consumers and local community representatives outside of the medical community. The Team encourages the School to engage community representatives through mechanisms the School views to be appropriate and effective, for example though advisory boards and other stakeholder forums.

2.2 Medical program outcomes

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

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

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

2013 Team findings

The Medical School has undertaken a comprehensive review of its overarching outcome statements for the program, Phase 1 (Years 1 and 2) of the program, and for the themes and frameworks within the curriculum.

The School has clearly defined learning outcomes, closely aligned to the AMC graduate outcome statements and in broadly similar thematic groupings, and consistent with the stated purpose of the program. The outcomes of the program meet the AMC requirement for producing a pluripotent intern capable of working in a variety of environments and able to pursue a variety of vocational training opportunities.

The Phase 2 outcomes are aligned with widely utilised roles for medical practitioners: scientist, clinician, professional and life-long learner. The program outcomes also indicate graduates will be equipped with a strong sense of global connection, associated with a research intensive environment and aware of the range of career pathways.

The School has detailed curriculum outcomes clearly articulated in themes and frameworks.

The themes include Medical Sciences, Clinical Skills, Professionalism and Leadership and Population Health. Vertically integrated framework outcomes covering Aboriginal and Torres Strait Islander Health, Social Foundations of Medicine, Rural Health and Research provide a clear focus for these components of the curriculum.

The School has made considerable progress towards aligning both global and lower level outcomes to curriculum, with particular reference to assessment across the program.

There is good alignment of curriculum content across the School's multiple clinical sites with many common resources (both online and face-to-face), together with common stated expectations for each rotation. While data for the Rural Clinical School have been compared with the rest of the cohort, there has been no consistent approach to analysis of outcomes in terms of assessment performance across sites.

The School indicated they monitor variation in student experience at different clinical sites through gathering qualitative information from both students and supervisors following placements. This information is then provided to the Phase 2 committee to inform quality improvement.

The Team could not determine if the medical program achieves comparable outcomes through comparable educational experiences and equivalent methods of assessment across all instructional sites. The Team recommends the Medical School develop methods of systematically analysing the outcomes of students undertaking rotations at its different clinical sites.

3 The medical curriculum

3.1 Duration of the medical program

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

2013 Team findings

The Team was satisfied that the four year program would provide students with adequate learning opportunities to achieve the graduate outcomes. The duration is consistent with other graduate medical programs in Australia and internationally.

3.2 The content of the curriculum

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

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

The curriculum includes the scientific foundations of medicine to equip graduates for evidence-based practice and the scholarly development of medical knowledge.

3.2.2 Clinical Practice: The medical graduate as practitioner

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

3.2.3 Health & Society: The medical graduate as a health advocate

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

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

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

2013 Team findings

The curriculum is comprehensive and well-integrated.

Students commented on the high quality of teaching in the basic sciences, in particular pathology and biochemistry. The School has made significant progress to improve the teaching of pharmacology since the last AMC assessment. This has been achieved through the introduction of additional basic lectures and labs in Block 1, and 12 lectures on clinical pharmacology in Year 4.

The Team noted significant improvements in the anatomy curriculum since the early years of the program. The School has increased the amount of anatomy teaching in Phase 1 Block 1 and restructured the content. The appointment of new staff and the construction of a new state of the art dissection laboratory has enabled changes to take place in the types of learning activities that are undertaken in the practical classes. The Team was impressed with the new and creative teaching methods (such as body painting) that are being employed in these classes. An anatomy elective is available for interested students in Phase 1 Block 7, which provides an opportunity to undertake an eight-hour dissection over a period of four weeks. This elective has proven to be extremely popular, with approximately 90% of the students

participating.

The ANU is a research intensive university, providing students with the opportunity to work with an array of researchers and supervisors. Approximately five percent of the medical program is devoted to the development of research skills to facilitate lifelong learning. The program includes formal instruction in basic research skills through the Evidence Based Medicine Program (comprised of eight sessions), a number of research assignments and a major research project (MEDI2003). MEDI2003 gives students the opportunity to design and pursue a research project on a topic of personal interest. Students first select a supervisor and, then, in consultation with the supervisor, design their project. The project is done in parallel with Year 2 courses and involves about 120 hours of student time and the production of a 4000 word report.

While students noted some problems with inconsistent supervision while undertaking the research project in past years, the Medical School is confident that the appointment of a co-supervisor for all student projects and regular review of feedback regarding the quality of supervision will address these issues. Students were satisfied with the many opportunities they are given to develop critical thinking skills and focus on evidence based medicine throughout the program, particularly through all years of the program in the Clinical Skills theme.

Students in Years 1 and 2 spend one day per week at The Canberra Hospital, where the clinical skills training takes place. The Phase 1 Clinical Skills program remains relatively unchanged in content since the last AMC assessment, although content delivery has been modified. Phase 1 emphasises learning the technical skills of history taking and physical examination. The feedback from students has been extremely positive and the Team commended the Phase 1 Clinical Skills curriculum and the quality and enthusiasm of its teachers.

During Phase 2, each student has an Academic Supervisor, as well as a Clinical supervisor for each term, with the portfolio also being used to facilitate their clinical skills acquisition. Students feel well prepared for contact with patients in clinical settings as a result of the previous training they have undertaken in Phase 1. While students reported some variability in the direct supervision available, students are happy with their access to patients and feel included as part of the clinical team.

Students reported good opportunities for practising clinical skills in a way that facilitated feedback in the Rural stream. However, there was significant variability in metro placements where learning was limited or enhanced due to the characteristics of different supervisors, students and clinical teams. While students were not always exposed to ‘general’ medicine or surgery in their clinical rotations, clinical supervisors are asked to focus on general skills while providing supervision and this reflects the ‘taught’ syllabus.

The Team noted the strong focus on recognition and management of the sick patient in preparing students for their early years of practice, and viewed this as a strength of the program.

Students are well-prepared as future health advocates through the Population Health and Professionalism and Leadership themes, which form a strong focus of the program (together approximately 25% of the curriculum). Assessments include group projects in Year 3 and Year 4 and clinical audit in Year 3. The curriculum in this area is comprehensive and students were positive about the quality of the content in these two themes.

3.3 Curriculum design

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

2013 Team findings

The medical program is underpinned by four themes (Medical Sciences, Clinical Skills, Professionalism and Leadership, and Population Health) and is delivered in two Phases, each of which is two years in length.

The Medical Science and Clinical Skills themes comprise 75% of the curriculum, with Population Health and Professionalism and Health comprising 10% and 15% respectively.

Phase 1 is divided into seven blocks. Block 1 (Foundations) introduces students to medical science disciplines through a series of linked lectures and practical sessions. In the system-centred Blocks 2 – 6, medical science learning is driven by the problem based learning process and specific discipline systematics. Block 7 is a four week consolidation.

Phase 1 Block Structure and Duration

	Blocks	Topic	Duration
Year 1	1	Foundations	17
	2	Cardiovascular, Respiratory & Renal	12
	3	Endocrine and Reproductive	7
Year 2	4	Digestive and Nutrition	7
	5	Oncology / Haematology / Infectious Diseases	10
	6	Musculoskeletal & Neurosciences	12
	7	Consolidation	4

Phase 2 includes weekly Fixed Resource Sessions (FRS) where core material is delivered in a multidisciplinary lecture series to both Canberra and rural based students, case-based learning (CBL) and clinico-pathological conference (CPC) sessions include relevant specific integrated medical science content.

Phase 2 Block Structure and Duration

	Blocks	Topic	Duration
Year 3	1	Integrated Community and Child Health (ICCH)	19
	2	Foundations of Internal Medicine and Surgery (FIMS)	19
Year 4	3	Psychiatry and Addiction Medicine (PAM)	8

	4	Senior Medicine and Surgery (SMS)	8
	5	Acute Care	8
	6	Women's Health and Newborn Care (WHNC)	8

The final component of the program is the major research project (MEDI2003) which draws on concepts developed in the four curriculum themes, and requires students to apply their learning to a subject of personal interest. MEDI2003 involves approximately 100-120 hours of student engagement and submission of a satisfactory 4000 word report.

The overall design of the curriculum remains relatively unchanged since the last AMC assessment. It was apparent to the Team that there is good horizontal integration in both Phases 1 and 2 and this was supported by comments made by students in their submission and at the visit.

Phase 1 Block 1 has been redesigned with the aim of providing all students, regardless of their undergraduate study, with an adequate background in all program themes. The revised Block 1 was introduced in 2011 and has been received positively by the students. The School made significant changes to the introductory anatomy and pharmacology activities (lectures and practical classes) and modified problem-based learning sessions. The Team heard some students with weaker science backgrounds may struggle during Block 1, however this is an issue facing all graduate entry programs in Australia that encourage diversity through not having specific science subject prerequisites.

Since the last AMC assessment, Phase 1 Block 7 has also been redesigned to better prepare students for the transition to Phase 2. The changes involve a move away from problem-based learning to integrated seminars, which are similar to the case-based learning seminars of Phase 2. The revised Block 7 was first implemented in 2012 and the new format continued in 2013. The program will consider approaches other than small group tutorials to engage students in review of the seminar proceedings. Current Year 3 students noted in the student submission and at site visits the value of the integrated seminars in preparing them for Phase 2, although the lecture series was considered to be disjointed.

Phase 2 extends over Year 3 and 4 and comprises six teaching blocks, in addition to opportunities for elective and selective placements. The Year 3 curriculum, which comprises two 19 week blocks (Integrated Community Child Health and Foundations of Internal Medicine and Surgery) remains unchanged since the last visit and appears to be working well. The Year 4 curriculum comprises four teaching blocks (Psychiatry and Addictive Medicine, Senior Medicine and Surgery, Acute Care and Women's Health and Newborn Care). Students are required to undertake an elective placement between Years 3 and 4. During Phase 2 all students are required to spend a minimum of 6 weeks in a rural setting, with those students in the Rural stream spending all of Year 3 within the Rural Clinical School (RCS).

Students attached to the RCS follow an integrated, patient-based longitudinal study program combining the elements of the curriculum as delivered in Canberra. Students value the excellent educational and community experience provide by the RCS.

The only significant change to the Year 4 curriculum since the last AMC assessment has been the addition of 12 additional clinical pharmacology lectures in 2013 to address the perceived deficiencies in pharmacology teaching. Students consider the reinforcement of biomedical

sciences within clinical contexts in Phase 2 as a strength of the program.

The orientation sessions to Integrated Community and Child Health and Foundations of Internal Medicine and Surgery in Year 3 are integral to ensuring a smooth transition from Phase 1 to Phase 2. It is evident from both staff and student submissions that there is good horizontal integration of material across all the Phase 2 Blocks.

Since 2011, students who have completed Year 4 can undertake an optional Preparation for Internship Term (PrINT) of three weeks duration at The Canberra Hospital. However the uptake for this option has been low (18 in 2011, 22 in 2012). The School reports that factors contributing to the low uptake include its optional nature, short duration and timing. The low uptake is of concern to the Team, who encourage the School and ACT Health to work to develop a more coherent purpose for PrINT, so that it is attractive and useful to all graduating students, not just those who intend to work in the ACT.

3.4 Curriculum description

The medical education provider has developed and effectively communicated specific learning outcomes or objectives describing what is expected of students at each stage of the medical program.

2013 Team findings

The Team commended the School for the considerable progress in aligning both overarching and lower level outcomes to the curriculum, with particular reference to assessment across the program. At the time of the AMC assessment, overarching outcomes, and learning outcomes for each Phase, theme and framework have been defined and they align well with the AMC graduate outcomes. Learning outcomes for each block and lower level instructional objectives are currently being revised. The Team considered the revision process has been a positive experience for the School, enabling more accurate mapping of the curriculum and better tracking of 'spiral learning' in the curriculum. There remains a need for clearer alignment between learning outcomes and student expectations at different stages of the curriculum and the Team recommends that the School consider how best to collate and clearly communicate the instructional objectives and outcome statements to students.

3.5 Indigenous Health

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

2013 Team findings

Indigenous Health is one of the School's stated priorities. The Indigenous Health program incorporates all eight areas of the CDAMS (formerly the Committee of Deans of Medical Schools Australia, now Medical Deans Australia and New Zealand) Indigenous Health Curriculum Framework, and provides good opportunities for all students to engage in clinical placements. Indigenous Health is integrated throughout the program and is delivered in a variety of formats: lectures, problem- based learning, workshops, panel style case-based learning, online resources, clinical practice and placements, and research partnerships in rural remote and urban practices.

The School has appointed new staff, including a Senior Lecturer in Indigenous Health, to the Indigenous Health Unit. This expertise provides the medical program access to a good mix of skills. This Unit is currently reviewing the content and delivery of the Indigenous curriculum and mapping it to the Indigenous Health Curriculum Framework objectives.

The students hold in high regard the program's Indigenous partnerships and the opportunities they afford for students to experience Indigenous communities first hand. The School has a high level of engagement with local Indigenous health providers.

There is a wide range of opportunities for students to gain experience with Indigenous patients. All students see Indigenous patients in chronic disease workshops, in general practices and emergency settings. There are also opportunities for approximately half the cohort to undertake placements at local Aboriginal Medical Services (Winnungah Nimityjah and Katungul) and in the Northern Territory. The inclusion of a required item in the portfolio where students reflect on experiences with Indigenous health ensures that all students experience some contact with indigenous patients. The Team was impressed that all students are guaranteed an experience with Indigenous patients before graduation.

The Team commended the School for the introduction in 2010 of a stream for students with a particular interest in Indigenous Health. Students in this stream participate in focussed training, attend cultural immersion programs and receive mentoring. Student uptake for this stream is steadily increasing.

3.6 Opportunities for choice to promote breadth and diversity

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

2013 Team findings

There appears to be a good diversity of opportunities for students to pursue areas of interest, including the Phase 2 elective term, Rural and Indigenous Health streams, selective clinical placements, and curriculum selectives (within the Women's Health and Newborn Care and Psychiatry and Addictive Medicine blocks in Year 4), as well anatomy dissection options. The research project also provides students with an opportunity to pursue research on a topic that is of specific interest to the student.

Students perceive this breadth of opportunity to be a considerable strength of the program.

4 Learning and teaching

4.1 Learning and teaching methods

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

2013 Team findings

The School employs an impressive range of teaching and learning methods which aim to align to the learning needs of students at different stages of the program.

Phase 1

Phase 1 (Years 1 and 2) is delivered mainly at the Acton Campus and is built around problem-based learning (PBL) or integrated seminar (Block 7) sessions. Students are introduced to the PBL technique during orientation and PBL tutors are seen to be generally well prepared for this type of teaching. The majority of PBL tutors are clinicians, a feature that is well appreciated by students.

Block 1 (Foundations) covers the basics of clinical sciences in an integrated curriculum. While students, especially those with a non-science background, find this challenging, it is felt that knowledge is built on over time. The cohesiveness of teaching in pathology and biochemistry is a strength of this block. Students appreciate changes implemented in the last two years in the approach to teaching anatomy, namely body painting, overhead visualisation and use of ultrasound. Students have a perception that some elements of the curriculum are not cohesively taught, and the means of integration of the curriculum is not well understood by students. The School may wish to enhance communication regarding curriculum integration to the students.

As a result of student feedback, modified PBL has been in place since 2011 in Block 1. The modified PBLs comprise one 2-hour session and one 1.5-hour session, both aimed at helping students better understand the different stages of the PBL process. This change has been well received by students.

Phase 1 Blocks 2 - 6 employ a standard form of PBL, comprising three 1.5 hour sessions per week.

Lectures complement the active teaching in Phase 1. Student feedback indicates that while notes for these lectures should be available on-line prior to the session, this not always the case. Students note the implementation of the new online platform (Wattle) has improved this.

In addition to lectures and PBL, students participate in data laboratories, clinical microbiology laboratories; small group teaching on various subjects; practical medical science workshops; anatomy and pathology practicals; and simulation sessions. The majority of students felt that PBL-based blocks adequately cover the curriculum. However, students from non-science backgrounds, in particular, often found the coverage of some areas to be too advanced for their skills. As a result, the ANU Medical Student Society has promoted student-led tutorials to address gaps in learning. The School may wish to consider supporting these tutorials.

The program provides students with an early introduction to basic clinical skills through weekly clinician – led teaching sessions. The Team commended the use of actors and volunteers (usually without clinical signs) in these sessions, which embeds a standard

approach to these skills and is a strength of the program.

The Research Project

The major research component of the program is a research project (MEDI2003) undertaken in Phase 1. Students are offered opportunities to engage with clinician and non-clinician researchers and develop their ideas for a project in Year 1, completing and submitting the project in Year 2. Students' experience of this project is widely varied and appears predicated on the engagement, availability and ability of their supervisor. The Team found limited support provided to supervisors and this is an area the School may wish to consider providing additional support.

Block 7: Transition from Phase 1 to Phase 2

Phase 1 Block 7 consolidates core concepts and demonstrates their application to clinical scenarios that are more complex than those in earlier PBL sessions. In 2012 this block introduced integrated seminars and moved away from PBL learning. The three hour seminars are organised around a clinical topic using grand rounds style approach. This change appears to have been well received and valued by students.

Phase 2

Phase 2 (Years 3 and 4) comprises six blocks and is coordinated by the staff at the Canberra Hospital Campus and the staff in the rural Clinical School, with students rotating to clinical facilities across the ACT and regional New South Wales.

Year 3 curriculum comprises two nineteen week blocks: Integrated Community and Child Health (ICCH) and Foundations of Internal Medicine and Surgery (FIMS).

Rural stream students undertake Year 3 in a rural community, while the remainder of the students complete a six week rural rotation during their integrated Community and Child Health (ICCH) block.

Immersive learning is a hallmark of Phase 2. Students are expected to be involved in patient care, and in learning from patients in all their activities. There is variation in the depth of the immersion as some rotations provide an experience similar to a pre-internship, while others are only able to offer an observational experience. This variability is also noted by the students, but appears not to be a cause of major concern at present.

Structure for student immersive learning experiences is achieved through the case- based learning (CBL) program, lectures and the portfolio process. In Year 3, formal sessions are delivered one day a week. The formal sessions include CBL, fixed resource sessions (FRS), and clinico-pathological correlation (CPC) sessions.

The CBL program aims to foster problem solving and critical diagnostic thinking, forming a natural continuum of learning with the interactive sessions in Phase 1 Block 7. Students are provided with a broad clinical topic or patient presentation, and are required to present patient cases they have seen as the basis for discussion and learning. While students provide the cases, CBLs are student-led with the support of a clinician. The learning outcomes cover the four curriculum themes (Clinical Skills, Medical Sciences, Population Health and Professionalism and Leadership).

Fixed Resource Sessions (FRS) are lecture style, non-compulsory, often multidisciplinary sessions which are streamed live via Adobe Connect, as well as recorded to ensure availability to all students. Canberra based Year 3 students are expected to attend FRS on Wednesday at Canberra Hospital. The Team had an opportunity to view a session through

Adobe Connect and considered this works well.

Clinico-pathological correlation (CPC) sessions are the principal means of delivering pathology content to Phase 2 students. The sessions, run during the Foundations of Internal Medicine and Surgery (FIMS) block, are delivered by a clinician and a pathologist and designed to illustrate common medical and surgical problems. Pathologists will travel to rurally based students to deliver these sessions.

Year 4 comprises four eight week blocks: Psychiatry and Addiction Medicine (PAM), Senior Medicine and Surgery (SMS), Acute Care, and Womens' Health and Newborn Care (WHNC). Year 3 students also undertake an elective of at least four weeks in between Years 3 and 4 which is accounted for in Year 4, and an optional three week Preparation for Internship Term (PrINT). Formal teaching in Year 4 differs between the block rotations.

Formal teaching in Senior Medicine and Surgery (SMS) includes both CPC sessions and lectures. In the Psychiatry and Addiction Medicine (PAM) Block, students attend teaching sessions one day a week, with formal consolidation and less formal interactive sessions taking place in the final week.

During the Women's Health and Newborn Care (WHNC) block, formal teaching is mainly restricted to the beginning and end of the rotation, and includes both lectures and CPC sessions. Seminars are held once each block which involve the entire cohort. Small group teaching also occurs.

The Portfolio is a resource and learning guide for students in Years 3 and 4, and is comprised of a range of learning activities including clinical skills, long case presentations, observed clinical interactions (ClinEx), reflective items pertaining to professionalism and leadership, Indigenous Health, social foundations of medicine, and an assignment of specific tasks. Clinical supervisors sign off each task and academic supervisors conduct reviews during and at the end of each semester. The use of the portfolio as an ungraded course requirement and its regular review by the academic supervisor ensures retention and enhancement of clinical skills for students in a largely supportive environment. While the training of all personnel involved in sign-off of skills is not possible, the oversight of the supervisor ensures the appropriateness of inclusion of skills. The Team encouraged the continuation of recent review of the reflective components of the portfolio.

4.2 Self directed and lifelong learning

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

2013 Team findings

The Team considered there was an appropriate balance and a progression from externally supported to self-directed learning through the medical program. There is an emphasis on self-directed and collaborative learning, including group projects and student-led CBL, throughout the program which is designed to adequately prepare students for life-long learning. Students are encouraged to reflect about their experiences in their portfolio, in preparation for their on-going practice.

Students are encouraged to take responsibility for their own learning under the guidance of academic supervisors. The Phase 1 research project allows students to undertake a research activity in an area of their interest, supported by two supervisors, with tuition in research methods and individual central statistical support. Further group learning projects in Phase 2 are designed to enhance these skills. During Phase 2, students meet with their clinical

supervisors to review their learning goals, articulated in a work plan called a Learning Agreement, developed in consultation with the academic supervisor. The Learning Agreement assists students to track the intended learning outcomes of their current curriculum and portfolio and to help the student address any perceived areas of weakness. Although core learning objectives are provided in the rotation guides (e.g. Integrated Community and Child Health, Foundations of Internal Medicine and Surgery, and Psychiatry and Addiction Medicine) students did not feel fully informed of their learning objectives for all blocks. The School may wish to consider ways to ensure students are more fully aware of core learning objectives for each term, which could be augmented by those additional objectives agreed between the student and supervisor.

Students felt there was a degree of confusion regarding what elements of the curriculum were to be formally addressed in class and what were to be self-directed. Students expressed a desire for one unified list of objectives that transparently indicated what will be formally taught and what will be self-directed learning. The School is currently undertaking a blue printing exercise, the appropriate communication of which will go some way to achieving this. The level 4 objectives which are now under development will demonstrate to students how specific teaching resources align to level 3 outcomes. The Team encourages the School to complete this work and communicate the required depth of knowledge.

4.3 Clinical skill development

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

2013 Team findings

The Phase 1 clinical skills curriculum is delivered in a variety of formats using mainly Community Volunteer Patients (CVP) and Real Patients (RP), the latter mostly coming from outpatient clinics. Approximately 25% of face-to-face teaching time is spent on clinical skills training in this Phase. Students have the opportunity to practice their basic clinical skills either in non-clinical settings with real people or via simulation in order to gain confidence prior to using these skills with patients. Students feel well prepared to further develop these skills in Phase 2. Both simulation and, to a lesser extent, patient substitutes, continue to be used in Phase 2 in addition to bedside teaching.

The Team explored the use of Community Volunteer Patients (CVP) and Real Patients (RP) in discussion with the students. The combination of patients, real and otherwise, is used in an appropriate staged fashion in both Phases of the program, and in a way which facilitates the acquisition of basic clinical skills.

Bed-side teaching commences in Year 1, initially with volunteer patients, and continues throughout the program with supervision provided predominantly by practicing senior clinicians. Senior students are also involved in teaching more junior students in some organised sessions as well as in sessions organised by the student society.

The use of simulation teaching is a strength of the program and the Team noted students would welcome further opportunities for involvement in simulated learning. Professionalism and medico-legal aspects of medicine are embedded in the curriculum. General communication skills are well taught, and students employ their early instruction in effective feedback techniques with supervisors, clinicians and peers.

Clinicians who spoke to the Team reported that they are impressed with the level of clinical skills observed in students commencing Phase 2 and also report the standard of new

graduates is impressive.

4.4 Increasing degree of independence

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

2013 Team findings

Student involvement with real patients in Phase 1 is limited. However, clinical skills teaching involving community volunteers and actors is supervised predominantly by practicing clinicians, with all students having the opportunity for clinician-led teaching. Students are able to attend the hospital wards under supervision of Phase 2 students if they wish to enhance their experience in this area. The School may wish to build on the current use of nurse and/or allied health clinical teachers (which now occurs in women's health and ICU), in appropriate areas, which would also strengthen the promotion of interprofessional collaboration and communication.

During Phase 2, the students spend the majority of their time within hospital and community health systems, increasing their engagement with patient care as they progress. Students are generally happy with the amount of patient contact during the course. However, there appears to be some variability with respect to the level of supervision provided during Phase 2. Rurally-based students report a high and consistent level of supervision.

The Team noted that while there are many opportunities for professional development available for supervisors, not all supervisors had undertaken training. While training for Phase 1 PBL and clinical skills tutors is mandatory and completed during the recruitment process, this is not the case for clinical supervisors in later years of the program. Students and staff were aware of and used the School's training guides which are made available for supervisors.

4.5 Role modelling

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

2013 Team findings

Role modelling appears to be integral to teaching and learning within the medical program. The School encourages teaching at all levels, from medical student to expert clinician.

Senior students act as tutors for junior students and group projects. Students have a good opportunity to interact with and learn from an experienced researcher who acts as a supervisor during the Phase 1 research project (MEDI 2003). Most students report that this is a positive experience. Students also have frequent interactions with tutors and teachers from both clinical and non-clinical disciplines.

Role modelling in Phase 2 is perceived by students as largely related to shadowing junior medical officers during clinical attachments. However, it is clear that students spend significant periods of time with more senior clinicians – often at consultant level - in all clinical settings. Students also noted that they had received specific instruction in dealing with poor role models. The Team commended the School for this initiative.

Specific mentoring programs exist for first year students (by second year students organised through the ANU Medical Student Society). Students in the Rural and Indigenous Health

streams are partnered with mentors. In Year 4, groups of eight students undertake a semester-length Policy, Evaluation or Prevention (PEP) project with a mentor who is generally a public health professional.

4.6 Patient centred care and collaborative engagement

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

2013 Team findings

The Team commended the early introduction of patient-centred care in the curriculum. The concepts of patient safety and patient autonomy are strongly emphasised in Phase 1 and cultural competence is a taught and assessed skill.

During Phase 2, some portfolio items are focused on the 'patient as the expert'; including 'chronic illness in the community' and 'personal experience of illness'. In addition, students are exposed to patients with a wide variety of conditions through their clinical attachments and case studies. In spite of good theoretical teaching of patient-centred care, some students have little practical exposure to continuity of care for patients due to rotations through terms. Rural stream students have excellent exposure to continuity of care due to the length of their placements.

Students perceive that approaches by clinicians to patient autonomy and safety are not consistent in their clinical placements. However, they feel that the foundations of these concepts, laid down in Phase 1, allow them to evaluate the attitudes, decisions and conflicts they witness.

4.7 Interprofessional learning

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

2013 Team findings

While there are some good examples in the program of learning about and from other health professionals, particularly in the rural stream, these appear limited. Students are exposed to some interprofessional collaboration, particularly in the geriatric medicine and cancer treatment setting. Students undertake some clinical placements where inter-professionalism is regarded as core to the placement (e.g. Intensive Care Unit) and there is some formal instruction regarding interprofessional communication and collaboration.

Students perceive that while there is some basic teaching regarding the roles of different team members involved in multidisciplinary care, there is little opportunity to be involved in interprofessional learning or learning about interprofessional care of patients. The Team acknowledged that the lack of other health professional programs at the University provides barriers in this area.

The Team recommends the School explore a well-articulated, cohesive approach to interprofessional learning across the curriculum.

5 The curriculum – assessment of student learning

5.1 Assessment approach

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

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

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

2013 Team findings

The School has made considerable progress in the area of assessment since the 2005 AMC site visit, at which time the Medical Education Unit was new and did not yet have a strong focus on assessment. The Team commended the development of an Assessment Committee and individual Year-based sub-committees to administer implementation of the assessment policies and procedures. This committee structure, in conjunction with support from the Medical Education Unit, appears to provide an excellent framework for policy decision making and operationalisation of assessment process.

In 2011 the ANU commenced a review of its Assessment Policy, and in January 2012 the University introduced a new assessment policy. The Medical School reviewed its Assessment Guideline and Assessment Program to ensure consistency with this new policy. The Assessment Guideline outlines the School's assessment principles of purposefulness, validity, reliability, efficiency and integrity.

The Team was concerned with the current assessment approach. The level of complexity in current procedures for standard setting and calculation of grades and the 'composite score' is overly complicated. This complexity leads to a significant lack of transparency for students.

The current approach to assessment is vulnerable to potential errors and may not be sustainable with current resources, particularly if there are changes in personnel at crucial times.

The School should develop an assessment plan which aligns with learning outcomes, clearly documents the assessment and progression requirements and makes those requirements available to students.

The Medical School has not released whole examinations to students, in part because of the need to keep a finite bank of assessment items secure. The Team considered the requirement that students sign a declaration immediately prior to an examination agreeing not to reproduce assessment material as unfair to student when the School has not provided comprehensive examples of examinations.

The small numbers of formative assessment items that have been released to students are seen as a step in the right direction. The School should consider making available to students more comprehensive examination material in the form of whole examination papers with structured answer guides in order to provide students with a tangible outline of the overall blueprinting schema and marking allocations.

The Medical School continues to work with the Australian Medical Schools Assessment Collaboration (AMSAC) and the Australian Medical Assessment Collaboration (AMAC), as well as other national collaborative efforts, aimed at addressing the sustainability issues for assessment in medical schools across Australia. The Medical School may wish to consider becoming part of the Australian Collaboration for Clinical Assessment in Medicine (ACCLAiM) collaboration.

5.2 Assessment methods

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

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

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

2013 Team findings

The mix of assessment modalities and formats appears appropriate across the medical program and is likely to assess the intended learning outcomes.

The blueprinting of some examinations had led to some misalignment with stated outcomes. The completion of the on going mapping exercise looking at high level overarching learning outcomes and lower level (level 3 and 4) learning outcome statements across the curriculum is likely to be of immense value in informing both the selection of assessment formats and the blueprinting of assessment at every stage. This work should be completed as a matter of priority.

The use of the Ebel methodology for standard setting for Multiple Choice Questions (MCQs) is appropriate. In the current process, the writer of a short answer question or mini-case item determines the pass mark for that question. The Assessment Committee then determine the exam pass mark by setting the number of questions that must be passed. This is not best practice.

Decisions regarding the requirements to pass numbers of ‘sections’ within each examination also appear arbitrary and it is not clear to the Team that these individual pass/fail decisions can be supported by relevant psychometric data (e.g. 23/50 poorly discriminating MCQs in the MEDI1001 Summative Examination for 2013). It is not clear to students how pass/fail decisions on individual examinations are determined in terms of needing to ‘pass’ a certain number of sections.

The School should develop a detailed assessment plan including details of the assessment blueprint, formats and standard setting. The Medical School may wish to undertake a critical review, possibly with external advisors, into the overall approach to assessment with a clear focus on transparency for students, sustainability, and fitness for purpose utilising the curriculum outcomes map that is currently in development.

5.3 Assessment feedback

5.3.1. The medical education provider has processes for timely identification of under performing students and implementing remediation.

5.3.2 The medical education provider facilitates regular feedback to students following

assessments to guide their learning.

5.3.3 The medical education provider gives feedback to supervisors and teachers on student cohort performance.

2013 Team findings

The Team was impressed by the commitment of staff and policies relevant to the identification of students at risk and the additional support and remediation that is subsequently provided. The Medical School is committed to identifying students at risk in a timely manner and then implementing a remediation strategy. The mid-year formative and summative examinations in Years 1, 2 and 4 are seen as being of value in this regard. The comprehensive process of formal and informal review of the portfolio by clinical supervisors and academic supervisors provides a similar function for Year 3. This high level of supervision and monitoring is seen as a considerable strength in the program and clearly assists in identifying students who have failed to adjust to the clinical environment.

The School provides a detailed breakdown of assessment performance to each student following assessments. The group feedback sessions after each examination, with input from relevant experts involved in item development, is a positive development.

The Team understood that all students have access to their own examination papers but that this is not supervised by an academic staff member and is performed under the condition that no cameras are permitted. Those students who have failed an examination are given an opportunity to go over their own paper with an academic. Targeting of staff resources in more detailed assessment feedback for failing students is applauded.

The Team acknowledged that staff resourcing makes the provision of feedback in medical schools problematic, and acknowledges the significant improvements that have been made in the last year. However, the Team was concerned that in an environment where there is a lack of past examination material, limited formative assessment items, poor communication of blue printing and ambiguity with regards to what is required to pass an examination, the current approach to assessment feedback is inadequate. The School needs to provide improved feedback to students following assessments.

Through the Medical Education Unit, the School has implemented a systematic process for reviewing cohort performance and feeding this back to Block Coordinators and teachers through the relevant Phase committees to inform curriculum development and strategies aimed at promoting student learning. The summation and feedback of assessment performance to the curriculum team in Phase 1 appears to be particularly effective in closing the curriculum development/assessment loop.

The Team was concerned that the level of feedback provided to clinical supervisors in Phase 2 is less consistent. The School indicated Year 3 and 4 Assessment Committees receive feedback on the performance of the cohort on the exam prior to the ratification of the results. This information is then presented in de identified format to the Phase 2 Curriculum Committee which includes representation from each of the rotations. The School should ensure representatives distribute assessment performance data back to clinical supervisors.

5.4 Assessment quality

5.4.1 The medical education provider regularly reviews its program of assessment including assessment policies and practices such as blueprinting and standard

setting, psychometric data, quality of data, and attrition rates.

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

2013 Team findings

There have clearly been significant issues with regards to the timing of the release of marks and accuracy in grades released to students, particularly in 2012. The Team recognised that there were a particular set of circumstances at that point in time related to staffing and that the Medical School has addressed this issue. The students appreciated the School's acknowledgement of the issue and actions to address the situation.

The School assigns adequate resources to assessment item performance and psychometric analysis for examinations. The Team commended the appointment of staff with expertise in statistical analysis within the Medical Education Unit. The sample of performance analysis data provided is of a high standard. However, review of the details of the psychometric analysis and the assessment items themselves for the MEDI1001 summative examination in 2013 reveals some concerns with regards to the quality of assessment items. A significant proportion of poorly discriminating and low difficult rating items reflect technical issues with many of the MCQ items used and a sub-optimal overall Cronbach alpha. Issues with quality, both in terms of assessment items and the process of assessment, are seen as being symptomatic of a potentially unsustainable approach to the current volume of assessment.

The School's program of assessment is reviewed annually through a review of examinations and results, as well as consideration of student feedback, and decisions arising from Curriculum Committee or Medical School Executive Council decisions. The School should also undertake a targeted process of quality improvement to identify poorly performing assessment items.

The Medical School provides uniform assessment processes for all students across the program and at all clinical sites. The School has undertaken a comparison of assessment performance for Rural Stream students against the remainder of the cohort and these data have been reassuring with regards to the quality of the rural experience. The School may wish to consider further comparisons of assessment performance for cohorts of students having differential experiences at the Calvary and the Canberra Hospitals in Phase 2. These data should be fed back to the relevant clinical supervisors and Sub-Deans.

The Medical School is encouraged to continue the program of staff development relating to quality improvement in assessment and it is recommended that this be extended to clinical supervisors at all clinical sites who have expressed a desire to be more involved with assessment.

6 The curriculum – monitoring

6.1 Monitoring

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

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

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

2013 Team findings

The Medical School engages in regular monitoring and periodic curriculum review. The Phase 1 and Phase 2 Committees monitor course delivery and discuss matters arising. In 2012/13 the Phase 2 Committee reviewed the individual rotations and the outcomes were presented to the Curriculum Committee. An example of the outcomes is the current review of the Year 3 and Year 4 portfolios which were a common theme in student feedback in the clinical rotations.

The Medical Education Unit (MEU) supports these review processes by preparing summary reports of student feedback, providing feedback to staff on assessment outcomes, and maintaining student records.

The Curriculum Committee is responsible for monitoring and review of the curriculum. This Committee receives reports of periodic curriculum reviews, and the summary outcomes of the University-wide evaluation tool, the Student Experience of Teaching and Learning (SELT).

The Medical School has a variety of mechanisms for gathering feedback from students on the delivery of the curriculum. Student representation on the Phase 1 and 2 Committees is particularly important in this regard.

The collection of student feedback on the quality of teaching has been lacking in Phase 2 due to the perceived low value of the university -wide survey. The MEU has been developing alternative surveys to systematically gather feedback on the student experience of teaching in Phase 2. The School plans to communicate the findings of the surveys to the Phase Committees and the Curriculum Committee. The School indicated that students will be informed of the results of the survey and any actions resulting from the outcomes will be posted to Wattle.

The Team commended the School on its response to student feedback, which resulted in successful major revisions of Phase 1, Blocks 1 and 7.

Block 1, which is particularly important for students from a non-science background, was revised in 2011 following a survey of staff and students. Feedback indicated a more structured approach was necessary in this introductory section of the program to ensure an understanding of the core basic medical science concepts required for the subsequent systems-based teaching. Student and staff feedback on these changes obtained during the Team's visit was positive.

The Team was impressed by the enthusiastic way that students were engaged in discipline-based feedback in Phase 2, particularly in the General Practice and Psychiatry arenas. This feedback appears to be used well locally to improve curriculum delivery. However, there does not appear to be a strong system in place to ensure that this feedback/response loop is communicated back to students, nor considered by the Curriculum Committee or Medical School Executive Committee. The Team recommends that the School ensure all feedback is analysed and evaluated at a program level to inform monitoring and program development. The School should also develop mechanisms to communicate back to students the outcomes of student feedback.

There appears to be strong representation of clinical staff from The Canberra Hospital on Phase committees and this facilitates constructive feedback. However, the Team received feedback and ideas from clinicians at the Calvary Hospital that could enhance the curriculum further. The School may wish to consider greater representation from The Calvary Hospital in the School's committees.

The Medical School is to be commended for its overall low attrition rates which attest to the high quality of teaching and remediation that is evident throughout the program.

The Medical School is investigating approaches to benchmarking its assessment with other Schools. It continues to work with the Australian Medical Schools Assessment Collaboration (AMSAC) and is a member of the emerging Australian Medical Schools Assessment Collaboration. It has also participated in a trial of the International Foundations of Medicine examination as a formative experience for students.

6.2 Outcome evaluation

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

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

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

2013 Team findings

The Medical School routinely analyses the performance of its student cohorts in its examinations and provides high quality psychometric data for consideration. At present, there is no formal analysis of these data in relation to student characteristics at admission.

The School noted that staff had published evidence of excellent examination performance of students who undertook the Rural Clinical School option in Year 3. However, there appeared to be little feedback to clinicians in both rural and urban sites as to why this may be the case so that teaching could be improved. With the School now having both Indigenous and Rural origin cohorts with different admissions score profiles than the larger cohort, the Team recommends that the School undertake further work to examine student performance in relation to student characteristics and feed this data back to relevant committees responsible for student selection, curriculum and student support.

Feedback received from clinicians during the Team's visit, in both hospitals and community practice settings, was uniformly high for the graduates of the program. Graduates who are now interns are viewed as excellent by their supervisors, and the graduates themselves felt well prepared for their role. However, there is no 'hard' evidence of the success or outcomes

of the program or individual graduates. The School conducted an alumni survey on graduate destination in 2013 which is a positive initiative in tracking graduate destinations and outcomes, however the survey had a very low response rate (15%).

The Team also received comments from clinicians and health services executives of the substantial and positive changes to the local health services as a result of the medical school's existence and engagement. These include vastly improved success rates with the recruitment of junior doctors, a more academic culture, improved infrastructure, and for some clinicians, a refreshed outlook on professional practice. The School is to be commended on this reported impact.

The Team noted that the Medical School participates in the annual Federation of Rural Australian Medical Educators (FRAME) survey, but that the data from this was not systematically fed back to the rural supervisors. The Team also noted that the Medical School was a late entrant into the Medical Schools Outcomes Database (MSOD) project based within the Medical Deans Australia and New Zealand. There appeared to be no data from this valuable resource that had been fed back to staff, students or clinicians.

The Medical School has not systematically collected data on its outcomes. The Team was of the view that the Medical School is missing an opportunity to both promote its achievements and to contribute to the international evidence base in medical workforce policy. The Team recommends that this research and evaluation are pursued vigorously.

6.3 Feedback & reporting

6.3.1 The results of outcome evaluation are reported through the governance and administration of the medical education provider and to academic staff and students.

6.3.2 The medical education provider makes evaluation results available to stakeholders with an interest in graduate outcomes, and considers their views in continuous renewal of the medical program.

2013 Team findings

Student examination results are analysed by the Curriculum Committee and the Medical School Executive Committee. However, student feedback in the clinical years appears to remain at the local discipline level and university-wide mechanisms to collect student feedback has limited relevance to the School. The Team suggests that work planned to enhance the value of these evaluation mechanisms to the Medical School is important in achieving a robust quality improvement framework.

The lack of explicit graduate outcome data, as described in the previous sub-standard, makes it difficult for the Medical School to meet Standard 6.3.

The Team did not see evidence that the School provided evaluation results, beyond staff and students, to stakeholders with an interest in the program. It did note that there did not appear to be any disquiet from the health service partners, and suggests that the 'multiple hats' that many Medical School staff wear in relation to government and health service roles have enabled informal discussions to take place.

7 Implementing the curriculum – students

7.1 Student intake

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

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

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

2013 Team findings

The Medical School plans for a student load of 360 Commonwealth Supported Places (CSPs) over the four years of the program, with up to an additional 10 International Fee Paying Students (ISF) in any year. This results in a total maximum of 400 equivalent full time student load (EFTSL) with no plans to increase the size of the cohort. This student load is agreed to with the ACT Government Health Directorate.

Since 2011, the School has modified the entry requirements for students with a track record of research, those of rural or remote origin, and those of Indigenous descent, and introduced programs to target these groups.

The 2012 student intake included 9% PhD holders, which is an increase from the overall average of 3% in the preceding three years.

27% of students entering the program in 2012 were from a rural background, which exceeded the previous three year average of 17%.

The Team commended the Medical School on the introduction of the Indigenous Entry Scheme. Although the number of students gaining places through this scheme has initially been low (one student in 2011, two in each of 2012 and 2013), the School has increased their efforts to recruit Indigenous students, and the tutorial assistance provided by the Tjabal Indigenous Higher Education Centre to prepare students for the Graduate Medical School Admissions Test (GAMSAT) exam should increase opportunities for Indigenous students to study medicine.

Since the last accreditation visit, the Medical School has enrolled five Indigenous students and all Indigenous students in the program receive scholarships with a value of $18,000 per year for four years, funded through the ACT Government and the John James Foundation. The Medical School guarantees any shortfall between the scholarship amount ($18,000) and the amount donated from benefactors in a given year. The Medical School also pays for tutors of potential Indigenous applicants to the program to assist in preparing them.

ANU also provide scholarship support for students participating in the Indigenous Health Stream. Rural students from specific regions are eligible to apply for an ANU Region scholarship.

The School does not have any specific entry pathways for students from low socioeconomic or educationally disadvantaged backgrounds. The School may wish to consider introducing an access scheme for these students in the future.

As part of the ten international students accepted per year, the program accepts up to six students from the International Medical University (IMU) in Malaysia, who enter the program in Year 3. Prior to entry into Year 3, students from IMU undertake a four-week bridging course focussing on clinical skills and the Australian heath care system. They are mentored by more senior IMU students in the program.

Under the renewed ten year agreement with ACT Health (2013-2023), the School is able to guarantee internship places at Canberra hospitals for all ANU medical school graduates, including international students. This commitment by ACT Health to include internship places for international students is a unique and very positive aspect of the program.

7.2 Admission policy and selection

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

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

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

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

2013 Team findings

The minimum entry requirements for the Medical School are a weighted Grade Point Average (GPA) of 5.6 and overall Graduate Admissions Medical School Admissions Test (GAMSAT) score of 55. In addition, an International English Language Testing System (IELTS) score of 7 is required for ISF students. The domestic selection process is hosted by Graduate Entry Medical School Admissions System (GEMSAS). A composite score is calculated with the GPA and GAMSAT scores equally weighted to rank students for interviews. The use of the interview process, a Multiple Mini Interview (MMI), is currently under review. The current aim of the interview is to identify students who are not deemed to have the appropriate characteristics to be medical graduate.

From the 2013 entry cycle onwards, students will be given a score for the interview and that score is combined with the composite score (for GPA and GAMSAT) to produce the final ranking of applicants. Interviewers for the 2013 entry cycle were trained prior to using the new scoring system (which uses a 7 point Likert scale). The School is confident that the new selection process will result in increased competition for places.

The School Leaver's Program, which was introduced to encourage ANU graduates to continue their studies in the medical program, was abolished in 2010 because of low uptake. In lieu of this program, the University has designed a new Bachelor of Philosophy (Honours) PhB/ MBBS pathway to attract ANU graduates. Students do not need to complete the GAMSAT exam but must undergo an interview in the lead up to the medical program. To be eligible for this pathway students must have achieved an Australian Tertiary Admission Rank (ATAR) of 99 or better and they must complete a four-year research-based PhB degree at ANU. One student entered through this pathway in 2013.

The School expects the move to a Masters level program will have significant implications on admissions and acceptance rates and the Team will be interested in receiving updates on any

changes to the admissions and acceptance rates.

The School has no profession-specific guidelines for the selection of and support for students with disabilities, although it is noted that a wide range of University support services are available. The School is currently participating in national initiatives concerning the development of an explicit statement of inherent requirements to practice medicine as a professional.

7.3 Student support

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

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

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

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

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

2013 Team findings

There is a full range of student support services provided by the University and the Medical Student Society, and the Medical School has two medically qualified counsellors to assist with issues unique to medical students.

Within the School the primary providers of support to the students are the Year Coordinators. The Year Coordinators act as advisors for students with academic difficulties, assisting with study plans, arranging extra tuition and reviewing exams with students. They also provide advice to the relevant Assessment Committees following examinations. Students considered at academic risk may be formally referred to the Year Coordinator by one of the Assessment Committees to discuss their academic progress. As a flow on from this role, Coordinators also find themselves providing initial pastoral support for students. This was not perceived as a conflict of interest by students or Year Coordinators. Students were aware of the other support services offered by the School and the University.

The high quality of both academic and pastoral support provided the Year Coordinators, and the role they play in the identification and remediation of students at risk, is highly valued by the students and commended by the Team.

Indigenous students receive good support from the Indigenous Project Officer and other staff of the Indigenous Health Unit. An Indigenous doctor or doctor with a background in Indigenous Health is assigned to mentor each Indigenous student. The ANU's Tjabal Indigenous Higher Education Centre provides up to eight hours per week of tutorial learning support.

The School has made good progress with provision of support for students on rural

placements. The Team was impressed by the excellent support provided by the Rural Clinical School for students on both short and long term rotations. Students value the accommodation provided as well as the individual support provided by the program staff and clinicians on site.

The curriculum provides excellent learning opportunities for self-care and self-identification of at-risk behaviours in Year 1 through its 'Self-care, Health and Well-being Program', as well as Psychiatry and Addiction Medicine sessions on Mental Health First Aid and drug addiction. Students are also encouraged to do an optional program called the Healer's Art, which involves a series small group sessions facilitated by experienced doctors with the aim to create an on-going model of peer support for students. Students value the lectures and self-care sessions highly and would welcome more curriculum-based activities on self-care.

7.4 Professionalism and fitness to practise

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

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

2013 Team findings

Year Coordinators hold responsibility for initial remediation in instances of specific behavioural concerns. Year Coordinators receive formal referrals arising from formative and summative academic assessments and portfolio reviews. Students may also self-refer to Year Coordinators. Peer review feedback that identifies behavioural concerns will also be reported to the relevant Coordinator. The Coordinator will where appropriate (in cases of unsatisfactory peer review or a written report from the Year Coordinator following an extraordinary assessment of professional behaviour) refer the case to the School's Professional Behaviours Committee (PBC).

The PBC provides the governance of student professional behaviour and is guided through a process of remediation or referral of a student by the process outlined in the Standards of Professional Behaviour Guidelines. These guidelines take into consideration the ANU policies concerning Disclosure of Information by Students with a Disability or Illness; Disability; Prevention of Discrimination, Harassment and Bullying; and the Code of Practice for Student Academic Honesty.

The Committee determines if a case requires no action, remediation, referral to the Disability Services Centre or referral to the Dean for possible subsequent action under the University's Discipline Rules 2011. The Committee advises the student of its findings and the right of appeal.

The Standards of Professional Behaviour Guidelines include provisions for a student to be excluded from the medical program or reported to Medical Board of Australia, however this has not been required.

In terms of learning and teaching related to professionalism and fitness to practice, expectations of professional behaviour form a key part of the Professionalism and Leadership theme, where students learn the role of peer review to facilitate their understanding and shaping of their own behaviour.

7.5 Student representation

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

2013 Team findings

Students are strongly represented on committees and in the decision-making processes of the School. Student views are valued, and the students appreciate the opportunities provided by the School for this level of participation.

7.6 Student indemnification and insurance

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

2013 Team findings

The School indemnifies students while at Australian health facilities and encourages students to supplement their University coverage to cover extra-curricular activities and overseas electives. A number of the Medicals Schools within Australia indemnify their students for these activities and the School may wish to further explore the provision of indemnification for their students when they are participating in overseas electives and extra-curricular activities within Australia.

8 Implementing the curriculum – learning environment

8.1 Physical facilities

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

2013 Team findings

The Medical School has excellent physical facilities at the Canberra-based campus sites and in the Rural Clinical School, all of which are well regarded by students. The Team visited the Acton, the Canberra Hospital and the Calvary Hospital campuses and was very impressed with the physical facilities, most of which were purpose built for the medical program.

The Medical School building on the Acton campus houses 12 teaching rooms, a computer lab, various meeting rooms, a student common room and the offices of the Medical Education Unit. Each of the teaching rooms for problem-based learning (PBL) is equipped with a computer, class-room monitor, and a small textbook library. The computers provide access to Wattle (the new online platform that hosts the PBL resources) and to the ANU library's online resources.

A new anatomy laboratory opened on the Acton Campus in 2012, which includes an AV system to allow up to 50 students to observe demonstration of cadaveric specimens. The laboratory has expanded its supply of transverse cadaveric specimens since the last AMC assessment. The Team inspected the laboratory and was impressed with its thoughtful design and with the range of learning resources.

The Hancock library, located on the Acton campus, is a well-resourced biomedical science library with adequate study facilities.

The ANU plans to spend $25.6 million to renovate two wings of the John Curtin School of Medical Research. The Medical School on the Acton Campus will be relocated to these wings together with some other health related entities. The move is anticipated to take place in early 2015. The physical co-location of the Medical School with the John Curtin School of Medical Research will establish a medical and health precinct on the Acton Campus and facilitate enhanced interactions between health and medical research activities and the Medical School's program.

The Canberra Hospital (TCH) is well equipped for medical student teaching. A purpose-built building houses a large lecture theatre and many tutorial rooms. Remote AV transmission to rural teaching sites is excellent and is used on a daily basis. The clinical school facilities at the hospital include simulation laboratories, study areas and access to an excellent and extensive library operated by ACT Health, to which students have unlimited access.

The Calvary Hospital campus includes teaching rooms, study areas and a student lounge. The supervisors and students who spoke with the Team agreed that there was a need for additional space in the clinical areas to allow students to work and study as close as practicably to the clinical setting.

AV facilities (Adobe Connect, videoconferencing) are available in the Calvary Campus meeting room to allow for Year 4 teaching to be video conferenced with the Canberra Hospital, however these facilities appear to be underutilised. The AV equipment that is set up in the Calvary Campus meeting room is currently only used for local tutorials.

The Medical School may wish to investigate means by which the increased utility of the AV

facilities may also result in increased participation of Calvary based supervisors in the Phase 2 Committee, which could accrue many benefits. For example, Calvary clinical supervisors told the Team that they had never been invited to write or draft new examination questions and expressed a keen desire to do so. In addition, these supervisors would be more likely to engage with the University and to seek opportunities for professional development and promotion.

The Medical School has agreements with several private hospitals which allow medical students to see patients in clinics, wards, and operating theatres under the supervision of visiting medical officers. There are no scheduled teaching sessions in private hospitals.

The Rural Clinical School operates on a hub and spokes model, with central coordination through a unit at the Acton campus and five rural nodes in South East New South Wales. Formal teaching is conducted at educational facilities located in Batemans Bay, Bega, Cooma, Goulburn, Queanbeyan and Young Hospitals.

Student teaching facilities vary but mostly comprise a multi-purpose meeting/tutorial room and student amenities. Student feedback suggests that facilities at the Bega Clinical School may currently be too small given the sharing of the facility with several other tertiary institutions.

There are excellent new facilities at Batemans Bay (Eurobodalla), located on the Batemans Bay Hospital site. The increase in student numbers necessitated the need for a purpose built facility, comprising offices, tutorial space, a clinical skills laboratory, a library and consulting rooms. Up to fourteen students can be accommodated at one time.

The Team visited clinical placement general practice sites in Moruya and Bateman's Bay. Both practices were new, spacious and included visiting specialists in the practice providing students with exposure to a range of clinical service provision.

The Team visited the Katungul teaching clinic at the Bateman's Bay RCS facility and met with the CEO of Katungul Aboriginal Corporation Community and Medical Services. The teaching clinic provides care to Aboriginal and non-Aboriginal community members and is a clinical placement site for short term rural placements. The CEO of Katungul credited the strong relationship between the Medical School and the Southern NSW Medicare Local as facilitating the partnership between the school and the teaching clinic. Katungul can offer excellent teaching opportunities in an Indigenous health setting and the Medical School is commended on this partnership.

The main facility in Goulburn is a demountable building on the grounds of the Goulburn Base Hospital. Students who spoke with the Team at this site were pleased with the meeting room, tutorial rooms, computer lab, and small library provided for the students.

The Team members who visited the Rural Clinical School sites were greatly impressed by the range of facilities provided for the students. The students were very positive about the residential accommodation provided at very little cost to students undertaking rural clinical placements.

8.2 Information resources and library services

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

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

clinical environment.

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

2013 Team findings

The School utilises a range of IT resources across multiple campuses and teaching sites. The students consider that access to IT resources is consistent across the wide range of sites and that access to computers is very good.

ANU online services can be accessed both on campus and off campus with some exceptions due to licensing. Remote log-in to the ANU campus is available to staff and students.

Students have access to The Canberra Hospital's clinical information systems (pathology and radiology) and to the hospital's medical records system. Students can apply for similar access to clinical information at The Calvary Hospital.

The ANU implemented an off the shelf Learning Management System, Moodle, across all the Colleges. The University named the LMS "Web Access to Teaching & Learning Environments", most commonly referred to as Wattle. Due to the difficulties of maintaining a bespoke Learning Management System in a small medical school, and following a comprehensive review of the possible solutions, the Medical School also implemented Wattle in 2013.

Students report some difficulties in the transition to Wattle, primarily around obtaining access to information, including library resources. This transition from a School-specific online learning platform to a University-wide system has been difficult and has delayed some teaching initiatives. The Team was concerned that there is insufficient e-learning expertise and support in the School which may impede future innovation.

Students have orientation and access to the Hancock Library which houses medical texts, journals and electronic collections. A library at The Canberra Hospital, which houses standard textbooks in addition to digital and print resources, is available at all times to students.

Smaller libraries are available to students at The Calvary Hospital and at each of the rural facilities, the latter keeping full sets of prescribed texts for Years 3 and 4.

Students consider that there is sufficient information for students on how to make the best use of IT resources.

8.3 Clinical learning environment

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

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

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

8.3.4 The medical education provider actively engages with other health professional

education providers whose activities may impact on the delivery of the curriculum to ensure its medical program has adequate clinical facilities and teaching capacity.

2013 Team findings

The School employs a variety of resources for clinical training including demonstration, simulation and clinical contact. The medical program is the only medical school using the clinical facilities in the ACT.

Patient contact begins in Phase 1 with bedside teaching days and tutorials using Community Volunteer Patients. In Year 3, clinical contact occurs in both outpatient and inpatient settings as well as in general practice. In Year 4, clinical placements in Psychiatry, Medicine, Surgery and Acute Care include direct exposure to patients.

The Team discussed the use of Community Volunteer Patients in Phase 1 with many students and concluded that this resource has facilitated the acquisition of sound clinical skills (history-taking and physical examination) by the end of Phase 1.

The Team noted the wide variety of clinical teaching facilities ranging from rural general practice through to tertiary acute hospital care which includes outpatient exposure, urban general practice and various community placements. The students see this variety as a considerable asset of the program.

The Medical School has worked with two Indigenous health services to develop clinical opportunities for students in the ACT and in South East NSW. There are also attachments in remote Indigenous communities in central Australia. Some students considered that exposure to Indigenous Health services could be improved, due mainly to the limited number of positions available. However, the Team commended the provision of opportunities for all students to gain experience with Indigenous patients as a strength of the program. Those students who experience Indigenous rotations report positively on the experience.

The Medical School shares teaching resources with non-medical students from other universities at different sites outside of the ACT, particularly with the University of Wollongong at Bega. Collaborative arrangements are in place in each case.

Social workers, physiotherapists, nurses and dieticians participate in tutorials and other educational activities in Phase 2 of the program, though opportunities for cross-fertilisation and concurrent teaching of students from other health professions appear limited.

8.4 Clinical supervision

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

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

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

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

2013 Team findings

The Team was impressed with the enthusiasm and commitment of clinical supervisors at all

sites that they visited.

The Team noted that supervision in clinical settings is often provided by registrars in addition to visiting medical officers. There is some non-medical supervision, particularly in mental health and addiction medicine services.

Student feedback on teaching was very positive. Some students noted the level of supervision may vary across the teaching sites.

While the School provides limited orientation and training, support for clinical supervisors could be enhanced. The School has published guidelines on teaching for some areas of the curriculum.

Most supervisors of medical students have experience training registrars under the auspices of relevant specialist colleges, which is a benefit to the medical program.

The students value the opportunity to provide anonymous feedback on their supervisors through formal evaluation. However, the Team noted that clinical supervisors receive variable levels of feedback on their performance. This is related in part to the University-wide system of collecting feedback and in part to the lack of central coordination of evaluation in some clinical domains. As a result, there appear to be limited opportunities for supervisors to improve their performance based on relevant feedback.

There are specific payments for some hospital staff involved in teaching. ACT Health service contracts for Visiting Medical Officer (VMO) have specific reference to fixed resource teaching in them and some VMOs are paid through this mechanism.

Some staff specialists (e.g. Professor of Medicine, Professor of Surgery, etc.) are paid ACT Health salaries but are expected to play significant roles in teaching. The Team was advised it was not unusual for up to 20% of such a person's time to be spent on academic activities including teaching across the continuum and research.

Although some protected time is allocated to teaching activities, there remains a reliance on the good will of supervisors who are often busy with clinical commitments. In general practices (where fee-for-service is in operation), GPs who spoke with the Team indicated that student teaching is seen as a cost to the practice.

The Team recommends that the School clearly define and communicate the responsibilities of clinical supervisors who contribute to the delivery of the medical program. The Medical School Executive Committee is undertaking work in this area, and the Team will be interested in receiving an update on this work.

Appendix One Membership of the 2013 assessment team

Professor Paul Worley (Chair) MBBS, PhD, DRANZCOG, FRACGP, FACRRM, MBA
Dean, School of Medicine, Flinders University

Dr Elizabeth Tancred (Deputy Chair) BSc, PhD
Senior Lecturer, Department of Anatomy, School of Medical Sciences, University of New South Wales

Professor Simon Broadley BSc (Hons), MBChB, MRCP, PhD, CCST, FRACP
Dean, School of Medicine, Griffith University

Dr Peter Dohrmann MBBS, FRACS, GradDipOccEnvH, FRACMA
Board member, Victorian Board of the Medical Board of Australia

Associate Professor Bronwyn Peirce MBBS, FACEM
Medical Coordinator and Associate Professor, Rural Clinical School of Western Australia (Bunbury)

Ms Annette Wright
Program Manager, Medical Education and Accreditation, Australian Medical Council

Ms Sarah Vaughan
Medical School Assessment Officer, Australian Medical Council

Appendix Two Groups met by the 2013 assessment team

Senior Leadership

Vice Chancellor
Deputy Vice-Chancellor (Academic)

Medical School Executive

Dean
Executive Officer
Associate Dean, Medical Education
Associate Dean, RCS & Indigenous Health
Associate Dean, Phase 1
Chair Medical Sciences
Principal Medical Advisor ACT Health
Associate Dean, Phase 2
Sub-Dean, Calvary Hospital Campus
Sub-Dean, Canberra Hospital Campus
Representative of CMBE
Manager, Canberra Hospital Campus

Medical School Staff

Anatomy Theme Representative
Anatomical Pathology Theme Representative
Biochemistry Theme Representative
Immunology Theme Representative
Pathology Theme Representative
Physiology Theme Representative
Pharmacology Theme Representative
Microbiology Theme Representative
Population Health Theme Representative
Professionalism and Leadership Theme Representative
Clinical Skills Theme Representative
ANU Online Lead
TCH/Rural IT Manager

Medical Students

Year 1 Students
Year 2 Students
Year 3 Rural Stream Students
Ex ANU Students – PGY 1 2 & 3

Medical School Committees

Medical School Curriculum Committee
Research Project Committee
Medical Educational Unit
Assessment Committee
Evaluation and Monitoring Committee
Admissions Committee
Student Support and Professional Behaviours Committee
Indigenous Health Unit
Rural Clinical School Staff
Medical School/Health Directorate Liaison Committee
IT Support
Phase 1 Committee
Phase 2 Committee

External Bodies

Medical School/Health Directorate Liaison Committee

Principal medical Advisor and all members of Committee

Southern New South Wales Medicare Local

Executive Manager, Clinical Services and Population Health

Clinical Sites

Rural Clinical School Associate Dean
Rural Clinical School Manager
Education Consultant (Braidwood)
Senior Lecturer in Rural Medicine
Research Manager (Goulburn)
Clinical Senior Lecturer (Bega)

The Canberra Hospital

Chief Executive
Principle Medical Adviser
Medical Director of Clinical Governance
Deputy Director General, strategy and Corporate
Executive Director, Womens Youth and Children
Executive Director, Surgery and Oral Health
Executive Director, Medicine
Executive Director, Pathology
Canberra Hospital based Students

Calvary Hospital

Calvary Executive, acting CEO
Acting director of Medical Services

Queens Street Medical Centre

Senior Lecturer ANU RCS
Practice doctors

Moruya Medical Centre

Senior Lecturer and Academic Coordinator
Other Practice Doctors

Moruya Hospital

Surgeon, Senior Lecturer, ANU RCS
Clinical Care Nurse Unit Manager

Batemans Bay Hospital

Students (Rural Stream and Short Team Students)
Administrative Staff, Nursing Manger
Director of Medical Services, Batemans Bay and Bega Hospitals

Katungul Teaching Clinical

Chief Executive Office
Katungul Aboriginal Corporation Community and Medical Services

Braidwood Medical Centre

Practice manager

Goulburn Medical Centre

Senior Lecturer and Academics Coordinator
Senior Lecturer and Physician

Goulburn Base Hospital

Director of medical Services (Goulburn)
Administrative Staff
Surgeon, Goulburn Hospital
GP, Marima Medical Clinical, Goulburn
ANU Graduates in junior doctor positions