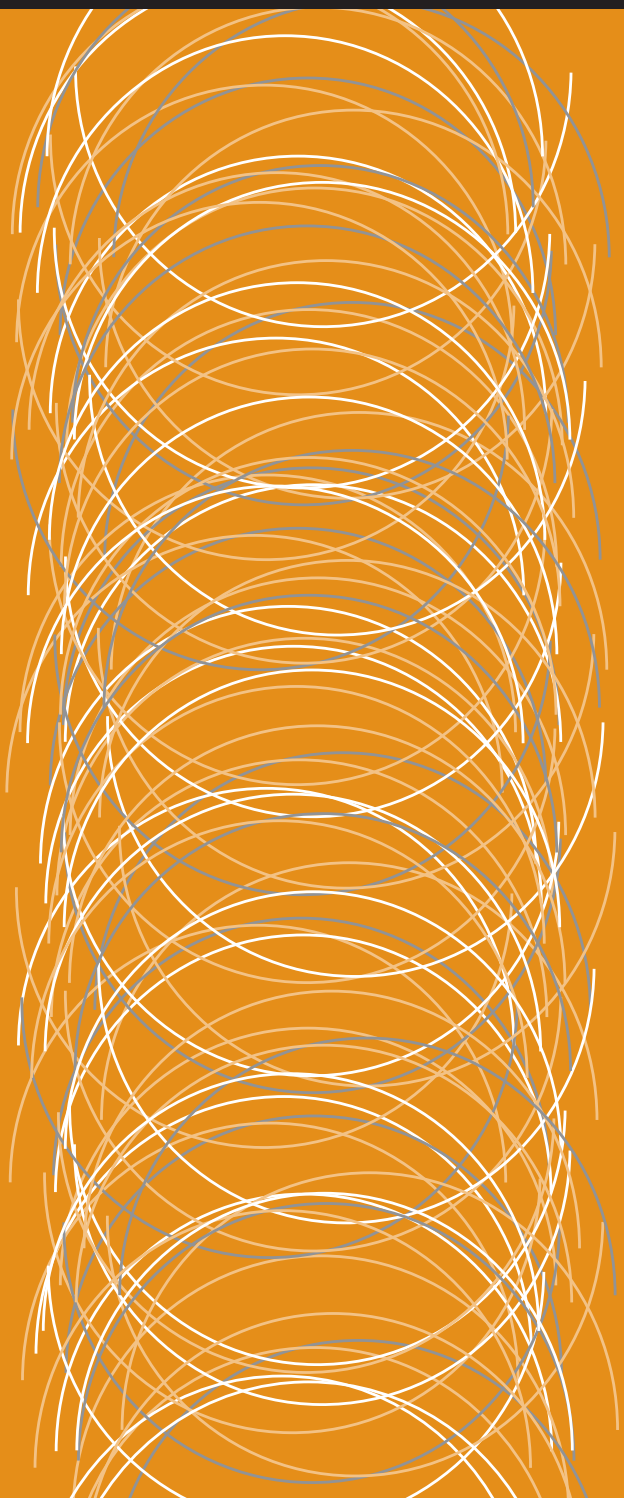
Australian Medical Council Limited

Accreditation of University of New South Wales Faculty of Medicine

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

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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 University of New South Wales, Faculty of Medicine is seeking reaccreditation of its medical program. The six-year undergraduate program was first accredited in 2003 following a major change to the Faculty's existing six-year program, until December 2011. Accreditation was subject to conditions, including a follow-up visit, which was conducted in 2004, and satisfactory progress reports. In 2006 the Faculty introduced a four-year graduate entry stream, which was approved within the program's existing accreditation. The Faculty submitted a comprehensive report in 2010 for extension of accreditation. On the basis of this report, accreditation was extended to 31 December 2013.

In 2012, the Faculty notified the AMC of plans to change its six-year bachelor degree program to a dual award, comprising a three-year bachelor degree and a three-year masters degree (extended), from 31 August 2013. Graduate entry stream students would enter the masters degree (extended) in the fourth year. AMC Directors, at their 17 May 2013 meeting, resolved the proposal was not a major change and that the medical program continued to meet the approved accreditation standards.

In this report, the term Medicine program refers to the Faculty's four programs ending in one or more academic awards, which have been accredited by the AMC. Where the report refers to a specific program, it uses the name of the academic award to distinguish the program. The four approved programs are: the Bachelor of Medical Studies and Doctor of Medicine (BMed MD) six-year undergraduate entry program; the Doctor of Medicine (MD) three-year graduate-entry program; and the Bachelor of Medicine Bachelor of Surgery (MBBS) (currently being phased out) as both a six-year undergraduate program and a four-year graduate-entry program. The BMed MD commenced in 2013 and the MBBS is being retained during the transition.

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 Faculty's submission and visited the Faculty and associated clinical teaching sites in the week of 28 October 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 in accordance with the accreditation options described in the AMC accreditation procedures. 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 8 April 2014 meeting of the AMC Directors found that the medical programs of the University of New South Wales, Faculty of Medicine meet the approved accreditation standards.

The AMC Directors agreed:

(i) To grant accreditation of the following medical programs of the University of New South Wales, Faculty of Medicine for a period of six years; that is until 31 March 2020, subject to satisfactory progress reports:

- Bachelor of Medical Studies and Doctor of Medicine
- Bachelor of Medicine/Bachelor of Surgery (Four-Year degree)
- Bachelor of Medicine/Bachelor of Surgery (Six-Year degree) and
- Doctor of Medicine.

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

In the Faculty's 2015 progress report:

- Standard 2.2.1: Provide evidence that the program's graduate capabilities are consistent with the AMC Graduate Outcome Statements.
- Standard 2.2.3: Provide evidence that the program achieves comparable outcomes through comparable education experience and equivalent methods of assessment across all instructional sites.
- Standard 4.7: Provide evidence that students have opportunities for interprofessional learning across the curriculum.
- Standard 7.4: Complete the update of the Faculty's Fitness to Practise policy, including review of its approach to identifying and supporting students who may be impaired.

In the Faculty's 2016 progress report:

- Standard 5.2.3: Provide evidence of validated methods of standard setting.

Key findings of the University of New South Wales, Faculty of Medicine

1. The context of the medical program	MET

Conditions

Nil

Commendations

Standard 1.6: The strong relationship between the Faculty and health administrators at each clinical site visited.

Standard 1.7: The curriculum is developed and delivered in a highly research informed culture and a research active environment.

Recommendation for improvement

Standard 1.6.2: Develop effective, formal partnerships with health consumer body/bodies to promote the education and training of medical graduates.

2. The outcomes of the medical program	MET

Standard 2.2 is substantially met

Conditions

Standard 2.2.1: Provide evidence that the program's graduate capabilities are consistent with the AMC Graduate Outcome Statements.

Standard 2.2.3: Provide evidence that the program achieves comparable outcomes through comparable education experience and equivalent methods of assessment across all instructional sites.

3. The medical curriculum	MET

Conditions

Nil

Commendations

Standard 3.2: The Independent Learning Project in Phase 2 adds a valuable research contribution to the curriculum and understanding of evidence-based practice.

Standard 3.3: The curriculum's structures and arrangements enabling horizontal and vertical integration, as well as those arrangements to articulate with later stages of medical education.

Standard 3.5: The involvement of the Muru Marri Indigenous Health Unit and the Rural Clinical School in the Indigenous health components of the curriculum, including cultural awareness studies, as well as extra-curricular activities.

Recommendations for improvement

Standard 3.2.1: Further incorporate specialties, including Ophthalmology and Radiology, into the biomedical sciences content, to ensure graduates are equipped for evidence-based practice.

4. Teaching and learning	MET

Standard 4.7 is substantially met

Condition

Standard 4.7: Provide evidence that students have opportunities for interprofessional learning across the curriculum.

Commendations

Standard 4.1: The level of involvement of teaching staff, including clinicians with a conjoint appointment, and the Faculty's organised processes that involve and encourage staff in the program's learning and teaching methods.

Standard 4.1: The near-peer learning model that promotes collaborative learning, peer support, mentoring and peer modelling through vertical integration of students one year apart in their medical education.

5. The curriculum – assessment of student learning	MET

Standard 5.2.3 is substantially met

Condition

Standard 5.2.3: Provide evidence of validated methods of standard setting by 2016.

Commendations

Standard 5.3.2: The Faculty's efficient and effective solutions to provide timely and informative feedback on assignments and reports for high student numbers.

Standard 5.4: The program's extremely convincing quality assurance and quality improvement processes.

Recommendations for improvement

Standard 5.3.1: Further develop the existing assessment systems to enhance the longitudinal tracking of under-performing students.

Standard 5.3.2: Trial alternative ways of publishing items after the tests and track and regulate the re-use of items in a structured way.

Standard 5.4.2: Implement a formalised coordinating role or body in the organisation to oversee existing consistency of assessment across teaching sites.

6. The curriculum – monitoring	MET

Conditions

Nil

Commendations

Standard 6.1: The engagement between the Faculty's Medical Education and Student Office and the University Learning and Teaching Unit in support of both curriculum evaluation and faculty development; the link with the Faculty of Education which runs a Graduate Certificate in University Learning and Teaching.

Standard 6.2: The publication of a comprehensive analysis of intern preparedness for hospital practice addressing specifically the development of generic capabilities, with correlation against supervisor reports.

7. Implementing the curriculum – students	MET

Standard 7.4 is substantially met

Condition

Standard 7.4: Complete the update of the Faculty's Fitness to Practise policy, including review of its approach to identifying and supporting students who may be impaired.

Commendation

Standard 7.1: The contributions and passion of the staff of the Rural Clinical School, the Muru Marri Indigenous Health Unit and Nura Gili in their support of Indigenous students, and the strong leadership and support of the Dean for Indigenous students.

Recommendations for improvement

Standard 7.3.2: Develop a comprehensive approach to identifying students for whom there are concerns about recurrent health problems or impairment, and implement a plan for ongoing support (links to Standard 5.3.1).

8. Implementing the curriculum- learning environment	MET

Conditions

Nil

Commendations

Standard 8.3: The exemplary collaboration with the University of Western Sydney and the South Western Sydney Local Health District at South Western Sydney Clinical School that highlights the potential benefits to all of a shared training site.

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 practise safely and effectively under supervision as interns in Australia and New Zealand, with an appropriate foundation for lifelong learning and further training in any branch of medicine.

The standards and procedures for accreditation are published in the AMC's *Assessment and Accreditation of Medical Schools: Standards and Procedures.* The accreditation standards list the graduate outcomes that collectively provide the requirements that students must demonstrate at graduation, define the curriculum in broad outline, and define the educational framework, institutional processes, settings and resources necessary for successful medical education.

The AMC's Medical School Accreditation Committee oversees the AMC process of assessment and accreditation of 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 composition of the team provides for a balance of educational knowledge and experience, including assessors from different regions and providers, the medical sciences 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 University of New South Wales, Faculty of Medicine

The University of New South Wales was established in 1949, and today has over fifty-thousand students from over 120 countries.

The Faculty of Medicine is one of nine faculties within the University of New South Wales. The Faculty offers two undergraduate programs (Medicine and Exercise Physiology) and seven postgraduate coursework programs. In 2013, 2,950 students were enrolled in the Faculty's coursework programs, including 1,667 medical students, 359 exercise physiology students and 924 postgraduate coursework students. The Dean of the Faculty of Medicine takes overall responsibility and accountability for the Medicine program as academic head.

The Faculty's main campus is in Kensington, Sydney. The Faculty has nine schools, and nine research centres or institutes. Within the nine schools are five clinical schools: the Prince of Wales Clinical School; St George and Sutherland Clinical School; St Vincent's Clinical School; South Western Sydney Clinical School; and the Rural Clinical School based at Wagga Wagga, Albury, Port Macquarie and Coffs Harbour. There are four schools defined by discipline base: School of Medical Sciences; School of Public Health and Community Medicine; School of Women's and Children's Health; and the School of Psychiatry.

The University's Academic Board in May 2012 approved the reclassification of the program from an Australian Qualifications Framework (AQF) Level 7 – Bachelor Degree to an AQF Level 9 – Masters Degree (Extended). The level of qualification awarded to graduates of the program changed in 2013 from a Bachelor of Medicine Bachelor of Surgery (MBBS) to Bachelor of Medical Studies and Doctor of Medicine (BMed MD). No change to the curriculum content was required in transitioning the program from the MBBS to the BMed MD although the structure of the curriculum in Phase 2 was adjusted. In this report, the term Medicine program refers to the four programs that result in one or more academic awards, and are accredited by the AMC. Where the report refers to a specific program, it uses the name of the academic award to distinguish the program.

This report details the 2013 assessment findings. The approved accreditation standards were revised in 2012 and the program was assessed against the revised standards. Each report section begins with the relevant approved accreditation standards.

Appreciation

The AMC thanks the University and the Faculty staff for the detailed planning and hard work involved in the assessment visit planning. 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 are at **Appendix One**.

The groups met by the AMC team during the assessment visit in 2013 are 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

The Faculty of Medicine is one of nine faculties within the University of New South Wales. The Faculty offers two undergraduate programs (Medicine[1] and Exercise Physiology) and seven postgraduate coursework programs including public health, international public health, health management, reproductive medicine, women's health, drug development, and forensic mental health. In 2013, 2,950 students were enrolled in the Faculty's coursework programs, including 1,667 medical students, 359 exercise physiology students and 924 postgraduate coursework students. The Faculty of Medicine also contributes to the teaching of a number of Faculty of Science programs including the Bachelor of Science, Bachelor of Advanced Science and Bachelor of Medical Science.

The Faculty of Medicine's relationships with the broader University institution are well defined and have not altered since the last AMC review, with the Dean, a member of the Vice-Chancellor's Advisory Committee, reporting directly to the Vice Chancellor but with delegated authority for Faculty management, operations and finance. The Dean has monthly face-to-face meetings with the Vice Chancellor, Deputy Vice Chancellor (Academic) and Deputy Vice Chancellor (Research). The University's Academic Board is responsible for monitoring the standards of programs every five to seven years which provides an additional approach to the maintenance of academic standards.

The organisation structure of the Faculty of Medicine includes the Office of the Dean, nine schools, and nine research centres or institutes. Each of the schools is led by a Head of School. Within the nine schools are five clinical schools which are defined geographically as follows:

The Prince of Wales Clinical School: The clinical school is situated between the three teaching hospitals at Randwick: the Prince of Wales Hospital, Sydney Children's Hospital and the Royal Hospital for Women. In 2012, the clinical school had approximately 300 undergraduate students, 8 honours and 70-80 postgraduate students. The clinical school's laboratory and clinical research groups are located in the

[1] As stated in the Executive summary, the term Medicine program refers to the Faculty's four accredited medical programs of study. Where the report refers to a specific program, it calls the program by the name of the academic award granted.

Prince of Wales Hospital, the Lowy Cancer Research Centre and Neuroscience Research Australia, and will soon be enhanced by a new clinical research centre.

St George and Sutherland Clinical School: The clinical school is a significant teaching and research site for the Faculty of Medicine. Its teaching program at St George and Sutherland Hospitals has been a major focus of the clinical school's endeavours. There are approximately 400 students from all years of the program across the St George and Sutherland Hospitals. The clinical school has various research programs including large scale, international clinical trials in intensive care, world-leading translational and clinical research in peritoneal malignancy, thrombotic disorders and diverse gastroenterology and hepatology research.

St Vincent's Clinical School: The clinical school has 300 undergraduate students from the program located at St Vincent's Hospital. It is the oldest teaching hospital in Australia having taught medical students since 1898. The clinical school is affiliated with several research institutes, including St Vincent's Centre for Applied Medical Research, Victor Chang Cardiac Research Institute, Garvan Institute and the Kinghorn Cancer Centre located in Darlinghurst and at the St Vincent's Hospital campus.

South Western Sydney Clinical School: The clinical school is unique in that it covers a full local health district, with student placements at Liverpool, Bankstown-Lidcombe, Fairfield, Campbelltown and Bowral Hospitals. The clinical school currently has over 300 undergraduate students in the program. It played a pivotal role in the development of the Health and Hospitals Fund application that saw the funding of a $42M research building for the Ingham Institute, a $10M clinical skills and simulation centre on the campus of Liverpool Hospital and a research linear accelerator MRI facility.

Rural Clinical School: Established in 2000, the Rural Clinical School has campuses at Wagga Wagga, Albury, Port Macquarie and Coffs Harbour, with sub-campuses located at Griffith, Kempsey and Grafton, and additional short term placements at rural hospitals at Broken Hill and Orange. The Rural Clinical School has over 185 students from the program similarly allocated to its four campuses. It is fully funded by the Department of Health under the Rural Clinical Training and Support Program. The clinical school coordinates the recruitment and retention programs for Indigenous students in the program and offers its staff opportunities to conduct research in rural clinical research, rural medical educational research, medical workforce studies and translational medicine and other scientific research.

In addition to the clinical schools there are four schools defined by discipline base:

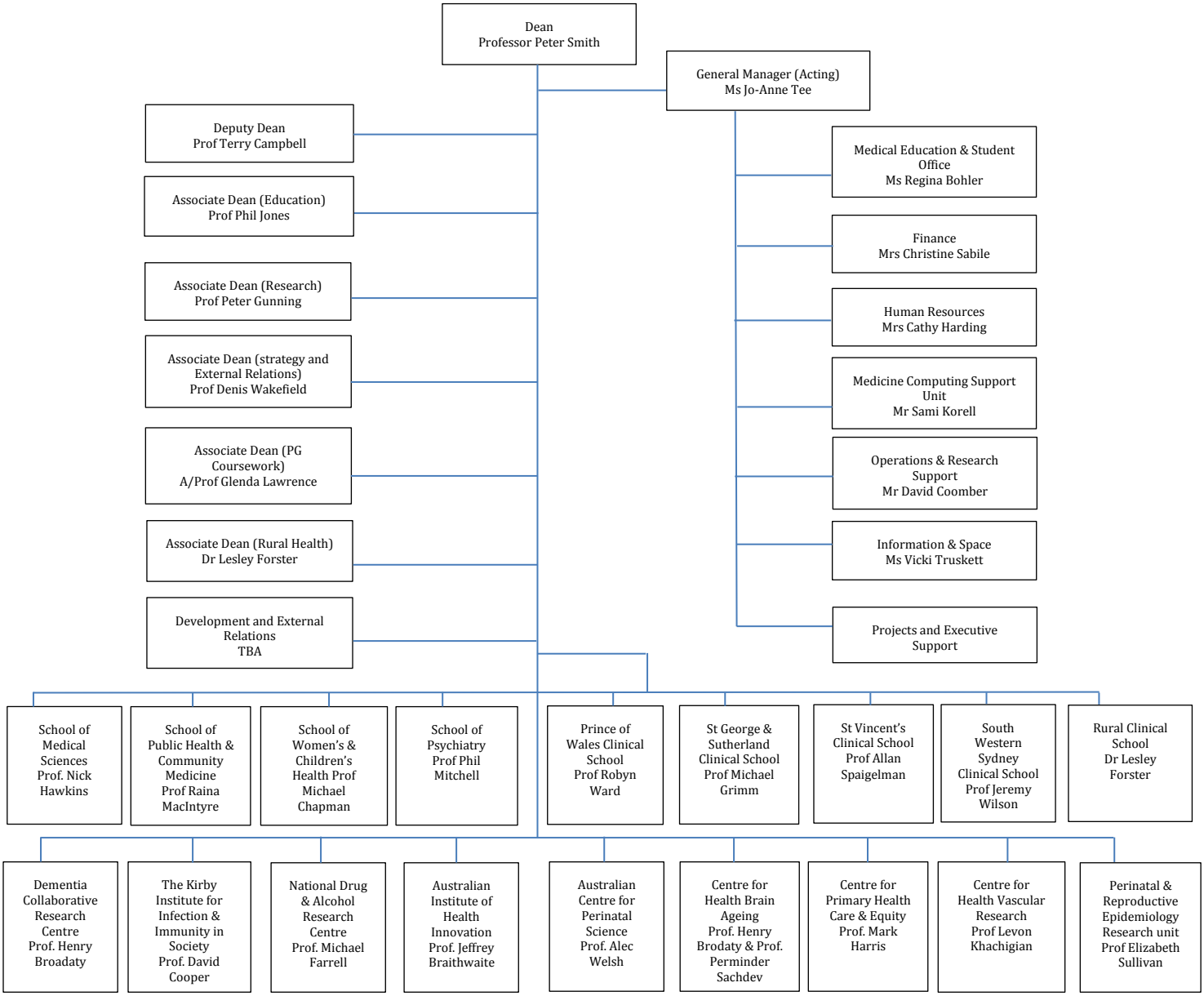
School of Medical Sciences: The school is a central element of the biomedical research precinct at the University main campus, and features modern laboratory facilities and leading-edge research infrastructure. It delivers courses to approximately 1,500 medical students each year. The courses across the disciplines of Anatomy, Physiology, Pathology, Pharmacology and Exercise Physiology share a major emphasis on applied and clinical teaching of the basic sciences and their application to medicine and biology.

School of Public Health and Community Medicine: The school is a leading Australian and regional school for the related disciplines of Public Health, Health Management and Community Medicine. The masters coursework programs attract more than 500 students per year and the school has a national and international profile in its core flagship areas of research: global health, primary care, infectious disease epidemiology and Indigenous health.

School of Women's and Children's Health: The school comprises the disciplines of Paediatrics, Obstetrics and Gynaecology, together with affiliations with the Perinatal and Reproductive Epidemiology Research Unit, the Children's Cancer Institute Australia and the Australian Centre for Perinatal Sciences. The Discipline of Paediatrics has a strong association with Sydney Children's Hospital, the second largest paediatric hospital in the state. The Discipline of Obstetrics and Gynaecology is based at the Royal Hospital for Women, which has been a major focus of obstetric and gynaecological excellence in Australia.

School of Psychiatry: The school has a strong research focus and is a leader in academic psychiatry in Australia and one of the major psychiatric research groupings internationally. The School of Psychiatry is geographically spread across multiple sites with an academic presence for research and/or medical student teaching at various campuses, institutes and hospitals, including the UNSW Kensington campus, the Prince of Wales Hospital, Neuroscience Research Australia, Liverpool Hospital, Ingham Institute, St Vincent's Hospital and Schizophrenia Research Institute.

The Faculty's organisational structure (October 2013):



The Faculty's leadership team comprises the Dean, Deputy Dean, Associate Deans, Presiding Member and Faculty General Manager. The management structure of the Faculty also includes the Executive Team, comprising the leadership team, Heads of Schools and Centres and Directors of administrative units. The Executive Team meets monthly and is primarily engaged in the oversight of the Faculty's operations.

The principal academic body is the Faculty Board which delegates authority to the Faculty Standing Committee, Education Committee (detailed further at Standard 1.3), Research Management Committee and Higher Degree Committee.

The overall management structure, although complex, appears to operate very effectively and is well understood by Faculty members. The team interviewed members of several key committees and was impressed by the degree of commitment and evident pride and identification of these individuals with the Faculty's mission. A spirit of collegiality together with alignment as a team around a common vision and purpose was consistently demonstrated. The Faculty undertakes broad consultation and engagement with a variety of stakeholders with respect to its strategic mission, its curriculum, its graduate outcomes and its governance.

It is recommended that the Faculty include broader community representation, especially health consumers or representatives of patient groups in their consultations. The Faculty is considering the establishment of a consumer health forum as a means of maintaining ongoing consultation with patient groups. (NB. Standard 1.6.2 contains a Recommendation for Improvement regarding consumer involvement.)

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 Faculty has autonomy to design and develop the Medicine program.

Teaching in the program is supported by the Faculty of Science's School of Biotechnology and Biomolecular Sciences, contributing to the teaching of biochemistry, molecular and cell biology, genetics, microbiology and immunology. The Faculty's autonomy in curriculum content and design is maintained within this arrangement with academic staff from the School of Biotechnology and Biomolecular Sciences included in both the course design and implementation groups and on the phase committees overseeing Phases 1 and 2 of the program.

The Dean of the Faculty of Medicine takes overall responsibility and accountability for the Medicine program as academic head. The Dean delegates some authority to the Associate Dean (Education) who is responsible for developing the Faculty's learning and teaching strategies and policies and coordinating their implementation. The individual in the position of Medicine Program Authority is primarily responsible for the development and implementation of the program and also has some delegations from the Dean. Prior to 2011 the Associate Dean (Education) was also the Medicine Program Authority, but these roles were separated at the end of 2010.

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 Education Committee remains responsible for all matters relating to undergraduate and postgraduate coursework programs of the Faculty. The members of the Education Committee include the Presiding Member, Dean, Deputy Dean, Associate Dean Education, Associate Dean Postgraduate Coursework, Faculty General Manager, and invited members including program authorities and representatives of subcommittees. It also has one medical student and one exercise physiology student representative. The Committee meets five to six times each year.

The Faculty's highly centralised approach to curriculum planning continues to be managed through the Curriculum Development Committee, which is the peak body for the implementation, evaluation and ongoing development of the program. Chaired by the Medicine Program Authority, the Committee meets on a monthly basis to develop policy and consider proposals from its five key subcommittees: Phase 1 Committee (for Years 1 and 2); Phase 2 Committee (for Years 3 and 4); Phase 3 Committee (for Years 5 and 6); Independent Learning Project/Honours Committee; and the Clinical Learning and Assessment Committee.

The Program Evaluation and Improvement Group and the Assessment Working Group provide advice to the Curriculum Development Committee. The Curriculum Development Committee forwards its recommendations to the Education Committee and Faculty Standing Committee for approval.

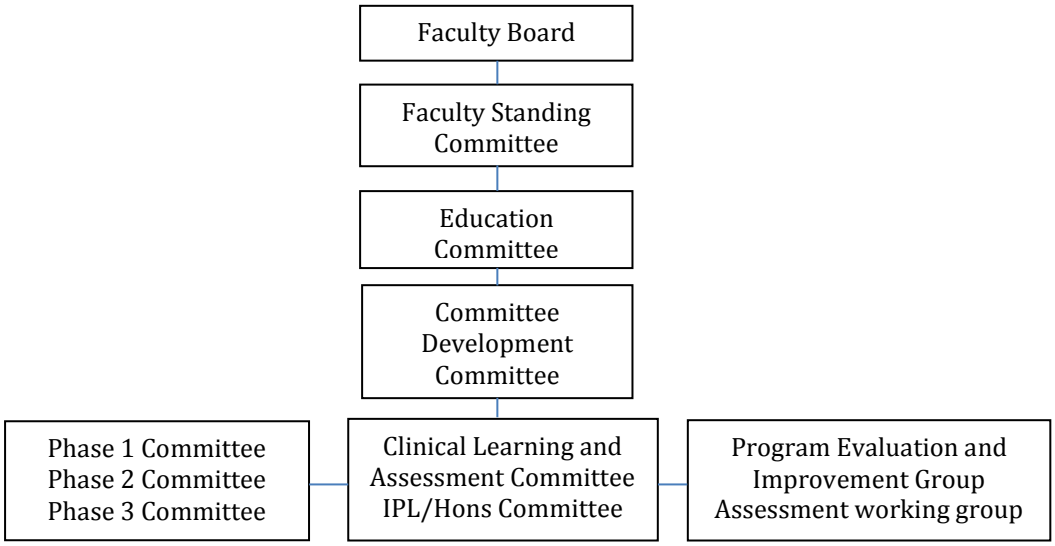
Phase committees are responsible for each phase of the program and are led by the academic convener for that phase. Each committee reviews teaching, learning and assessment activities; convenes groups to set examinations; oversees the conduct and marking of examination and portfolio reviews; and reviews evaluation and assessment data for the phase, suggesting modifications to content and design of teaching activities and assessment as appropriate.

The phase committees have well-defined responsibilities in aligning course content with course outcomes, design and implementation of assessment processes and oversight of evaluation.

The Independent Learning Project/Honours Committee manages the Independent Learning Project and the Bachelor of Science (Medicine) Honours program. It meets monthly and its responsibilities include approval of projects, selection of students for honours, design and delivery of coursework, supervisor support, evaluation of data and review of content.

The Clinical Learning and Assessment Committee oversees learning and assessment activities related to clinical competence. Its responsibilities include clinical skills teaching and learning in each phase, clinical skills assessment and standardised teaching and assessment in procedural skills.

The diagram below shows the Committee structure:



The Faculty acknowledges that its centralised approach carries a potential risk of decreased responsibility within disciplines and schools and the potential to stifle innovation at the local level, but it believes the inclusive structure of the program design allows for feedback to phase committees and sufficiently mitigates this risk.

The phase committees provided examples of feedback informing curriculum change, noting that as the phase committees are not bound by discipline there is flexibility in recommending change. The Curriculum Development Committee considers any proposed changes across the program and also formally reviews the change against University policy. The Faculty advised that the process allows for the implementation of innovative ideas, and has also driven change outside of the Faculty, including the introduction of University graduate outcomes, and the adoption by some programs of a balanced student selection process that considers parameters other than the Australian Tertiary Admission Rank.

Implementation of the Medicine program is the primary responsibility of the academic staff in the schools. The Medicine Education and Student Office is also directly responsible for the academic oversight of some aspects of the program. The Office is divided into two functional units: student/program administration and academic medical education. As the primary administrative unit of the Medicine program, it provides administration of all students, program courses and teaching spaces used exclusively by Medicine. The Office also provides funds to schools to reinforce academic positions to specifically fulfil responsibilities relating to the program. The clinical school administrative staff are responsible for the clinical teaching and assessments on-site.

The University and Faculty governance structures provide the pathway for the review and approval of changes to programs. The level of qualification awarded to graduates of the program changed in 2013 from a Bachelor of Medicine Bachelor of Surgery (MBBS) to Bachelor of Medical Studies and Doctor of Medicine (BMed MD), as approved by the University's Academic Board in May 2012. This change was in accordance with the first edition of the Australian Qualifications Framework (AQF) with evidence that the existing MBBS program satisfied the AQF requirements for both a Bachelor Degree and a Masters Degree (Extended). 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 Degree (Extended)).

No change to the curriculum content was required in transitioning the program from the MBBS to the BMed MD although the structure of the curriculum in Phase 2 was adjusted (further detail is provided at Standards 3.1 and 3.2).

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 Medicine Education and Student Office has a designated group of academic staff with broad educational expertise and excellent leadership from the Associate Dean (Education). The Office provides academic leadership in the development and evaluation of the program, facilitates learning and teaching professional development for staff, and leads and supports innovation in teaching and educational research. The Office staff members also contribute directly to the Medicine program as academic convenors and teachers. Staff with expertise in medical education are represented on the Curriculum Development Committee, its subcommittees and working groups.

The Faculty has a sound medical education culture. The Medical Education Interest Group has been active since 2006 and is the principal forum for bringing staff together. The Learning and Teaching Gateway provides information about learning and teaching activities provided by the Faculty and the University's Learning and Teaching Unit. All full-time academic staff at the University complete the 'Foundations of University Learning and Teaching' educational program.

The Muru Marri Indigenous Health Unit provides particular strength and unique expertise in Indigenous issues in the program, with careful oversight of the implementation of the Indigenous Health Curriculum Framework.

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 program is adequately resourced to deliver on its core objectives with sufficient autonomy and discretion for the Dean to make decisions on appropriate internal allocations.

Budget parameters are set by the University's Executive Team and provide a framework for the Faculty's budget development. The Dean takes responsibility for overall financial management working closely with the Heads of Schools/Centres and the General Manager to manage the Faculty's budget. In 2013, in alignment with the University

budget model, the undergraduate student load and teaching revenue were allocated to Schools based on teaching activities. It will be of interest to see how this budget model impacts on the Faculty in coming years. The Faculty has adequate capacity to manage its resources via its Medicine Finance Unit.

Increased financial pressures (in line with the rest of the tertiary sector) are anticipated as the Faculty is research intensive yet research is not fully funded. In October 2013 at the time of the assessment visit, the recently announced federal government efficiency dividends for tertiary institutions for the 2014–2016 period and the foreshadowed reduction in tax deductibility of self-funded educational expenses were expected to have an impact. In 2014, it is noted that while still relevant, this has diminished as an issue. The Faculty has secured significant grants from Health Workforce Australia and achieved significant increases in annual fundraising income of the Faculty. These are impressive achievements in the face of the budget challenges.

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 Faculty's clinical schools are located within six New South Wales local health districts or specialty networks. Clinical placement arrangements are broadly covered through a standard Student Placement Agreement which primarily addresses work place safety. At the initiative of the Faculty more comprehensive memorandums of understanding (MOUs) with each local health district are being revised and developed which better articulate the mutual responsibilities of both parties, some of which are already in place (e.g. the MOU with South Eastern Sydney Local Health District).

Students may also complete clinical training in private hospitals, medical practices and non-government health services. The Faculty advised in its submission that it has MOUs with the relevant private hospitals to cover these placements. It has informal MOUs with general practice placements (similar to the Student Placement Agreement) and it has MOUs with many of its community-based non-government health organisation centres.

The NSW Ministry of Health has significantly increased the administration and formality of clinical placement arrangements within public hospitals through the implementation of 'ClinConnect', a web-based application used to record placement and student details for Medicine, and book clinical placements for students of other health professions. Ministry representatives advised that this has improved the efficiency of ensuring all student immunisations and checks have been completed and has freed up staff time within the local health districts, but reciprocally the Faculty reported it has meant an increased administrative burden for Faculty staff.

The team was impressed with the strong relationship between the Faculty and health administrators at each clinical site it visited. The Faculty's teaching and training mission and strategic research agendas appear to be incorporated into operational priority plans and these partnerships are highly valued by the clinical sites. A chief executive officer of one site informed the team that a major challenge for the future is to ensure the indivisibility of teaching, training and research from the effective delivery of clinical service; and moreover, to ensure that teaching and research is not seen as a poor relation to the priority for optimal clinical care, but an essential component in achieving it.

NSW Health's foreshadowed move to activity-based funding is not seen to have any immediate implications for these relationships with a commitment to maintain existing arrangements for clinical academic staff and capacity for further expansion at sites of large growth (e.g. Liverpool Hospital at the South Western Sydney Local Health District). Full costing of teaching and research under activity-based funding arrangements is not anticipated by the Ministry until at least 2018.

The Faculty advised that some local health districts have contemplated billing the Faculty for student placements, and this situation is under discussion.

The team noted the major challenge, shared by both the health sector and the Faculty, is maintaining the quality of health care delivery while providing a vigorous teaching, training and research agenda in the face of diminishing resources and an increasing patient workload. The incorporation of senior academic staff into the executive groups of some local health districts is seen as a valuable contribution in responding to such challenges.

The formation of four Academic Health Science Centres around the hospital campuses at Randwick, St Vincent's, St George/Sutherland and South Western Sydney is developing another level of mutual commitment especially in the area of research. However, these are at varying stages of development and their relative roles, future key performance indicators and structure are not yet well understood by all those within the clinical school environment of NSW Health. Some chief executive officers, however, see the Academic Health Science Centre initiative as critical in emphasising the importance of continuing to integrate teaching and research with optimal clinical care into the future.

In the Indigenous health sector, the Muru Marri Indigenous Unit and the Rural Clinical School have developed strong relationships with the sector in their teaching, research and service missions. Muru Marri provides a particular strength and unique expertise in Indigenous issues with careful oversight of the Indigenous Health Curriculum Framework within the program.

The team observed that the program could benefit from formal engagement with a health consumers' body or incorporation of health consumer input into the governance of the Faculty. The Faculty advised it receives feedback from local health district consumer health forums; it canvassed consumers about the MD development; and consumers contribute to student selection interviews. The Faculty's Executive advised the team that serious consideration is currently being given to the constitution of a Consumer Health Forum to meet and advise on salient issues on a regular basis.

Recommendation for Improvement

Standard 1.6.2: Develop effective, formal partnerships with health consumer body/bodies to promote the education and training of medical graduates.

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

There is a strong thematic presence of research activities in the Faculty's submission, and numerous research institutes and centres form part of the Faculty. All but one of the research entities sits under governance arrangements that report to the Dean of Medicine.

The Faculty has an exceptional research track record across the major research themes. Its research income has increased by ten to fifteen percent per annum over the past five years and regularly accounts for over forty percent of the total research income of the University. In the Excellence in Research for Australia (ERA) 2012 initiative, 100% of UNSW Medicine's ratings were at world standard and above, and UNSW ranked fifth in all assessable disciplines. With $122.96M, UNSW Medicine contributed 42% of the total UNSW research income in 2011.

In 2012, UNSW Medicine received six National Health and Medical Research Council (NHMRC) Program Grants totalling $51M, representing a 100% success rate in the funding round due to commence in 2014. Faculty investigators were also awarded 40 NHMRC Project Grants in 2013, totalling $20M; 8 Career Development Awards, totalling $2M; 10 Early Career Fellowships, totalling $2.9M; 2 Targeted Call for Research Grants (Mental Health), totalling $2.6M; and six Research Fellowships, totalling $4M. The Faculty has consistently reported high numbers of research publications, and in 2012 Faculty members published 6 books, 80 book chapters, 2,162 journal articles and 27 conference papers.

Research outputs and inputs are impressive and growing but while having high reputational value, the development of a sustainable resource framework for these activities is seen as the major challenge of the Faculty for the future. A deliberate strategy to enhance success in the National Health and Medical Research Council Program Grant arena, to improve multidisciplinary and cross faculty collaborations and to increase the recruitment of Higher Degree by Research students is now in place. This strategy is garnering increasing support with a focus on underpinning research sustainability through the development and maintenance of a critical mass in areas of research excellence.

The program places a strong emphasis on the research-teaching nexus with students being exposed to the Faculty's research activities and being actively engaged in research themselves. Most academic staff are research active which informs their teaching, as they model scientific thinking, critical evaluation of the literature and an evidence-based approach. Students have a broad base to engage in research via their 28-week Independent Learning Projects (ILP) in Phase 2 (further detail on ILP is provided at

Standard 3). Additional coursework is completed in research ethics, methodology, statistical analyses and scientific writing.

Both campus-based staff and those within the clinical school environment enthusiastically commented on the value of the ILP in fostering a research culture and cementing staff-student relationships. It is clear from both staff and students that the curriculum is developed and delivered in a highly research informed and a research active environment, and the Faculty is commended on this culture.

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 Faculty is comprehensively staffed to deliver the Medicine program with a total of 667 staff holding academic appointments (equating to 549 full-time equivalent (FTE) positions), with 285 staff designated as holding combined teaching and research positions. There is a very low turnover of staff on continuing appointments. The chart below provides a breakdown of academic teaching/research staff:

Level	Male	Female	Total
Associate Lecturer	3	6	9
Lecturer	32	60	92
Senior Lecturer	59	33	92
Associate Professor	24	13	37
Professor	35	20	55
	153 (113 FTE)	132 (97 FTE)	285 (210 FTE)

The breakdown of academic teaching/research staff by School:

School	Persons (FTE)
School of Medical Sciences	66 (57.1)
School of Public Health & Community Medicine	41 (36.1)
St Vincent's Clinical School	13 (9.9)
Prince of Wales Clinical School	15 (14.5)
St George & Sutherland Clinical School	13 (9.0)
South Western Sydney Clinical School	13 (10.7)
School of Women's & Children's Health	22 (18.0)
School of Psychiatry	17 (15.5)
Rural Clinical School	49 (12.2)
Office of the Dean and Medicine Education and Student Office	20 (12.3)
Research Centres*	16 (14.7)

*represents academic staff appointments to research centres which are classified as teaching & research positions.

The Dean ensures that staffing profiles match the requirements of the Faculty and has been successful in maintaining a staff profile to effectively manage the curriculum with no significant senior vacancies noted at the time of the AMC assessment. In the clinical arena there are 54 clinical academic teaching staff in the metropolitan clinical schools and 49 across the four rural campuses. In addition there are 2,199 conjoint appointees with a notional contribution of a minimum of thirty hours per year each.

The table below shows the breakdown of conjoint appointments by level of appointment and School:

	SOMS	SPHCM	POWCS	SGSCS	SVCS	SWSCS	RCS	SWCH	PSYCH	TOTAL
Associate Lecturer	11	14	58	40	47	127	41	128	26	**492**
Lecturer	48	94	68	63	83	114	84	120	90	**764**
Senior Lecturer	45	52	51	39	95	85	72	61	49	**539**
Associate Professor	29	19	28	23	54	39	30	23	10	**255**
Professor	24	14	12	10	31	10	7	15	8	**131**
Total	157	183	217	175	310	375	234	247	183	**2181**

SOMS School of Medical Sciences
SPHCM School of Public Health and Community Medicine
POWCS Prince of Wales Clinical School
SGSCS St George and Sutherland Clinical School
SVCS St Vincent's Clinical School
SWSCS South Western Sydney Clinical School
RCS Rural Clinical School
SWCH School of Women's and Children's Health
PSYCH School of Psychiatry

Approximately 636 general/professional staff (557 FTE) support these academic positions.

As of 2012, there were seven full-time academic staff employed in UNSW Medicine who had documented that they were Indigenous. The University's Indigenous Employment Plan is coordinated by the Nura Gili Centre for Indigenous Programs. Nura Gili has an Indigenous Staff Network that facilitates communication between Indigenous staff across campus and provides specific staff support dependent on needs.

The Faculty provides appropriate induction and support for volunteers who contribute to the program as simulated patients for clinical skills, communication skills and examinations.

The University has satisfactory arrangements for the indemnification of all staff for all work carried out during the conduct of their University-related activities.

1.9 Staff appointment, promotion and 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 Faculty has clearly documented guidelines and policies for staff recruitment and appointment, managed by the Faculty's Human Resources Unit, with merit-based selection processes linked to the specific knowledge and expertise required for each position. Appointments of all clinical academics are managed jointly with NSW Health in order to maximise benefits to the Faculty and the local health district. There are clear guidelines in relation to the criteria for academic promotion which include the opportunity for assessment via a research or teaching track or both. There is an established pathway for promotion based on scholarship of teaching and learning, and a healthy focus on medical education research with substantive outputs and inputs.

Orientation and induction processes are comprehensive and were favourably evaluated by staff during interviews with the team. The UNSW Organisation and Staff Development Services offers a range of staff development opportunities. In addition, a variety of professional learning programs are offered by the UNSW Learning and Teaching Unit with twenty-two staff in the Faculty currently enrolled in the Graduate Certificate in University Learning and Teaching.

There is a process of annual performance appraisal against pre-agreed targets in teaching, research and service with high rates of completion, and these have been welcomed by staff.

There are well-defined criteria for conjoint staff appointment and promotion; and conjoint appointments are reviewed annually by the Head of School.

2 The outcomes of the medical program

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 Faculty values highly its status within the Group of Eight research intensive universities in Australia. It is finalising its next five-year plan having used a broad-based consultative engagement process that has included all schools, research centres and institutes; staff from all Faculties teaching into the program; clinical academic staff; conjoint academic staff; and students. The five-year plan is closely aligned to the UNSW Strategic Intent document, with objectives defined within the domains of student experience, research, community engagement, capabilities and resources.

The engagement of the community in the development of the strategic plan has primarily been addressed through the Dean's Circle and Advisory Group. As noted at Standard 1.6, it is recommended the Faculty include broader community representation, especially health consumers or representatives of patient groups, in their consultations.

The Faculty has an Indigenous Health Statement that recognises the unique position of Aboriginal and Torres Strait Islander peoples in both Australian and global culture and history as the original owners of the Land, and the role of the Faculty in helping to contribute to efforts to address current challenges in the broader practice of Indigenous health and wellbeing. The Statement was updated in 2013. The Faculty has an excellent working relationship with the Muru Marri Indigenous Health Unit and the university-wide Nura Gili Centre for Indigenous Programs.

There is clear evidence of a close alignment of the teaching outcomes and research priorities of the Faculty to the health care needs of the community.

2.2 Medical program outcomes

AMC graduate outcomes are organised into four domains:

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

2 Clinical Practice: the medical graduate as practitioner

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

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

2.2.1 The medical education provider has defined graduate outcomes consistent with the

AMC Graduate Outcome Statements and has related them to its purpose.

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

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

2013 Team findings

The Faculty has defined eight Medicine graduate capabilities to which all student learning and assessment is linked. The graduate capabilities remain unchanged since the commencement of the program in 2004, with only some revisions to sub-standards under the capabilities, undertaken most recently in 2011 in response to feedback from academics and students. No change was made to the graduate capabilities with the commencement of the BMed MD.

The eight graduate capabilities are grouped into three broad and interconnected areas:

Personal Attributes	**Interactional Abilities**	**Applied Knowledge and Skills**
Self-directed learning and critical evaluation	Effective communication	Using basic and clinical sciences in the practice of medicine
Ethics and legal responsibilities	Working as a member of a team	Understanding the social and cultural aspects of health and disease
Development as a reflective practitioner		Patient assessment and management

The graduate capabilities are broadly consistent with the thematic groupings used to organise the AMC graduate outcome statements.

AMC Domain 1 Science and Scholarship generally aligns to 'Using basic and clinical sciences in the practice of medicine', and 'Self-directed learning and critical evaluation'.

AMC Domain 2 Clinical Practice generally aligns to 'Understanding the social and cultural aspects of health and disease'; 'Patient assessment and management'; and 'Effective communication'.

AMC Domain 3 Health and Society generally aligns to 'Understanding the social and cultural aspects of health and disease'.

AMC Domain 4 Professionalism and Leadership aligns to 'Working as member of a team'; 'Ethics and legal responsibilities'; and 'Development as a reflective practitioner'.

The Faculty has mapped the capability sub-standards to the AMC graduate outcomes demonstrating broad consistency. There are several UNSW specific outcomes, related to

self-directed learning, in addition to the AMC outcomes which the Faculty has indicated in its mapping. The UNSW capabilities aim to produce the same level of graduate as the AMC outcome statements, while also addressing the journey that students will undertake to become that graduate. As a consequence, the program has additional capabilities regarding 'directing own learning' that do not map back to the AMC graduate outcome statements. It is a strength of the program that its graduate capabilities are comprehensive, established and linked to all stages of the curriculum. While there is general alignment with the AMC graduate outcome statements, the team recommends closer examination of the graduate capability statements against the new AMC domains to identify areas where the emphasis or requirements of the AMC standards are not explicit in the program's statements.

For example, AMC Graduate Outcome Statement (GOS) 2.14 'Place the needs and safety of patients at the centre of the care process. Demonstrate safety skills including infection control, graded assertiveness, adverse event reporting and effective clinical handover'.

This maps to two defined UNSW statements in the capability of 'Patient assessment and management - Quality and Safety: Understands the part that clinical practice improvement processes, audit and clinical guidelines play in improving clinical quality and safety' (3.3.10) and 'Recognises the concepts of risk and error, understands the importance of quality medical care and the principles of Open Disclosure' (2.3.8); but specific aspects of safe patient care are not mentioned in the UNSW outcomes such as infection control and graded assertiveness.

AMC GOS 2.8 'Elicit patients' questions and their views, concerns and preferences, promote rapport, and ensure patients' full understanding of their problem(s). Involve patients in decision-making and planning their treatment, including communicating risk and benefits of management options'.

This maps to five UNSW outcome statements but does not fully capture the AMC concept of adequately communicating probability of harm versus side effects and risks versus benefits of management options.

AMC GOS 4.5 'Demonstrate awareness of factors that affect doctors' health and wellbeing, including fatigue, stress management and infection control, to mitigate health risks of professional practice. Recognise their own health needs, when to consult and follow advice of a health professional and identify risks posed to patients by their own health.'

UNSW outcome 3.7.3 'Can identify inappropriate behaviour of self and others and identify effective goals and strategies for overcoming these difficulties' encompasses aspects but the AMC GOS 4.5 specifies a wider remit regarding wellbeing and recognising one's own health needs.

The team could not determine if the program achieves comparable outcomes across all instructional sites within a given discipline, with student feedback indicating some inconsistency in their educational experiences from site to site and in some key disciplines. Commendable efforts are being made at some clinical sites to ensure careful standardisation of clinical teaching and assessment within the multiple clinical placement locations within a clinical school. Broader efforts to evaluate and compare the clinical experience across clinical schools and specific disciplines (e.g.

Ophthalmology, Radiology) will be important in addressing this standard into the future.

Conditions

Standard 2.2.1: Provide evidence that the program's graduate capabilities are consistent with the AMC Graduate Outcome Statements.

Standard 2.2.3: Provide evidence that the program achieves comparable outcomes through comparable education experience and equivalent methods of assessment across all instructional 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 six-year program is divided into three phases of equal duration which vary in structure and in teaching and learning style. The content of each phase is outlined at Standard 3.2.

The Faculty has mapped its graduate capabilities to each of the three phases of the program. As the program is designed predominantly as an undergraduate program, the minimum duration was determined to be five years. The MBBS program was designed to include the Independent Learning Project thereby increasing the duration to six years. The introduction of the BMed MD program in 2013 caused no change in the duration of the program or the graduate capabilities, as defined in the MBBS program. Students cannot enter the MD without completing the BMed or the BMedSc (Hons), and the program duration remains six years.

The team is satisfied that the duration of the MBBS and BMed MD programs provide students with adequate learning opportunities to achieve the graduate outcomes.

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 content is comprehensive and integrated. The program is organised within vertically integrated disciplines and themes.

The curriculum content of the program has not changed from the MBBS to the BMed MD. The BMed is completed in Years 1 to 3 and the MD is completed in Years 4 to 6. The

structure of the content of the BMed MD differs from the MBBS in Phase 2 as BMed MD students must complete the Integrated Clinical Courses in Year 3 and the Independent Learning Project in Year 4. Previously, MBBS students could complete the Phase 2 components in either sequence. This change ensures that the MD includes the 28-week Independent Learning Project research experience.

The structure of the program by year and teaching periods (TP) is shown below:

Year	Summer	Semester 1		Semester 2	
	TP	**TP1**	**TP2**	**TP3**	**TP4**
1		Foundations	BGD – A	HM – A	AE – B
2		S&H	BGD – B	HM – B	AE – A
3		Phase 2 Clinical Course		Phase 2 Clinical Course	
4		Independent Learning Project		Independent Learning Project	
5	Phase 3 Course	Phase 3 Course	Phase 3 Course	Phase 3 Course	Phase 3 Course
6	Phase 3 Course	Phase 3 Course	Phase 3 Course	Phase 3 Course	PRINT

BGD Beginnings, Growth and Development
S&H Society and Health
HM Health Maintenance/Adult Health
AE Ageing and Endings/Aged Care and Rehabilitation/Oncology and Palliative Care

Phase 1 in Years 1 and 2 comprises four eight-week courses per year. The teaching periods relate to the standard University academic calendar and are organised around scenario-based learning which presents authentic activities of a medical graduate. In the first two courses in each year, students complete courses within their cohort. However in the two courses in Semester 2, the two cohorts are combined, that is Years 1 and 2 do the same learning activities as one group.

Learning and teaching in Phases 1 and 2 (Years 1–4) is organised broadly around the Human Life Cycle, with four domains: Beginnings, Growth and Development; Health Maintenance/Adult Health; Ageing and Endings/Aged Care and Rehabilitation/Oncology and Palliative Care; and Society and Health. Each domain has four major themes related to the domain.

Phase 2 in Years 3 and 4 is structured around clinical and practical experiences that students use to refine and develop their medical knowledge. It consists of two major components: the Integrated Clinical Courses which are taught over two 16-week semesters in Year 3, and the Independent Learning Project which is completed over 28 weeks in Year 4. Students also complete a four-week Clinical Transition Course after the Independent Learning Project.

Phase 3 in Years 5 and 6 is focused on independent reflective learning and comprises ten eight-week clinical courses or clerkships. There are six core courses: Medicine, Surgery, Psychiatry, Primary Care, Paediatrics, and Obstetrics & Gynaecology. The students must complete four weeks in an Emergency Department. They have twelve weeks for selective placements in UNSW-affiliated teaching sites and eight weeks for elective placements (in Australia or overseas). All domestic students are required to complete at least one four-week clinical placement in a rural setting. The final course is

the Preparation for Internship (PRINT) course of six weeks which follows the final examinations.

The scientific foundations of medicine are taught mainly through the biomedical sciences stream. The biomedical sciences curriculum is presented and examined over the six years of the program with greater emphasis in Phases 1 and 2. Phase 1 introduces the basic concepts of each major biomedical science discipline from the perspective of both normal function and alterations and processes in disease states. Each Phase 1 course focuses on a different body system in which teaching of the biomedical sciences is integrated. In Phase 2, students relate their biomedical science knowledge to clinical cases and patient management. The Independent Learning Project in Year 4 provides an opportunity for a significant research activity and associated coursework. In Phase 3, a case-based approach continues, with a greater emphasis on pathology although the students continue to be taught anatomy (especially in the context of diagnostic imaging), microbiology and clinical pharmacology. The team spoke to biomedical science teachers who explained that the 'spiral curriculum' model reinforces revision of the biomedical sciences throughout the program.

The formal teaching activities in biomedical sciences[a] are summarised below:

Phase	Discipline	Lecturers	Practical Classes (hours)	Tutorials
1	Anatomy	73	102	2
1	Biochemistry and Genetics	39	20	
1	Microbiology and immunology	44	34	3
1	Pathology	37	32	7
1	Pharmacology	38	14	1
1	Physiology	67	32	7
2	Anatomy	1	28	
2	Microbiology and immunology	3	18	
2	Pathology	10	30	1
2	Pharmacology	11	4	
2	Physiology	7	4	5
3	Anatomy		16	
3	Pathology		4	42[b]
3	Pharmacology			2
3	Physiology			2

a Excludes teaching in scenario group sessions.
b Phase 3 tutorials are multidisciplinary including microbiology and clinical pharmacology.

Some students commented to the team that there is not enough teaching covering basic clinical science or the clinical relevance of sciences. The Faculty advised that more biomedical science has been introduced in Phase 1 in the last two years in response to feedback. It acknowledges that specialties including Ophthalmology and Radiology are not adequately covered in the biomedical sciences content, and the team welcomes the Faculty's expressed intent to explore solutions including diagnostic imaging in Phase 3.

Recommendation for improvement

Standard 3.2.1: Further incorporate specialities, including Ophthalmology and Radiology, into the biomedical sciences content, to ensure graduates are equipped for evidence-based practice.

Regarding anatomy, students raised concerns regarding the use of video-based classes in Phase 1; and the clinical relevance of the anatomy content of the program, with some perceiving they were not adequately prepared for practice, despite the volume of material presented.

The Faculty advised that it uses tutorial-based anatomy classes for conceptually complex topics with a ratio of one tutor to sixteen students. From 2009, video-based classes commenced for topics where the emphasis is on learning by examination of specimens. Students watch a gold-standard video followed by hands-on examination of specimens. The ratio was initially four tutors to sixty-five students (1:22), and this was increased in September 2013 following a formal student request through the Phase 1 Committee. The Faculty provided evidence showing substantially improved performance (including a drop in failure rates) in the Phase 1 anatomy practical examinations since 2009.

Some students from the Rural Clinical School were dissatisfied with arrangements for a week of intensive anatomy teaching on main campus as preparation for the Year 5 Biomedical Sciences examination. The team noted that the Faculty has reviewed the performance of students from the Rural Clinical School in this examination compared with the metropolitan cohort over a three-year period, and found no differences in student performance either in anatomy or overall. However, the team noted the ongoing student anxieties regarding the travel and accommodation issues created by the intensive week course.

The team acknowledged the analysis of student concerns undertaken by the anatomy teachers and the steps taken to improve the teaching resources. The Faculty is developing a large number of adaptive eLearning modules that supplement regular classes and emphasise the clinical significance of anatomy. These are available for Phase 1 students, and nineteen online modules are also available for Phase 2 and 3 students which allow the delivery of adaptive clinical anatomy teaching to students at distant sites. These tutorials provide immediate feedback allowing a personalised learning path.

The team considers that the anatomy content and teaching resources are adequate, recognising an ongoing need for the Faculty to address the issue of student confidence about their preparedness for practice in relation to clinical anatomy knowledge.

The team commends the Independent Learning Project (ILP) in Phase 2 which adds a valuable research contribution to the curriculum and understanding of evidence-based practice. Students are able to undertake the project in any area of research relevant to medicine, including biomedical science, public health, and clinical research. About 80% of students choose to jointly develop a project with a supervisor and the remaining 20% choose a pre-designed project from a list. The projects can be undertaken at any of the schools, hospitals, rural campuses, research centres or institutes associated with UNSW Medicine. Up until 2012, over 500 supervisors had participated in the ILP. Over 70 peer-reviewed manuscripts have been published in which an ILP student has been an author.

Many staff and students were very positive about their ILP experiences and some alumni the team spoke with commented that the ILP had greatly assisted them as postgraduates. However, there remained a significant amount of dissatisfaction among students about variation in the quality of projects, a fact which is recognised by the Faculty. Students appreciated the Faculty's efforts to enhance the ILP by providing student support in methodology and data analysis, and the team encourages further evaluation and standardisation of the ILP. This may be supported by achieving the Faculty's stated intent of having an ILP coordinator at all sites.

The curriculum provides for acquisition of medical knowledge, development of clinical skills, communication skills and clinical experiences across different disciplines and clinical settings. The Quality of Medical Practice (QMP) element is designed to give students a good grounding in evidence-based medicine and medical statistics, as well as quality medical practice and patient safety. QMP is taught across all three phases of the Medicine program, interspersed within almost every course, including the Independent Learning Project. The key elements of evidence-based medicine, statistics and patient safety are taught in Phase 1. This knowledge is then built upon in Phase 2 with the clinical coursework extending the understanding and use of evidence-based medicine and statistics and then applying these skills in the clinical environment. Specific activities address quality and safety of patient care as well as the fundamentals of professional practice. As noted at Standard 2.2, closer examination of the AMC graduate outcome statements regarding quality and safety of patient care against the program's graduate capability statements and content is recommended.

The submission provided curriculum detail in two areas (Paediatrics and Primary Care) to illustrate how the curriculum prepares graduates to assess and manage patients effectively and safely under supervision in the early postgraduate years.

The program addresses the Health and Society domain by integrating public health concepts into all courses. There are an additional three courses with a strong public health focus: Society and Health (Phase 1); a Society and Health term in Integrated Clinical Studies A (Phase 2), and Primary Care (Phase 3).

The Medicine program addresses the domain of Professionalism and Leadership through teaching in three vertical elements in the program: ethics, quality medical practice, and clinical skills. Reflective practice, and use of the portfolio[2] is integrated into teaching and assessments throughout the program, allowing aspects of professionalism to become components of many tasks the students are required to perform. The team considered that the curriculum might foster professionalism more so than leadership, although it was argued that the development of leadership skills is inherent in the development of teamwork skills, goal setting, and peer- and self-assessment. A number of the students met by the team demonstrated commendable achievement as leaders.

3.3 Curriculum design

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

[2] As discussed at Standard 4 and 5, the Portfolio is a summative examination requirement for each phase of the program that links graduate capabilities to assessment to help drive learning.

2013 Team findings

The program is designed to achieve horizontal integration of each course and vertical integration across the program. Students revisit the domain themes as they progress through the program developing an understanding of how the themes apply to medical practice in a wide range of contexts and with a diverse range of people.

The content is organised by a number of frameworks. There are three vertical elements relating to the skills/attributes of medical practice represented in all courses including: Clinical Skills encompassing the development of communication and clinical skills throughout the program; Ethics and Professionalism encompassing the learning of ethical and legal responsibilities and the development of professionalism; and Quality of Medical Practice encompassing the learning of evidence-based practice and patient safety. Other themes such as Public Health and Indigenous Health are also integrated vertically. Biomedical sciences and the major clinical disciplines are taught and assessed in all years.

The team was impressed with the structures and arrangements enabling horizontal and vertical integration, as well as those arrangements to articulate with later stages of medical education.

The ability to track curriculum content in an otherwise integrated curriculum is enhanced by the establishment of a Curriculum Map, a component of the Faculty's eMed system. The map provides information on course outlines, learning activities and assessments. The learning activities are indexed by context, teacher and chronology, including aims, keywords and references, and the map is searchable by several criteria including discipline. Near-peer teaching is featured, with one aspect of the Phase 1 courses being that Year 1 and 2 students complete courses within their year cohort in Semester 1, but in Semester 2 the two cohorts are combined, that is Year 1 and 2 students do the same learning activities as one group.

Stages of transition between the phases are supported by specifically designed courses. The Foundations course in Year 1, the Clinical Transition Course after the Integrated Learning Project, and the Preparation for internship (PRINT) course in Year 6 are designed to support students in transition stages. Since the introduction of the Clinical Transition Course, student feedback received via the Medicine Student Experience Questionnaire on transition to the clinical phase has led the course design and implementation group to revise the course. The PRINT course which is undertaken following the final assessment for the program provides graduands with the opportunity to prepare for internship. The objectives of the course include patient assessment and management, performance as a reflective practitioner, and the ethical and legal framework relevant to internship in particular.

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

Specific learning outcomes describe what is expected of students over the three phases of the program. These are accessible in a range of ways including the UNSW Medicine

Program Guide which incorporates Phase and Course Guides, all of which explain the learning, teaching and assessment requirements. Communication methods also include websites, Blackboard, newsletters, emails from the Medicine Education and Support Office and regular interaction with the student Medical Society.

The Faculty's submission presented student feedback from its annual Medicine Student Experience Questionnaire about its communication of the program goals and objectives. Phase 1 and 2 students were consistently satisfied with the communication of key aspects of the program such as learning goals and courses. The data suggested less satisfaction from Year 5 students prior to 2012 but this is no longer evident. Student understanding of some policies and processes consistently rates a key negative, with less satisfaction noted by students in rural clinical settings. The Faculty continues to seek ways of improving clarity around policies, including the Clinical Allocation Policy for rural students (discussed at Standard 8.3.2).

The team noted that recently appointed staff, including conjoint appointments, acknowledge the support and resources provided by the Faculty, including information about the learning outcomes and objectives. The Faculty recognises that conjoints are busy working during the day so offers concise teaching updates. Some staff were less clear about learning outcomes and objectives and therefore, continued communication and additional approaches to communicating such information may assist. Overall, the team is impressed with the Faculty's communication of the program's objectives via an effective range of methods.

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

The Director of the Muru Marri Indigenous Unit, and the Rural Clinical School oversee the Indigenous health content of the curriculum. The Faculty has also participated in reviews of its approach in addressing the Committee of Deans of Australian Medical Schools' (CDAMS) Indigenous Health Curriculum with the Leaders in Indigenous Medical Education (LIME) Network. Content is primarily delivered earlier in the course, via scenarios in Phase 1 and a week of Indigenous and Cross-Cultural Health in the Society and Health term in Phase 2. Students can also complete an Indigenous health Independent Learning Project which is coordinated by Muru Marri.

Phase 3 presents the opportunity for an elective in Indigenous health. Phase 3 also includes an essay on Indigenous patients that students have seen in their final year, completion of which is required prior to sitting the Year 6 final examinations. The student submission stated that 71% of students feel that the Indigenous health teaching equips them to identify and address the healthcare needs of Indigenous Australians. Students also praised the Indigenous health content, based on its relevance and integration in the program.

The team was impressed with the involvement of the Muru Marri Indigenous Health Unit and the Rural Clinical School in the Indigenous health components of the curriculum, including cultural awareness studies, as well as extra-curricular activities.

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

The team observed that the program offers many opportunities for students to pursue studies of choice, and these opportunities increase as the program progresses. There are appropriate options for specialty interests via the Phase 2 Independent Learning Project where the number of projects and supervisors available to students continues to exceed the requirement; and in the selective and elective programs. For example, in Phase 3 students can choose clinical placements within the core placements; and the eight-week Elective may be split with many students completing four weeks in a developing country and four weeks in a developed country.

A feature of the program which ensures diversity is the Portfolio, a summative assessment discussed further at Standards 4 and 5. The Portfolio requires students to choose and design prescribed assessment tasks, with guidance on how to collate evidence for their portfolio against the graduate capabilities. Students have choice in the assessment tasks they select in Phases 1 and 2, and in Phase 3 flexibility is provided, allowing students to identify the most suitable evidence for their development.

The University's General Education program is innovative and interesting, requiring the medical students to complete courses outside their field of study. It is included in Year 4 concurrent with the Independent Learning Project. The Faculty supports this requirement as it provides alternative contexts for students to develop the generic outcomes of the program.

A small number of students each year undertake a combined Medicine/Arts Program, which can be completed in seven years provided the student completes an additional Arts course above the normal load in at least one semester. There are opportunities for additional study/research including a combined Masters (for example in Public Health) and a PhD following the BSc (Med) Honours year.

4 Learning and teaching

4.1 Learning and teaching methods

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

2013 Team findings

The Faculty uses a broad range of instructional methods to deliver the program, such as lectures, scenario-based sessions, tutorials, adaptive eLearning, laboratory classes and bedside tutorials. In addition, the Faculty applies various educational methods such as didactic approaches, discovery learning and self-directed learning. The methods and approaches are well aligned with the capabilities that are used to organise the outcomes. All formal learning activities in the Medicine program are recorded in the Curriculum Map in eMed (discussed at Standard 3.4). There is a clear and deliberate programmatic approach to education, based on current medical education literature.

In Phase 1, scenario-based learning uses constructed health scenarios to provide context to the presentation of fundamental biological, behavioural and social sciences. Each Phase 1 course is structured around two to three health scenarios that typically depict health-related issues and the real-world application of content.

In Phase 2, case method teaching is used as a way of developing students' reasoning skills based on the weekly themes in the courses. Each case method tutorial is a facilitated discussion of a pre-circulated written case in which active student participation and preparation are required. The Faculty observed significantly greater satisfaction in students from the existing program with the case method tutorials than amongst those who had undergone training in a traditional, content-based program. Biennial training is offered to facilitators to promote this style of teaching and learning.

Phase 3 entails clinical placements. In general, a week in Phase 3 predominantly involves the student's engagement with the clinical unit's activities including ward-based patient care, outpatient clinics and operating theatres. Coursework in Phase 3 is mostly clinical tutorials which involve case presentations by students followed by tutor-facilitated discussion or interactive tutorials. Students also attend clinical skills tutorials, including procedural skills, and tutorials on diagnostic services e.g. radiology. In most courses, clinical tutorials are limited to approximately four to six hours per week. Some courses, including Paediatrics, Obstetrics and Gynaecology, Psychiatry, and Primary Care, provide an initial series of lectures (typically over two to three days) at the beginning of the course and in week five of the course.

Adaptive eLearning is a new learning and teaching medium that uses an Intelligent Tutoring System to adapt online learning to the student's level of knowledge. The platform was developed by the UNSW School of Computer Science in collaboration with UNSW Medicine and the Faculty of Science. Adaptive eLearning provides students with customised educational content and personalised feedback when they need it. Academic staff in the School of Medical Sciences for example, have created online adaptive tutorials using virtual slides, to assist in students' interpretation of microscopic changes in tissue, and to remediate common misconceptions. These adaptive tutorials were implemented in the Phase 1 virtual microscopy classes, with overwhelmingly positive responses from students and teachers. The team was impressed with the Faculty's

development of these resources.

In all phases of the program, near-peer learning or vertical integration of learners occurs in small groups of students who are one year apart in their medical education. For example, a Phase 1 scenario group comprises six or seven students from each of Years 1 and 2; a Phase 2 tutorial group comprises a mix of students from Years 3 and 4; and in Phase 3, students on a clinical placement may be from Years 5 and 6. The educational aims of vertical integration of learners include collaborative learning, peer support, mentoring and peer modelling. Moreover, vertical integration of learners encourages students to take on leadership roles. The Faculty is commended on the success of this model, with staff and students reporting benefit.

There are some disparities in the way staff and students perceive the value of some educational activities, as evident in the Faculty's and students' submissions and in the visit interviews. For example, students expressed concerns about the usefulness of some anatomy sessions and the communication skills sessions, whereas staff were convinced of their educational value. The team acknowledges that this is a matter of improving the communication between staff and students and exploring specific concerns. The team learned that students have reorganised the student Medical Society to ensure that student committee members are a better representation of their constituencies, and the team recommends revised joint Faculty and student strategies to optimise communication.

Students further expressed concerns about the effectiveness of non-expert small-group facilitators, and about the comparability of the quality of teaching across sites. The team recognises that comparability of teaching across sites can only be addressed to a certain extent organisationally as it may prove to be impossible to completely eliminate students' uncertainty. Therefore the team suggests that the Faculty addresses the issue in a communication strategy. Concern regarding non-expert facilitators however, relates to the credibility of the teacher and their teaching and therefore the credibility of the material taught.

The Faculty invests in exploring and developing the use of information technology in education, for example by the Technology Enabled Learning and Teaching (TELT) Group, which has a strong interdisciplinary collaboration. TELT is innovative and its ongoing support is encouraged by the team. The development of clear terms of reference and an organisational remit could ensure stronger use is made of TELT for strategy development and in choosing how resources are directed for certain developments.

The team was impressed by the level of involvement of teaching staff, including clinicians with a conjoint appointment, and applauds the Faculty's organised processes that involve and encourage staff in the program's learning and teaching methods.

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 gradual development of students as independent and self-directed learners is clearly integrated in the curriculum. The graduate capabilities, 'Self-directed learning

and critical evaluation' and 'Development as a reflective practitioner', ensure the program develops and assesses these skills. Commencing students receive training in information skills and accessing online resources. The concepts of self-directed learning and reflective practice are also introduced to students in the Foundations course.

The Portfolio plays a crucial role in ensuring students take responsibility for their learning. It is the students' responsibility to ensure that they provide the evidence needed to substantiate their development in all the capabilities in each phase. To do this the program provides choice in prescribed assessment tasks, particularly in Phases 1 and 2, and flexibility in allowing students to identify the most suitable evidence for their development in Phase 3. The end-of-phase Portfolio examinations require students to reflect on their progress and present plans to address areas which need further development.

Increasingly students are encouraged to self-select assignments and take control of their own learning. In addition there is a gradual increase in health care activities requiring students to take responsibility and ownership of their learning. A point of attention is to identify early those students who do not manage this transition and to have appropriate scaffolding strategies, however the team saw no indication that these would be lacking.

The program relies heavily on students' production of self-reflection reports and assignments to assess capabilities such as self-directed learning and critical evaluation. There might be a risk of using one modality to assess complex capabilities and thus of trivialising the education and assessment.

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 Faculty has an excellent skills program both at the horizontal or phase level, and at the vertical level as skills learning and teaching is progressed and integrated into the latter phases. In Phase 1, campus clinical skills sessions involve a clinician and communication tutor working side-by-side. The campus session is then alternated the following week with a supervised bedside tutorial session. In Phase 2, clinical skills are developed around weekly themes and students become capable of independent practice with communication and physical examination skills. In Phase 3, students then apply and refine their skills in clinical units. Students seem to be optimally prepared for clinical practice through the combination of campus-based skills teaching and bedside tutorials, and the increasing integration of skills in a thematic approach which culminates in the Preparation for Internship course.

As stated at Standard 4.1, the team observed a difference in perception of the effectiveness of the communication skills program between Faculty and students. The team was informed that anecdotally alumni are more positive about the communication skills program than the current students. Further analysis may determine if better communication to the students about the effectiveness of the program improves this, or if specific improvements to the program are needed.

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

Students have ample supervised interactions with patients in all phases with an increasing level of involvement and responsibility.

In Phase 1, students attend teaching hospitals in four metropolitan clinical schools for bedside tutorials with real patients, complementing the campus-based skills completed the previous week. Clinical tutors provide teaching to groups of six to seven students.

In Phase 2, students have clinical learning activities for three days of the week and are required to assess patients with clinical conditions related to the weekly theme. Students typically work in pairs and present at their clinical tutorials. Students have no involvement in patient care.

In Phase 3, students are in clinical clerkships in all the UNSW affiliated metropolitan teaching hospitals. Most clinical units accept one to two students. Clerkships in Paediatrics, Obstetrics and Gynaecology, and Psychiatry are completed in either general or specialty hospitals. Students also complete a clerkship in General Practice. In Phase 3, students are expected to participate in patient care under supervision, including involvement in ward rounds, clinical assessment, and multidisciplinary meetings.

4.5 Role modelling

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

2013 Team findings

The curriculum provides ample opportunities for role modelling as a learning method, from clinical staff during the clinical educational settings and from basic sciences and behavioural sciences staff during the basic sciences, and general professional and communication activities.

The Independent Learning Project is a valuable researcher role-modelling learning method, as the student interacts with their research supervisor and others in the research team for the duration of the project. Some students also have the opportunity to present their research at international conferences. The team met alumni who recognised the value of this learning in their careers and vocational training.

The strong focus on using near peers in the educational process widens the opportunities for role modelling to those groups as well. As discussed at Standard 4.1, in each two-year phase the students are vertically integrated. Faculty evaluation shows strong student support for the model, with both levels of students experiencing learning benefits, which has led to a greater sense of community in the student body. More than half of the Phase 2 and Phase 3 students had been near-peer teachers.

The Faculty has techniques to navigate differences between what is taught on campus and what is observed in practice, by having students reflect on what they observe, such as clinician noncompliance with guidelines, unethical or unprofessional behaviour. The

team notes that this strengthens student understanding of the role modelling they experience.

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

This is an integral part of the educational process which starts from the foundation course in Phase 1. In Phase 2, patient centred care in the collaborative management of patients is featured in the Clinical Transition course. In Phase 3, the approach to patient-centred consultations is developed further in the Primary Care course.

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

The program's graduate capability, 'Working as a member of a team' ensures that students develop the skills to work effectively in clinical teams. In Phase 2, students are exposed to multidisciplinary teams in Aged Care and Oncology terms, and in Phase 3 clinical placements, students are expected to engage with all members of the clinical team, and have clinical simulation sessions with nursing students. The Faculty advised that as the University does not have many other health professional programs, there are fewer opportunities for medical students to learn alongside other health professional students on campus.

The Faculty received Health Workforce Australia (HWA) funding of $1.2 million in 2012 for the School of Medical Sciences to develop a virtual approach to interprofessional learning, using the Adaptive eLearning platform. The inCH (Interprofessional Collaboration in Healthcare) Project is led by the Faculty in collaboration with four other universities and will give professional experts the opportunity to participate in building interdisciplinary educational tools to be used across disciplines and universities.

The interprofessional activities in the clinical environment appear to be mainly instigated by the clinical schools rather than centrally organised. The HWA-funded pre-admission clinic project at St Vincent's Hospital is one example, and the Fairfield Hospital medical and nursing student joint learning pilot study another. The team was assured by various sources that once interprofessional education activities are developed and deployed the Faculty has been supportive of them continuing at those sites.

The team acknowledged that the scarcity of nursing and allied health programs at the University provides barriers in this area. It is recommended that the Faculty explore possibilities to assume a more central organisational role in interprofessional education, for example by documenting activities, and by providing a forum to facilitate the exchange of ideas and experiences between the clinical schools.

Condition

Provide evidence that students have opportunities for 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 Faculty has a clear 'assessment for learning' philosophy which embeds the assessment in the curriculum and optimises its use to foster student learning. The assessment system is outcome based, requiring demonstrated development in the eight graduate capabilities. Learning tasks, such as individual assignments or group projects, form a significant part of the assessment, and examinations integrate the basic, clinical and social sciences. The program has a Portfolio examination in each phase that requires the student to collect evidence of performance in specific areas of capability, select and submit the best examples with a commentary on their learning. Grading systems are criterion-referenced making the expected standard of performance clear.

The Faculty has autonomy in its assessment approach in the program. The program's assessment approach complies with the University's Assessment Policy. As noted at Standard 1.3, all assessments are centrally managed by the Curriculum Development Committee with responsibilities delegated to the phase committees, Clinical Learning and Assessment Committee, and the Independent Learning Project/Honours Committee. An Assessment Working Group advises the Curriculum Development Committee on proposals for changes to assessment. This Group is also responsible for the Portfolio examinations at the end of each phase. The Portfolio provides a continuous and cumulative profile of a student's development throughout the program.

The principles of 'assessment for learning' are coherently adhered to both in rules and regulations and in practice. The rules and regulations contain the requirements for assessment and progression and are clearly documented and communicated to all stakeholders via the program's website, the Program Guide and each Phase Guide. Changes are communicated by phase newsletters and Blackboard. The team received the strong impression in discussions with various stakeholders that the means of communication are sufficient.

The University rules require the Faculty to have an Assessment Review Group to decide on the outcomes of tests, moderation and progression. The test results are first reviewed by the academic convenor responsible. Recommendations are then made to the Medicine Program Authority and to the Faculty Assessment Review Group which has the authority to suspend or exclude students.

The Faculty has a range of formative and summative assessments, and importantly, it combines the summative and formative functions of examination where possible. For this the Portfolio is the backbone of the assessment program, combining and analysing both formative and summative information.

The team sees the Portfolio as the starting point for future development of the program to optimise the alignment of the 'assessment for learning' philosophy with the assessment practices. The Faculty's efforts to better ensure timely and informative feedback, in combination with periodic analysis of the more developmental graduate capabilities, such as 'Development as a reflective practitioner', 'Self-directed learning and critical evaluation skills' and 'Working as a member of a team', are acknowledged. The team sees opportunities for more frequent portfolio meetings between a student and a coach for a closer analysis of each student's results. This would also identify students at risk earlier, especially where professionalism or well-being is involved. The team acknowledges that time and resource limitations may impact on the introduction of additional meetings.

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

There is good alignment between the purpose of the assessment and the methods employed. The program contains a wide variety of assessment methods including oral and written assessment, open-ended and multiple choice formats, OSCEs, essays and long reports. There is a higher load of structured, summative examinations in Phase 1, while in Phases 2 and 3 course-based assessments require student input in determining the content of assessment. In Phase 3, observation-based clinical assessment methods are incorporated in the assessment program. The Portfolio is integral to assessment of all graduate capabilities, including those capabilities such as 'Working as a member of a team' and 'Development as a reflective practitioner' that are less amenable to being assessed by conventional methods.

Assessment is guided by and integrated throughout the program with the outcomes defined by the eight graduate capabilities. All test items are mapped to the graduate capabilities and the alignment is recorded in the Curriculum Map and in the Assessment Item Bank in eMed. Course and end-of-phase assessments address specific learning objectives for that point in the program, and also achievement of graduate capabilities.

The Faculty does not currently use any standard-setting procedures for determining numerical cut-scores, based on concerns about the reliability of these methods, given insufficient judging panels and the small number of experts available. It recognises the need for reliable cut-scores and is exploring alternate strategies. The team acknowledges the Faculty's endeavours to ensure equivalence of test difficulty, judgements and standards both between different student groups within a cohort and between cohorts. The recruitment of a staff member with expertise in the field of psychometrics and standard setting is an important development.

The team agrees that the Faculty's use of equating procedures is important but considers that equating procedures alone are not sufficient. While equating ensures that

a fair assessment is administered to all students and that graduates are of comparable competence, it does not address the question of whether competence is sufficiently aligned with the expected standard of quality of the students who pass.

The Faculty shared with the team their concerns about standard setting methods described in the literature. However the use of validated methods of standard setting is required, or alternatively, the Faculty should ensure that methods developed in-house are demonstrably sufficiently valid to make important decisions about students' academic careers before they are implemented.

The Faculty has generally adopted a conjunctive (non-compensatory) standard for determining outcomes in examinations where there is expected or proven multidimensionality. The team noted the Faculty provides supplementary assessments to compensate for any increased fail results from the use of conjunctive standards. The combination of students' results on the individual assessments is partly compensatory and partly conjunctive, which sometimes requires arbitrary choices as to the relative contribution of individual assessments to the final grade. Although this is a common feature of assessment programs, here conjunctive combinations may create some tensions with the stated 'assessment for learning' philosophy. To minimise this tension, the provision of feedback is essential, and this is discussed at Standard 5.3.

Condition
Standard 5.2.3: Provide evidence of validated methods of standard setting by 2016.

5.3 Assessment feedback

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

5.3.2 The medical education provider facilitates regular feedback to students following assessments to guide their learning.

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

2013 Team findings

The Faculty has processes to identify underperforming students early. Students who fail an end-of-phase examination are referred to an academic advisor, and students who are under-performing early in the program can be referred to the University's Learning Centre for academic student support. Supplementary examinations are provided for all course and phase examinations irrespective of the score from the initial examination. The supplementary examination may be sat after a period of additional study and remediation, or following the original assessment to reassess the student in the case of an unreliable result, for example failing a component of a conjunctive standard on a small number of items.

The program has procedures to identify and support students whose professional behaviour raises concerns. Wellbeing issues are identified more by incidental reporting than by longitudinal tracking of such students. There is a good system of support and remediation for these students, but handover from one course, or one phase, to the next is difficult. The competing interest of continuity of care with student privacy issues is not easily resolved. The team noted that with the longitudinal Portfolio instrument,

centralised control of test production, assessment quality, and student results management, the Medicine program already has in place the organisational requirements for a longitudinal approach to identification of students with problems. The team recommends the Faculty consider this area further.

The Faculty advised it aims to provide both individual and cohort feedback to students following all assessments. The team appreciates the Faculty's actions to ensure that timely and informative feedback on assignments and reports of all students is sustainable in the long run, even with high student numbers. Developments such as feedback provision on iPads, using standard feedback templates and vignettes, and even reporting the word counts of the feedback are intelligent solutions in this situation as they marry efficiency with effectiveness. The team commends the developments in this area which are addressing a central issue concerning an 'assessment for learning' approach.

As discussed at Standard 5.2, the provision of feedback is considered essential to minimise the tension with the stated 'assessment for learning' philosophy. A suggestion might be to provide students with the written test questions after the test to optimise its formative function. The team found that during the visit, various Faculty staff expressed a fear that doing this would limit the re-use of items, however students may memorise and collate items regardless. The team recommends that the Faculty trial alternative ways of publishing items after the tests and track and regulate the re-use of items in a structured way.

The Faculty advised that data from assessments are reported to the Curriculum Development Committee (and its relevant subcommittee), and the Assessment Working Group and this data can inform change as required. The reports to students on the cohort performance showing the distribution of results are also available to teaching staff. Data on aggregate student performance at the school level are available to the clinical schools, although each clinical school only receives its data with the whole cohort data for comparison.

Recommendations for improvement

Standard 5.3.1: Further develop the existing assessment systems to enhance the longitudinal tracking of under-performing students.

Standard 5.3.2: Trial alternative ways of publishing items after the tests and track and regulate the re-use of items in a structured way.

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

The Medicine program has extremely convincing quality assurance and quality improvement processes in place. There is pre-administration quality assurance in the form of staff development and review panels and there is post-administration quality

assurance and improvement in the form of item analyses and feedback to staff. The Faculty advised that at a minimum, descriptive statistics are provided for all test results and item difficulty and discrimination indices are provided for all items. It plans to increase more detailed evaluations routinely after all examinations. For post-administration quality information to be optimally useful it has to be understood by the teaching staff.

The Faculty has conducted a number of projects to evaluate assessments in the past three years including its 2010 Review of all assessment results, evaluation of the Biomedical Sciences VIVA, and an evaluation of the Portfolio in conjunction with the Medical School, University of East Anglia.

The Faculty's centralised approach to curriculum and assessment assists it to ensure that assessments are consistent across its teaching sites. It implements measures to ensure consistency, targeting identified sources of variability, such as clear assessment criteria, marking rubrics, and the development of guidelines to assist portfolio examiners.

When psychometric approaches cannot be used to ensure and evaluate quality of the assessment, the Faculty appropriately uses organisational strategies to improve the assessment expertise of the assessors, by way of targeted training, to avoid the occurrence of judgement errors or mitigate the influence of judgement biases, for example by rotating assessors between sites and the use of external assessors. In addition to this, site-specific assessments are combined with more centralised standardised assessment, such as the end of Year 5 Biomedical Sciences VIVA as a measure of triangulation.

Although these are important strategies to ensure quality and equality in assessment practices across teaching sites, the team considers that this does not negate the need for the Faculty to consider a more formalised coordinating role or body in the organisation to oversee and steer these processes.

Recommendation for improvement

Standard 5.4.2: Implement a formalised coordinating role or body in the organisation to oversee existing consistency of assessment across teaching sites.

6 The curriculum – monitoring

6.1 Monitoring

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

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

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

2013 Team findings

The Medicine program is continually evaluated through quality assurance processes implemented by the University and the Faculty. The University operates a continuous improvement approach to quality assurance and improvement of learning and teaching which inform a three-year Learning and Teaching Enhancement Plan. The Core Learning and Teaching Indicators are indicators of student quality, student satisfaction, and graduate satisfaction based on the Course Evaluation Questionnaire administered by the Commonwealth government.

At the Faculty level, the quality of learning and teaching is monitored through the annual Faculty Review of Learning and Teaching process. At the individual/course level, the quality of learning and teaching is monitored through annual performance appraisals utilising for example feedback from students, such as the University's Course and Teaching Evaluation and Improvement instrument (CATEI).

All University faculties are required to submit an annual report on learning and teaching which is assessed by a review panel including external reviewers. The report includes processes for assuring and improving the quality of the four priority areas: reports of performance in undergraduate coursework programs, achievements in improving the quality and efficiency of assessment of student work, and any additional goals for learning and teaching enhancement. It also includes a plan for goals, desired outcomes and strategies for improving learning and teaching. The team noted the positive information provided in the 2012 Faculty Report on Learning and Teaching relating to the program, particularly the University reviewers' commendation of the Faculty's achievements in engaging with students and external stakeholders.

The Faculty reviews, revises and implements its own strategic and operational plans to ensure that the goals, strategies and desired outcomes align with those of the University. The team was presented with ample evidence of a variety of evaluation strategies which ensure that the quality of curriculum content, teaching, supervision, assessment and student progress decisions are monitored carefully.

Central to the Faculty's quality assurance process is its Program Evaluation and Improvement Group, established in 2003 to implement a continuous evaluation and improvement strategy. It meets quarterly and reports to the Curriculum Development Committee. Its framework monitors the program through four aspects: formal

curriculum and available resources; student experience throughout the program; quality of the staff and teaching; and student and graduate outcomes. The Group has expert working parties that focus on each of these aspects and it uses a set of key quality indicators to provide a focus for evaluation activities.

The evaluation instruments presented to the team included surveys such as CATEI, the Medicine Student Experience Questionnaire (MedSEQ), focus groups, online evaluations and face-to-face meetings with students and student representatives, both on campus and in the clinical schools. Efforts to evaluate teacher quality, using both CATEI and a Clinical Evaluation Survey (developed in-house), is evidence of commitment to quality teaching. The recent smartphone-enabled University Course Evaluation forms have improved response rates in pilot trials and are a welcome initiative.

The MedSEQ, developed by the Program Evaluation and Improvement Group for evaluation of the medical student experience, considers five aspects of the student experience comprising: Organisation and Student Understanding; Learning, Teaching and Assessment; Community Interaction and Value; Student Support; and Resources. Demographic data on students including gender, year in program, enrolment status (local, rural, international) and site of clinical training allows for analyses by these subcategories. Administered biennially since 2006 with response rates from 40–55%, MedSEQ provides longitudinal data to inform ongoing improvements to the program. The team was particularly pleased to see the student evaluation findings are regularly published on the Faculty website.

Noteworthy evaluation projects led by the Program Evaluation and Improvement Group include the Preparation for Internship course, the Clinical Transition course and the Independent Learning Project. The team is very supportive of the plans to specifically evaluate the Independent Learning Project supervisor experience in the near future.

The Faculty has invested in evaluating a unique aspect of the program, that of the vertical integration of students from adjoining years in the same courses. In 2011–12, a major project consisting of a literature review, student focus groups, and online evaluation was undertaken to evaluate the student experience of peer learning. The team was also presented with a number of individual examples of evaluation of innovation in specific tutorials within courses, and/or changes to scenarios and assessments.

The Faculty collaborates with other education providers, particularly in relation to assessment, notably with: the AMC; the University of Notre Dame Medical School in Sydney; and as part of the Australian Medical Assessment Collaboration. It has also made efforts to engage with the Association for Medical Education in Europe in 2014. It is a partner medical school of the International Medical University in Malaysia which allows for sharing of practices. The team was impressed with the level of engagement between the Faculty's Medical Education and Student Office and the University Learning and Teaching Unit in support of both curriculum evaluation and faculty development, and a number of education innovations developed in partnership have been piloted in the Faculty. The links between the Faculty of Medicine and the Faculty of Education, the latter of which runs a Graduate Certificate in University Learning and Teaching focusing on the development of teaching capability in Higher Education, are also impressive.

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 Faculty's submission provided comprehensive analyses of the performance of the four commencing cohorts from 2008 to 2011. It is noted on average that the failure rate has not changed significantly since the 2010 report. Of the four cohorts who have now completed the program up to 2012, approximately 82% of students completed the program within the minimum six-year duration. Approximately 2% of students were excluded due to academic failure. A further 5% of students withdrew from the program, primarily in Phase 1.

In terms of graduate outcomes, the published evidence of a comprehensive analysis of intern preparedness for hospital practice addressing specifically the development of generic capabilities in the areas of communication, teamwork, critical analysis of information, problem solving and ethical practice, is impressive. The Faculty is commended on its efforts to correlate this self-reported data with hospital supervisor reports[3].

Analysis of data from a Program Evaluation and Improvement Group-led study exploring whether important generic capabilities are being acquired by students in the Medicine program found that medical students were significantly more positive than other UNSW students that their university experience is developing several generic capabilities.

Preliminary data from the Medical Schools Outcome Database (MSOD) and the Rural Clinical School students highlighted the proposed career pathway choices of recent graduates and senior students. The Faculty is encouraged in its ongoing efforts to monitor the outcomes of the program in terms of postgraduate performance, career choice and career satisfaction. Although the results of outcome evaluation are regularly reported through the relevant governance structures to academic staff and students, it is suggested that the Faculty continue to engage with the student body to ensure more effective promulgation of results of program evaluations. The use of innovative communication strategies, such as social media, may assist.

The Faculty has carefully examined assessment results with analysis by year, site of clinical training, site of examination and student demographic. These analyses have consistently shown no significant differences in test results, except for comparisons between test results from rural and metropolitan sites in the Phase 3 Integrated Clinical Examination. For the past two years, the test results from the rural sites have been significantly higher than the metropolitan sites.

It is Faculty policy that students in the metropolitan sites cannot be examined at the clinical school where they trained. In the rural sites, external examiners from other rural and metropolitan sites are used. The team noted that comparison of the

[3] Scicluna et al. BMC Medical Education 2012, 12:23 http://www.biomedcentral.com/1472-6920/12/23

distribution of results from internal and external examiners shows no evidence of preferential grading by internal examiners. Further, the higher clinical examination results correlate with higher written examination results and a higher proportion of these Phase 3 rural students achieve honours at graduation, suggesting that the differences in test results are due to student performance. Academic outcomes of rural students, defined by either the Rural Student Entry Scheme or site of clinical training, show no reported differences in rates of progression or completion.

Comparable analyses of assessment results by Indigenous status are not reliable given the relatively small number of Indigenous students in each cohort. However data on overall progression shows that since 2004, sixty-five Indigenous students have commenced the program. Seven students (11%) have graduated and fifty students (77%) are still enrolled. While the majority are on time with their studies, the progression rate of Indigenous students is slightly lower than the total cohort with a higher rate of unsatisfactory academic performance in those students who are delayed. The retention rate is lower, though discontinuations (12%) are primarily due to non-academic reasons.

Analyses of assessment results and overall progression rates do not show any significant differences between international and domestic students. In 2011, a comprehensive evaluation of the selection process was undertaken. Overall, prior academic achievement was more predictive of overall performance in the program, specifically for knowledge-based outcomes, than interview or UMAT scores. In contrast, the communication dimension of the interview was more predictive of, and accounted for higher variances in clinical-based outcomes, than prior academic achievement.

6.3 Feedback and reporting

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

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

2013 Team findings

The monitoring and evaluation data is reported to the Curriculum Development Committee and to other relevant subcommittees and groups. Data is also disseminated to students as noted at Standards 5 and 6.

The Faculty acknowledged in its submission that there is limited distribution of data on graduate outcomes to external stakeholders. The principal external stakeholders include the clinical teachers in the teaching hospitals. Assessment results and graduate outcomes are reported to the clinical schools for distribution to their clinical teachers.

In terms of communication with the wider group of external stakeholders, the Faculty is encouraged to consider greater consumer consultation, as noted at Standard 1.6, and monitor and respond, where appropriate, to community perceptions about the qualities of its graduates. Community representation on Faculty committees with responsibilities for governance, curriculum development and evaluation is recommended. Those with an interest in the program's outcomes also include education and health care

authorities, Aboriginal and Torres Strait Islander peoples, professional organisations and postgraduate education bodies including the specialist medical colleges. This input can provide an additional and relevant source of continuous renewal of the program.

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 student cohort size is defined and stable. The predominant pathway for entry into the BMed MD remains as first level entry students from high school, with 90% of commencing Year 1 students being school leavers. In 2006 the Faculty set a maximum class size of 280 for Year 1 with a quota for international students of 68. Between 2009 and 2013 total student numbers at Year 1 have ranged from 261 to 277, with numbers of international students ranging from 58 to 69.

The quota for domestic commencing students as currently set by the Commonwealth government is 208. Students apply for the BMed MD program via a single code through the University Admissions Centre. Students selected into the program enrol in both degrees and from commencement the students are classified as medical students and registered with the Medical Board of Australia. There are no fee-paying domestic students.

There is a graduate-entry pathway limited to fifteen UNSW BMedSc (Hons) students per year. There have been no substantial changes to the BMedSc since the Faculty's 2010 comprehensive report. The students are required to complete two bridging courses in the year before they start the medical program, then in the summer teaching period they undertake an intensive graduate-entry bridging course before entering the MD in Year 4. In Phase 2, they complete the Integrated Clinical Courses and then complete Phase 3.

Some international students transfer at Year 4 from the International Medical University (IMU) in Malaysia, with a small number of special transfers (for example on compassionate grounds) also entering at this level. The commencement of the BMed MD will require IMU students requesting a transfer to UNSW from 2016 to have completed a BMedSc research project at IMU, so as to be eligible for the MD, and the Faculty has notified IMU of this change. Between 2009 and 2013 student numbers entering in Year 4 have ranged from 6 to 21.

Existing MBBS Year 6 students in 2013 were offered the opportunity to transfer to the BMed MD or to continue and graduate with the MBBS. The Faculty advised that it graduated 264 students in 2013 with 243 choosing to transfer to the BMed MD award and 21 electing to graduate with the MBBS. Of these 21 students, 8 were not eligible to transfer to the BMed MD as they had transferred into the program from other medical schools (mostly from International Medical University Malaysia) and so had not completed the equivalent of the BMed. Overall, 95% of eligible Year 6 students

transferred to the BMed MD. The Faculty will also offer remaining MBBS students the opportunity to transfer to the BMed MD.

The Faculty reports no difficulty in delivering the program for the current student numbers although placements for some specialty disciplines including General Practice are under pressure, given increasing service demands on conjoint staff and potential growth in student numbers at other NSW health care education providers (discussed further at Standard 8.3.2). Adequate clinical capacity for any potential increase in cohort size would be a challenge. The Faculty advised it has no plans to change the total student numbers or proportions.

There are specific schemes designed to attract and support Indigenous and rural students including the ACCESS scheme for students who have experienced long-term educational disadvantage. There are no specific admission schemes for mature students and no concessions are given for previous study in any program other than the BMedSc program at UNSW.

The Faculty has effectively increased the numbers of students from rural and Indigenous backgrounds. There are strong and sustained efforts to identify barriers to entry of underrepresented students and to design tailored strategies to overcome these. Current students in the Rural Allied Health and Medical Society are actively involved in these efforts. The pre-entry courses help to ensure that rural and Indigenous students understand what is involved in entering the program. There is no minimum or maximum limit on the intake of Indigenous students.

The University offers a range of scholarships to rural and Indigenous students commencing the program. Rural scholarships range in value from $1,000 to $12,000 per annum and Indigenous scholarships range in value from $1,000 to $25,000 per annum. Scholarships may be for Year 1 or the whole program. There is also a residential scholarship program for 25 Indigenous students at Shalom College that provides full accommodation and board, tutoring and counselling support. The Rural Clinical School through community engagement has a range of organisations that support rural and Indigenous students in the form of scholarships and awards.

The emphasis on support and encouragement for Indigenous students is particularly impressive and reflected in the relatively large numbers of graduating Indigenous students, in comparison with other Australian medical schools. The Faculty is commended on the contributions and passion of the staff of the Rural Clinical School, the Muru Marri Indigenous Health Unit and Nura Gili in this area, and the strong leadership and support provided by the Dean.

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

Implementation and evaluation of the selection policy are the responsibility of the five-member Admission and Re-enrolment Committee. This committee determines policy, quotas and changes to the admissions process. The UNSW Admissions Office reviews any proposed changes to policy to ensure compliance. The current selection process has applied to students enrolling in the program since 2004 with no change in process following the commencement of the BMed MD. For general entry first-year students, the selection criteria are based on three factors:

1 Academic merit: Australian Tertiary Admissions Rank (ATAR) scores of 96.00 or above are required for local and international applicants

2 Undergraduate Medical and Health Professions Admission Test (UMAT): minimum score of 50 required for local students; or International Student Admissions Test (ISAT) scores: international students – no minimum score set; and

3 Interview: All local applicants are interviewed face-to-face by two interviewers using a semi-structured instrument with specific questions asked of all interviewees. International applicants are interviewed by Skype. Each interview pair has one member of Faculty and one community member, one of whom is male and one female. There is only one doctor in each interview pair. Interviewers are trained with calibration exercises using videoed interviews. The interviews focus specifically on life experiences and motivation to study and practise medicine.

The selection algorithm weighs each criteria equally as the Faculty considers the three main criteria essential in medical practitioners. There is an additional criterion of 'rurality' for Rural Student Entry Scheme applicants. A summary of the instruments used in the selection process for different schemes is shown.

Instrument	Local	Rural	Graduate Entry	International	Detail
UMAT	✓	✓	✓		The overall score is used with the three sub-tests weighted equally.
ISAT				✓	The overall score is used.
Higher School Certificate (HSC)	✓	✓		✓	The ATAR, calculated from the HSC subject scores, is used to select for all but first round of interviews (based on predicted ATAR).
University Results	✓	✓	✓	✓	For applicants with a partly completed or completed degree, the ATAR and university results are combined equally.
Interview	✓	✓	✓	✓	Six dimensions and an overall rating are used to rate applicants at interview. The seven ratings are weighted according to their relative importance.
Rural ratings		✓			Four rural ratings based on Rural, Remote and Metropolitan Areas (RRMA) classification scores are weighted equally.

An ATAR score of 91.00 or above is required for students entering under the Rural Student Entry Scheme. For graduate-entry applicants, Year 1 and Year 2 results in the UNSW BMedSci program are considered. A UMAT minimum score of 45 is required for rural and BMedSci applicants. There are additional questions with a rural focus for rural applicants and interviewers for these applicants have a rural background. There is a separate entry process for Indigenous applicants. This includes a written application outlining academic achievement, a submission outlining reasons for wanting to become a doctor, an interview and completion of a four-week Pre-Medicine program.

The selection policies and processes are clear. The interview format will be reviewed in 2014, ten years after it was first designed and instituted. The interview content has been revised most years since implementation. There could be value in more frequent evaluation and review of the selection process, using the available data to link performance at selection with subsequent student performance. It was noted that the profile of students (includes gender balance, ethnicity and academic capability) selected into the program has remained stable over many years.

The Faculty does not specifically prohibit the admission of any student on grounds related to disability. The Faculty plans to develop a policy on the inherent requirements for studying medicine pending the development of guidelines by Medical Deans Australia and New Zealand (MDANZ). Students with disabilities which may affect their ability to study or practise medicine are advised to seek advice from Faculty and University student support units. The Faculty has a Fitness to Practise Policy for current students who may be impaired, for example, as a result of medical or mental illness, or physical disability; and it has an Immunisation and Blood-Borne Viruses Policy that accords with the Guidelines established by MDANZ.

The Faculty's Indigenous Health Statement makes specific recommendations on employment within the Faculty of people of Aboriginal and Torres Strait Islander descent; on development of programs to encourage and support student entry and continuing participation in the undergraduate and postgraduate programs; and on working with scholarship providers and others to provide support. Performance in meeting these objectives is measured annually and the results are detailed in a report by the Associate Dean of Education which is released each December. The commitment to providing a range of supports for Indigenous students (as detailed at Standard 7.1) is reflected in the success of the Faculty in attracting and supporting the current numbers of Indigenous students throughout the program.

Information about the selection process is publicly available through a variety of formats including the UNSW Medicine website, which includes a video, booklets and information evenings. Unsuccessful applicants are informed that they can contact the Faculty office directly and information about how to do this is available on the website.

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.

There is a range of general University student support services, as well as additional support specifically available for medical students, on the main campus site. The information about the general support services is easily accessible on the website and is also in the Program Guide. The additional support specifically available for medical students is a Student Wellbeing Advisor who is a practising clinical psychologist, nominally available for one session per week although the time currently spent in this role considerably exceeds this. The Medical Society has recently established a position of AMSA Welfare Officer to be the first student point of contact for referrals to support services.

Students value highly the additional support for medical students but both students and some members of the Faculty expressed considerable concern about the adequacy of the current system and formally allocated hours. This is due to the large numbers of medical students in the program, the stresses of medical student life including the confronting issues inherent in medical practice, and the dispersed nature of the student population. There are particular risks for international students who may be isolated and with few social supports, with those most at risk being least likely to take advantage of the existing support services.

The current system for providing additional support is heavily reliant on a key staff member and the team views the workload as unsustainable given the volume of requests for support. A more workable method of providing additional support is required. There would be value in actively monitoring the use of available support services to determine the type and level of additional support needed and to identify whether there are common or more general student wellbeing issues that could be addressed in alternative ways.

Any member of staff may identify and find support for students who require health and academic advisory services; and referrals are made to the University Support Services or the Faculty Student Wellbeing Advisor. Tutors or supervisors are not made aware of any health or other problems affecting the student's progress unless the student is registered as impaired or has given consent to disclosure, as student confidentiality is given priority over other considerations.

There is a recognised tension between the need for student privacy and confidentiality and the need to actively monitor and support students who have health issues. The present informal process emphasises the importance of student privacy and of not biasing future assessment of academic performance. The lack of an active formal system where behaviour for at risk students is managed and monitored over time is a risk given that the program has such an emphasis on self-directed learning and that in the larger clinical schools students may have intermittent interactions with staff rather than a

sustained relationship. The team recommends that the Faculty aims to engage both staff and student representatives to develop a comprehensive approach to identifying and providing ongoing support for medical students where there are concerns about potentially recurrent health problems or impairment.

The Faculty provides additional support through the Rural Clinical School to rural students and Indigenous students, working with the Nura Gili Indigenous Programs. There is also a tutoring program for rural students experiencing difficulties and a mentorship program available for Indigenous students. The emphasis on support and encouragement for these students is impressive.

There is separation of student support and academic progression decision-making. The Student Wellbeing Advisor does not make academic progress decisions but does act as an advocate for students.

Recommendation for improvement

Standard 7.3.2: Develop a comprehensive approach to identifying students for whom there are concerns about recurrent health problems or impairment, and implement a plan for ongoing support (links to Standard 5.3.1).

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

There are specific professionalism and fitness to practise policies and procedures: the University Student Code Policy, the Faculty's Fitness to Practise Policy and the NSW Health Code of Conduct. The Faculty systematically monitors plagiarism. The system described in the Faculty Fitness to Practise policy for identifying students who may be impaired or whose behaviour is unprofessional does not operate effectively as information about internal University contact arrangements is out-of-date. The Faculty relies on a passive informal process of notification from academic or administrative staff to identify these students. The Faculty's Fitness to Practise policy was under review at the time of the assessment.

The updating of the Fitness to Practise policy should be expedited and the approach to identifying and supporting students who may be impaired should be reviewed as outlined at Standard 7.3.

Condition

Standard 7.4: Complete the update of the Faculty's Fitness to Practise policy, including review of its approach to identifying and supporting students who may be impaired.

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

There are student representatives on several Faculty committees. There is a very active body of students involved in organising academic initiatives and peer support, as well as a range of special interest groups. There are a number of innovative student-led initiatives (such as the teddy bear hospital program) where students contribute to the broader community as well as specific programs (such as student-organised tutoring and peer mentoring) aimed at providing additional peer support.

The Medical Society receives financial support from the Faculty for its activities. The Medical Society representatives have a great deal of commitment to the program and clearly wish to contribute to the governance system to ensure that the Faculty continues to provide a rich, fulfilling experience for its students. The capacity of the student leaders and their motivation to contribute to the program is impressive. The degree to which the Faculty fosters and values the contribution of the students is also a real strength of the program.

While many students and alumni appreciated the extent to which their feedback on the program was noted and incorporated into ongoing improvements, others appear unaware of this. Giving the main body of students occasional opportunities to interact directly with the executive might help ensure that all students are able to perceive the ways in which the program is being modified to meet identified needs.

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

Students are covered by the University's insurance and indemnity arrangements. The University Personal Accident Insurance provides certain benefits including Non Medicare Medical Expenses if students are accidentally injured while participating in any approved and recognised course or activity including clinical placements and the elective course. Students are advised in the Program Guide of these insurance covers.

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 physical facilities of the Medicine program's main campus and at many of the clinical sites that the team visited are of a high standard.

At the University's Randwick campus, the teaching spaces managed by the Faculty are located primarily in the Wallace Wurth Building and the Samuels Building. After multiple phases of building upgrades with the most recent building program commencing in 2011, the Wallace Wurth Building now has modern and upgraded facilities for lectures, tutorials and personal study. The team viewed the facilities and found them to be impressive.

The Wallace Wurth Building houses two lecture theatres, ten new small-group teaching rooms for use in Phase 1, and two larger connected teaching rooms for groups of up to thirty students. Recent renovations included two large computer laboratories with over 200 computer work stations for histology and pathology, the anatomy museum, three physiology wet laboratories, and two biology and biochemistry laboratories, all with capacity for seventy students. The existing gross anatomy laboratories on the west wing have been retained. The remaining work on the west wing is scheduled for completion in early 2014 and includes an interconnecting clinical skills centre and exercise physiology skills centre that together may be used for supplementary examinations.

The new large-group and small-group teaching spaces are well equipped and during non-tutorial times these are available for personal study. Responses from campus-based teaching staff are favourable, with comments including how the new tutorial and lab-based teaching spaces have contributed to a world-class facility. Technological innovations in the new teaching laboratories and seminar rooms such as virtual microscopy for histology and pathology teaching, and excellent videoconferencing are exciting developments and the Faculty is encouraged to assess the impact of these facilities and technologies in delivering teaching outcomes.

The reconstruction of the Wallace Wurth building will see the completion of work planned for teaching spaces for the Faculty, resulting in all teaching spaces for the program being closely collocated on the upper campus. Medicine program staff on main campus are accessible to students as they are primarily located in the various buildings housing the Faculty's teaching and research spaces as well as the Australian Graduate School of Management building.

The Faculty directly manages most of the teaching space used by the program, and the University allows preferential booking for Medicine for any University facilities that it is required to book. The Faculty's extensive efforts in relocating teaching activities and in contingency planning during this building period are recognised by the team.

The only future capital works to impact on the program is the reconstruction of the Biological Sciences building, and adequate plans are in place to accommodate students

in the new teaching laboratories in 2014 and in lecture theatres in the central lecture block near the main library.

Off-campus metropolitan facilities are primarily based at the four clinical schools (St Vincent's Clinical School, Prince of Wales Clinical School, St George and Sutherland Clinical School, and South Western Sydney Clinical School) and also at two discipline-based schools, being the School of Women's and Children's Health and the School of Psychiatry. Each of these clinical schools may encompass satellite or partner campuses. The Rural Clinical School consists of another four campuses in Coffs Harbour, Port Macquarie, Wagga Wagga and Albury-Wodonga.

A number of these clinical sites have been fortunate to receive Health Workforce Australia funding for simulation and clinical skills facilities, including the Liverpool Hospital, St George Hospital, and the Royal Women's and Sydney Children's Hospitals. In particular, the rural campuses have benefited from significant development with a highlight being the new teaching facilities at the Port Macquarie campus.

Adequate lecture and tutorial facilities were noted at most hospitals. In some locations small-class learning and tutorial facilities have been a limited resource. Positive steps have been made to address this including the acquisition of a university-funded demountable building at Sutherland Hospital, and the sharing of tutorial and lecture facilities across the Sydney Children's and Royal Women's Hospitals. The team was pleased to learn that plans are in place to further develop a Research and Education Precinct at the Randwick campus, and equitable access to these facilities for students throughout the clinical sites on this campus is strongly encouraged.

High quality videoconferencing facilities are also increasingly available throughout teaching sites and are helping to inform and develop shared teaching resources for all students, and improve access and consistency of teaching.

Overnight facilities are lacking at a number of clinical sites and this represents a policy decision that students are intended to be on-duty during overnight clinical attachments. Twenty-four hour access is generally available to common rooms and staff areas. Nevertheless the team recognises that students attending overnight emergency department or maternity sessions may reasonably request access to a quiet area for rest and recovery prior to returning home.

Students are rotated to General Practice Community Placements in Phase 3 and one of these sites was inspected by the team. This was an excellent facility with enthusiastic and highly engaged staff. Some university funds were available to improve teaching facilities and these had been put to good use. The team commends the Faculty on selecting and supporting high-quality community-based teaching environments for General Practice 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 University library provides a comprehensive range of scientific and medical journals and textbooks on campus and is close to medical student buildings on the upper main campus. Online access is available to a wide variety of full-text journals and archives, literature search facilities and compiled medical databases and textbooks, in line with offerings from other top tier universities.

Off-campus students have electronic access to University library facilities and most clinical sites have a hospital library with workstation and personal study areas, and a range of reference materials. Wireless networking hotspots are not universally available and for security reasons students do not have access to NSW Health wireless networks. Deployment of wireless networking hotspots within clinical school tutorial and study areas may assist students who increasingly wish to bring their own personal or mobile networked devices (i.e. personal computers or smartphones) into the clinical school or study areas.

EMed is critical to the delivery of the Medicine program, curriculum organisation, and provision of curriculum, teaching and learning materials. Any future change to IT infrastructure or services within the University or program requires careful and well-resourced transition and integration processes.

The Faculty provides course materials and library resources to teaching staff, including those off-campus and those on small-fractional, casual and conjoint appointments. This is an integral part of maintaining staff engagement and communicating content standards throughout the clinical learning phases.

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

Clinical learning placements are spread over six clinical and discipline-based schools and twenty campus locations. There are numerous community and general practice placements where individual or small-group learning occurs. There is a diverse range of

learning environments that is generally more than adequate for the intended outcomes of the program, and for preparing students for basic clinical practice.

The number of students allocated to each school by course in 2013 is summarised in the table below. The data for the Rural Clinical School are combined, though the proportions of students allocated to its four campuses are comparable.

<table>
<tr><th></th><th>SVCS</th><th>POWCS</th><th>SGSCS</th><th>SWSCS</th><th>RCS</th><th>SWCH</th><th>Psych</th></tr>
<tr><td>Phase 1[a]</td><td>140</td><td>140</td><td>140</td><td>140</td><td></td><td>280</td><td></td></tr>
<tr><td>Phase 2[b]</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
<tr><td>Adult Health 1</td><td rowspan="4">51</td><td rowspan="4">54</td><td rowspan="4">102</td><td rowspan="4">34</td><td rowspan="5">53</td><td></td><td rowspan="5"></td></tr>
<tr><td>Adult Health 2</td><td></td></tr>
<tr><td>Oncology</td><td></td></tr>
<tr><td>Aged Care</td><td></td></tr>
<tr><td>Beginnings, Growth and Development (BGD)</td><td></td><td></td><td></td><td></td><td>271</td></tr>
<tr><td colspan="8">Phase 3[c]</td></tr>
<tr><td>Medicine</td><td rowspan="2">41</td><td rowspan="2">44</td><td rowspan="2">66</td><td rowspan="2">65</td><td rowspan="8">133[d]</td><td></td><td></td></tr>
<tr><td>Surgery</td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="3"></td><td rowspan="2"></td><td>216</td></tr>
<tr><td>Psychiatry</td><td>216</td><td rowspan="3"></td></tr>
<tr><td>Paediatrics</td><td>216</td></tr>
<tr><td>Obstetrics & Gynaecology (O&G)</td><td rowspan="3">41</td><td rowspan="3">48</td><td rowspan="3">67</td><td rowspan="3">59</td><td rowspan="3"></td></tr>
<tr><td>Emergency</td></tr>
<tr><td>Selective</td><td></td></tr>
<tr><td>PRINT</td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
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a Represents the total number of students attending clinical tutorials. All second year students attend 3 tutorials during BGD.

b The number of students per course for each metropolitan site is ¼ of the allocated students. The number of students completing BGD at the SWCH is ¼ of the total cohort in Sydney.

c The number of students per course for each metropolitan site is ¼ of the allocated students except PRINT which is completed by all students in the final teaching period in Year 6. The number of students completing Paediatrics, O&G and Psychiatry in any one teaching period in Sydney is on average $^1/_5$ of the total cohort.

d The number of students allocated to the RCS in Phase 3 represents both years. On average the number of students completing any one course in any one teaching is approximately $^1/_8$ (noting that the Elective is completed elsewhere and all students complete PRINT at the same time). The number per campus is ¼ of this figure.

SVCS	St Vincent's Clinical School	SWSCS	South Western Sydney Clinical School
POWCS	Prince of Wales Clinical School	SWCH	School of Women's and Children's Health
SGSCS	St George and Sutherland Clinical School	Psych	School of Psychiatry
RCS	Rural Clinical School		

The Faculty has increased its clinical capacity from 2008 to cope with increased student numbers moving through the program, by way of increased students at South Western Sydney Clinical School, merging Sutherland Clinical School with St George, and increasing capacity with four private hospitals. As the cohort size has now reached a steady-state the program has sufficient clinical teaching facilities to meet student needs.

The Faculty advised that metropolitan clinical schools have all indicated that there is still capacity to increase student numbers in their hospitals for Medicine and Surgery placements. Paediatric placements are a challenge given the limited capacity within NSW for all medical schools. The program currently has the required paediatric capacity given the Faculty's strong relationship with the Sydney Children's Hospital and paediatric services at other sites, despite loss of placements in Wollongong and Campbelltown. Placements in Obstetrics and Gynaecology and Psychiatry are also currently manageable but both these disciplines have little unused capacity. The team notes the Faculty's proactive solutions to secure adequate ongoing clinical placements in General Practice, given increased clinical placement demand across the greater Sydney region. The Rural Clinical School is also proactive in identifying new facilities, and opened the Griffith Base Hospital as a training site in 2013 for Phase 2 students.

The delivery of consistent clinical teaching across all disciplines in such a geographically dispersed environment is challenging. At present students are able to access a range of different clinical training placements so that they have opportunities to ensure any perceived deficiencies in clinical skills can be addressed prior to conclusion of their training. There may be value in instituting a more active approach to reviewing key aspects of student clinical experience across sites to ensure that any deficiencies can be rectified before outcomes are affected.

Student allocation to clinical placements is performed centrally by the Medicine Education and Student Office at the start of Phases 2 and 3. Some students expressed dissatisfaction with the allocation. The Faculty's Clinical Allocation Policy is available in the Program Guide and on the website and students are made aware of it prior to commencement. A computer-based ballot preference is used and if a site is over-subscribed, random selection of students occurs. Students may appeal their allocation mainly for health reasons. Further collaboration between clinical schools to share teaching innovations may improve any real or perceived inequity amongst students, and providing more information to students about Clinical School placements may lead to more informed allocation preferencing.

Rural schools appear to be well-resourced with good access to clinical teachers and supervisors. The performance of rural students at assessments is extremely encouraging, but students have raised concerns about inadequate accommodation support whilst returning to the main campus for biomedical sciences practical sessions (as noted at Standard 3). Otherwise the degree of engagement of students in the rural community setting is commendable, and there is extensive academic support for students in this environment.

The team noted the concerns of international students who wished to do a rural placement and encourages the Faculty to ensure that international students have the opportunity for a rural experience given that internships for international graduates are offered in rural settings.

The Faculty has engaged with Indigenous health services, rural hospitals and community practices to provide broad exposure to cultural variations. Students in the city clinical schools also meet a large population of Sydney-based or referred Indigenous patients and are taught that any patient could be an Aboriginal or Torres Strait Islander. Vertical integration of aspects of Indigenous health care, cultural awareness, and ethical and respectful behaviour extends throughout the program and

the collaboration with the Rural Clinical School and Muru Marri Indigenous Health Unit is admirable.

At some clinical sites the program is collocated with the University of Western Sydney Medical School, the University of Notre Dame Australia School of Medicine Sydney and to a lesser extent, the University of Wollongong. The team was pleased to hear from the medical deans of these schools that their school's relationships with the Faculty are sound and effective. Collaborative engagement has ensured adequate clinical capacity for students

The team commends the Faculty on the exemplary collaboration with the University of Western Sydney and the South Western Sydney Local Health District at South Western Sydney Clinical School that highlights the potential benefits to all of a shared training site. For example, the associate deans of each clinical school work closely together on the hospital board, there is a joint Clinical Teaching Committee, student allocations for both Universities operate under one system, the recruitment of academic teaching staff is in collaboration, and the students value the contact with both universities.

South Western Sydney's substantial and projected growth in patient numbers allows excellent student access to a wide mix of acute patients. Liaison between other medical schools will be an ongoing process to ensure equitable training opportunities at collocated sites where high student numbers can lead to competition for access to patients and conjoint teaching staff.

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

Clinical supervision requirements vary depending on the phase. In Phase 1, students attend bedside tutorials under supervision of a clinical tutor. In Phase 2, students are expected to see patients independently though they are not involved in patient care and bedside clinical skills tutorials are supervised by a clinical tutor. In Phase 3, a senior clinician is designated as supervisor.

The team found there to be an adequate number of supervisors available but that at some clinical sites students feel insufficiently supported due to reduced engagement of clinical staff. The Faculty noted that some students may feel unsure who is responsible for them due to delegation to junior medical staff. In smaller sites students generally have a closer working and learning relationship with clinical school staff and hospital clinicians.

Mentoring relationships within several clinical schools appear highly effective in promoting student wellbeing, effective learning and professional identity, and the Faculty should consider this model for full implementation throughout the program.

The Faculty has 2,199 conjoint staff, as detailed at Standard 1.8. Conjoint staff at all sites value the support the Faculty provides by way of orientation packages, training workshops and ongoing education and faculty participation opportunities. Nevertheless uptake of training is variable.

The team observed that the program's conjoints identify with their respective clinical school and with the Medicine program, and value the recognition afforded by the Faculty and clinical schools such as library access, invitations to social events and the Faculty's 2011 Conjoint magazine for example[4]. Conjoint staff also commented favourably on opportunities to be an Independent Learning Project supervisor.

The team recognises that conjoint staff generally volunteer their time and that any contracted teaching allocation time may well be shared amongst multiple university, postgraduate hospital, and specialist vocational training roles. Clinical teaching staff are universally enthusiastic and passionate about their roles and long-term, conjoint staff retention, strategic recruitment and orientation to changes in the curriculum will be an ongoing role of the Faculty.

Some clinical schools have excellent quality review and feedback mechanisms with regular teaching staff meetings and meetings with Faculty, although feedback to, and performance review mechanisms for clinical teachers is inconsistent across sites. Campus-based and non-conjoint teachers generally received prompt 'Course and Teaching Evaluation and Improvement' based feedback on tutorials and lectures as part of performance review mechanisms. Peer-review arrangements are available and have been used by some teaching staff. Feedback for hospital-based clinical tutors is variable and is obtained from students when requested by the tutor.

The team found the general level of engagement and enthusiasm of hospital executive staff with the Faculty to be extremely encouraging. The degree of commitment to fractional allocation of research and teaching time is not uniform, and service delivery requirements continue to challenge the ability of clinical staff to conduct teaching. There may be scope for further advocacy for teaching activities to be quarantined from service delivery requirements.

Overall, the team was impressed with the enthusiasm and commitment of clinical supervisors across all clinical sites who teach, mentor and care for their students.

[4] http://med.unsw.edu.au/sites/default/files/_local_upload/others/Conjoint_Med-2011.pdf

Appendix One Membership of the 2013 Assessment Team

Professor Ian Puddey (Chair) MBBS, MD, FRACP
Dean, Faculty of Medicine, Dentistry and Health Sciences, The University of Western Australia

Professor John Finlay-Jones (Deputy Chair) BSc PhD
Deputy Vice-Chancellor (Research), Edith Cowan University

Dr Heather Buchan MBChB, MSc, FAFPHM
Director, Implementation Support, Australian Commission on Safety and Quality in Health Care

Dr Jason Chuen MBBS, PGDipSurgAnat, FRACS (Vasc)
Department of Surgery, University of Melbourne; Vascular Surgeon, Austin Hospital

Professor Geraldine MacCarrick BMedSc(Hons), MBBS, MPH, MBA, DTM, PhD FRACMA, FRAGGP
The Royal Australasian College of Medical Administrators, Research Training Program Fellow

Professor Lambert Schuwirth MD, PhD
Professor of Medical Education, Flinders Innovations in Clinical Education, School of Medicine, Flinders University

Ms Stephanie Tozer
Manager, Medical School Assessments, Australian Medical Council

Ms Fiona van der Weide
Accreditation Administrator, Australian Medical Council

Appendix Two Groups met by the 2013 Assessment Team

Senior Leadership

Acting Vice Chancellor, DVC Research
Dean
Senior Associate Dean
Associate Dean Education
Medical Program Authority
Faculty General Manager

Medical Faculty Staff

Associate Professor, Pathology, School of Medical Sciences
Associate Professor, School of Public Health & Community Medicine
Associate Professor, St George & Sutherland Clinical School
Learning Resources Manager
Lecturer, Rural Clinical School (Griffith Campus)
Professor and Head of Prince of Wales Clinical School
Professor and Head of St George & Sutherland Clinical School
Professor and Head of the Rural Clinical School
Professor and Head of the School of Medical Sciences
Professor and Head of the School of Psychiatry
Professor, Australia Institute of Health Innovation
Professor, Centre for Primary Health Care & Equity
Professor, Medicine Education & Student Office
Professor, Microbiology, School of Biotechnology & Bimolecular Sciences
Professor, O&G, School of Women's & Children's Health
Professor, Office of the Dean – Associate Dean Research
Professor, Office of the Dean – Associate Dean Strategy & External Relations
Professor, Office of the Dean – Senior Associate Dean
Professor, Paediatrics, School of Women & Children's Health
Professor, Pathology, School of Medical Sciences
Professor, Physiology and Pharmacology, School of Medical Sciences
Professor, School of Psychiatry
Professor, School of Public Health and Community Medicine
Professor, the Kirby Institute
Recent UNSW Graduates
Senior Lecturer, Anatomy, School of Medical Sciences
Senior Lecturer, Prince of Wales Clinical School
Senior Lecturer, Rural Clinical School, (Albury campus)
Senior Lecturer, Rural Clinical School, (Coffs Harbour campus)

Senior Lecturer, Rural Clinical School, (Wagga Wagga campus)
Senior Lecturer, Rural Clinical School, (Port Macquarie campus)

Medical Students

MedSOC President-Elect
MedSOC Vice-President
MedSOC Faculty Liaison Officer
Students representing different subgroups – domestic, rural, international and Indigenous
Students from clinical schools

Medical Faculty Committees

Admissions and Re-Enrolment Committee
Assessment Working Group
Campus-based Teachers
Clinical Practice Domain
Curriculum Development Committee
Evaluation and Improvement Group
Executive Team
Health and Society Domain
Independent Learning Project/Honours Committee
Indigenous Health
Phase 1 Committee
Phase 2 Committee
Phase 3 Committee
Professional Development
Professionalism and Leadership Domain
Rural Clinical School Representatives
Scenario Group Facilitators Meeting
Science and Scholarship Domain
Student Support
Technology Enabled Learning and Teaching

Stakeholders

Dean of Medicine, University of Notre Dame Australia, School of Medicine Sydney
Dean of Medicine, Wollongong University
Dean of Medicine, University of Western Sydney
New South Wales Ministry of Health - Director

Clinical Sites

Burraneer Family Practice

Practice Principal

Practice Manager

Port Macquarie Campus Rural Clinical School

Head of Rural Clinical Schools
Clinical School Staff
Administrative Staff
Hospital Executive

Prince of Wales Clinical School

Clinical School Staff
Hospital Executive Staff
Clinical Teachers and Supervisors

School of Psychiatry

School Staff
Clinical Teachers and Supervisors

Sydney Children's Hospital

Clinical School Staff
Hospital Executive Staff
Clinical Teachers and Supervisors

Royal Hospital for Women

Clinical School Staff
Hospital Executive Staff
Clinical Teachers and Supervisors

South Western Sydney Clinical School

Clinical School Staff
Teaching and Learning Support Coordinator
Hospital Executive Staff
Clinical Teachers and Supervisors

St George & Sutherland Clinical School

Director of Undergraduate Teaching
School Manager and Administrative staff
Clinical Teachers and Supervisors
Hospital Executive

St Vincent's Clinical School

Clinical School Staff
Hospital Executive
Clinical Teachers and Supervisors
St Vincent's Private Hospital Staff