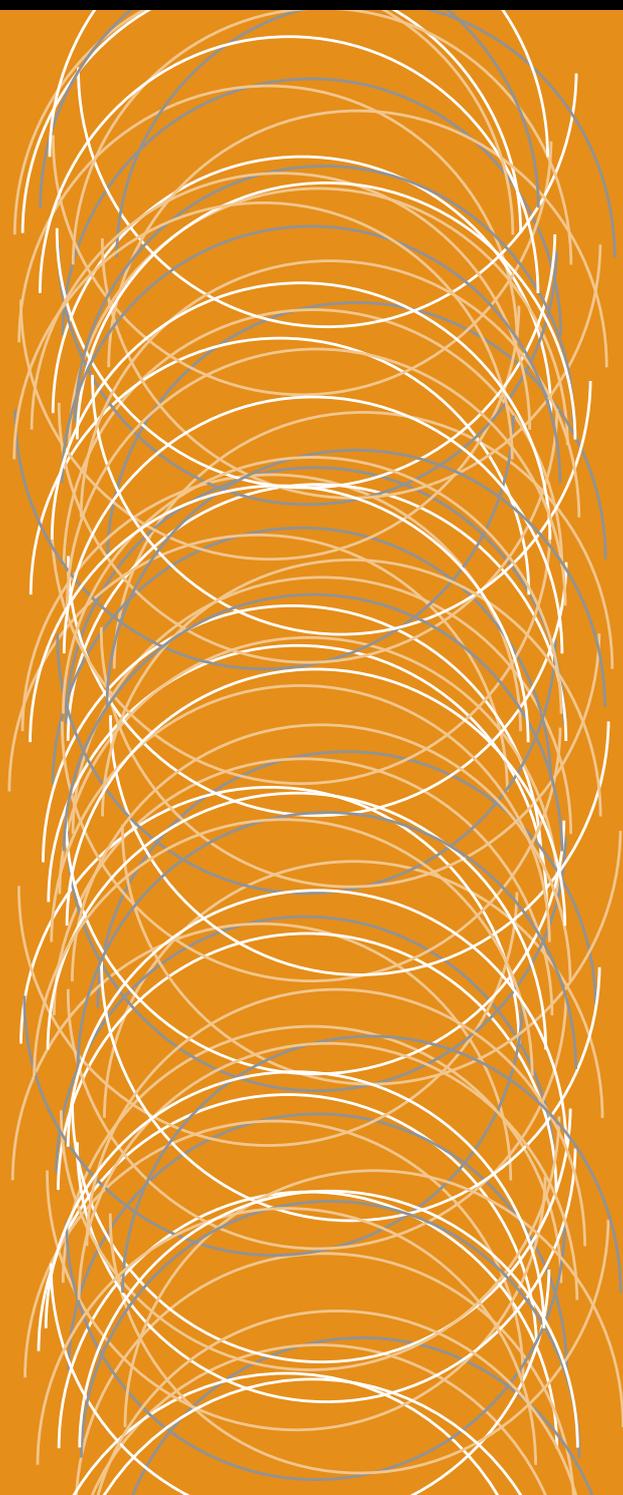


Australian Medical Council Limited

Accreditation of
University of Queensland
School of Medicine

AMC



Medical School Accreditation Committee
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Executive summary 2014

In 2014, the AMC conducted a follow-up assessment of the University of Queensland, School of Medicine's medical program. This follow-up assessment was a condition on the School's accreditation following the AMC's 2010 major change assessment of the program. The AMC's *Procedures for assessment and accreditation of medical schools by the Australian Medical Council 2011* describe the procedures regarding assessment of major change in an accredited program. This accreditation report includes both the 2010 and the 2014 assessment findings.

2010 major change assessment

In 2008/9 the School sought approval to make changes to its program that included a proposal to admit up to 120 fee-paying students per year from the United States (US citizens or permanent residents) who would complete the first two years of the program at the University's Brisbane campuses, and then undertake the majority of their Years 3 and 4 clinical training through the School's Ochsner Clinical School, established through the Ochsner Health System, in New Orleans. This represented a fifty per cent increase in student intake since the last AMC program assessment in 2005. The School also planned to deliver the first two years of the program at the University's Ipswich campus.

The AMC's *Assessment and Accreditation of Medical Schools: Standards and Procedures* required the Medical School Accreditation Committee to decide whether the major change could be approved within the current accreditation or were of comprehensive impact and required reaccreditation of the whole program.

The AMC policy statement *Medical Courses Conducted Offshore by Australian and/or New Zealand Universities* sets out additional criteria that apply when the AMC considers a proposal to deliver an accredited program offshore. The program should be offered by an AMC accredited medical school, where the Australian/New Zealand university has developed the program and has responsibility for overseeing the academic standards. The resulting award should be a recognised higher education qualification of the university; the program should be essentially the same in terms of educational objectives, curriculum framework, educational process and assessment outcomes; and it should include adequate experience within the Australian/New Zealand health care system.

The AMC Directors accepted the School's submission as a proposal for a major change to the University of Queensland's accredited medical program, and invited the School to proceed to full assessment of the plans by an AMC team. In 2010, the AMC conducted a major change assessment, visiting three campuses and all ten clinical schools, including Ochsner (Louisiana), Brunei, and the Rural Clinical School.

In November 2010 the AMC Directors decided that the Bachelor of Medicine / Bachelor of Surgery (MBBS) program of the School of Medicine, University of Queensland met the approved accreditation standards and approved the major changes. The AMC granted the School accreditation until 31 December 2016 subject to the submission of satisfactory progress reports, reports on a range of conditions at Standards 1, 3, 5, 7 and 8, and a follow-up assessment in 2014 to review the School's progress in implementation of the major changes, and any changes that may follow from the School's internal 2009 MBBS review.

In 2011, 2012 and 2013 the School submitted progress reports which the AMC considered to be satisfactory.

Introduction of the Doctor of Medicine

In 2012, the School notified the AMC of its proposal to introduce a Doctor of Medicine (MD) in place of its MBBS from 2015. Having considered the proposal and received additional information from the School the AMC decided this did not represent a major change to the accredited program though considered that assessment of the MD implementation plans should be part of the 2014 AMC follow-up assessment of the program.

In this report, the term medical program, or program, refers to the School's two programs unless noted otherwise: the School's four-year direct graduate entry MBBS program and the four-year Doctor of Medicine (MD) program. The School will introduce the MD program in 2015 with a parallel teach-out phase of the MBBS program. Existing MBBS students will not be permitted to transfer to the MD program.

The AMC applies one set of accreditation standards for programs of study that lead to professional registration. It recognises 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.

2014 follow-up assessment

The 2010 AMC accreditation decision required the 2014 assessment to include a review of the School's progress in implementation of the major changes and the School's 2009 internal review. Since the 2010 major change assessment, AMC monitoring has observed incremental changes in the program, and found that a number of accreditation conditions at Standard 5 Assessment have not yet been met. In 2013, the Medical School Accreditation Committee agreed the scope should also include review of governance (including restructures and the change in head of school); and the curriculum change to the MD program and assessment of implementation plans.

The 2014 team reviewed the School's follow-up accreditation submission and the medical student society's submission, and visited the School and associated clinical teaching sites in the weeks of 4 – 6 June 2014 (Ochsner Clinical School, Louisiana) and 15 – 20 June 2014 (Queensland). This report presents the team's findings against the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012*.

Decision on accreditation: 2014

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.

The accreditation decision that can be made by the AMC as a result of this assessment is:

- (i) confirm the accreditation decision made in 2010, being the maximum six-year period of accreditation to 31 March 2017¹, subject to satisfactory progress reports
- (ii) if the approved accreditation standards are substantially met, set conditions to ensure the standards are met in a reasonable timeframe
- (iii) revoke the accreditation if the approved accreditation standards are not met.

The AMC is reasonably satisfied that the medical programs of the University of Queensland, School of Medicine meet the approved accreditation standards.

The 20 October 2014 meeting of the AMC Directors agreed:

- (i) That accreditation of the following medical programs of the University of Queensland, School of Medicine be confirmed to 31 March 2017, being the maximum six-year period of accreditation, subject to satisfactory progress reports:
 - o Bachelor of Medicine/Bachelor of Surgery - four-year degree (final cohort enrolled 2014)
 - o Doctor of Medicine - four-year degree (for cohorts commencing from 2015)
- (ii) That accreditation is subject to the following conditions:

2014 condition

By 28 November 2014, evidence that the School has addressed the following condition from the accreditation report:

- Finalise the MD Year 1 content by November 2014 (Standard 3.2).

2015 conditions

In the 2015 progress report, evidence that the School has addressed the following conditions from the accreditation report:

- Ensure adequate medical education expertise to support the program in the areas of educational design, e-learning, assessment and evaluation (Standard 1.4).
- Demonstrate the School has the ongoing financial resources and capacity to sustain the program (Standard 1.5).
- Finalise the MD Year 2 content (Standard 3.2).

¹ The 2010 accreditation granted the program accreditation until 31 December 2016, however from 2014 at the time of an accreditation decision, AMC accreditation end dates will change from 31 December to 31 March (the following year).

- Complete the MD course structure, including the mapping of Phase 2 to the Graduate Outcome Statements, for the full MD program (Standard 3.2).
- Develop a curriculum strategy for interprofessional learning activities across all sites, to ensure all students have the opportunity to work with, and learn from and about, other health professionals (Standard 4.7).
- Produce a formal blueprint for each year or phase of the program to systematically guide assessment (Standard 5.2).
- Implement processes to ensure separation of student support from assessment and progression decision making (Standard 7.3.4).
- Develop a School of Medicine Fitness to Practise policy specifically for medical students; and ensure adequate communication of this policy to clinical teachers and staff, to ensure effective identification and support of students who may be impaired (Standard 7.4).
- Demonstrate the School has the capacity to manage the full 2016 Year 1 cohort on main campus / Brisbane sites, including details regarding lecture, problem-based learning, lab, clinical skills and clinical coaching delivery, and availability of academic and clinical teaching staff (Standard 8.1).
- Given the transfer of the Ipswich campus from UQ to the University of Southern Queensland, confirm arrangements for student and staff access to physical facilities, including teaching space allocation, from 2015 until the end of 2016 (Standard 8.1).
- Given the withdrawal from Sunshine Coast Clinical School in 2015, confirm plans to accommodate these students at other clinical schools (Standard 8.3).

2016 conditions

In the 2016 progress report, evidence that the School has addressed the following conditions from the accreditation report:

- Given the School's projected budget deficit to 2016, demonstrate the School has the ongoing financial resources and capacity to sustain the program (Standard 1.5).
- Demonstrate the 2016 Year 1 students have adequate access to teaching and learning sites to achieve the outcomes of the program, including details regarding lecture, problem-based learning, lab, clinical skills and clinical coaching delivery, and availability of academic and clinical teaching staff (Standard 8.1).

Key findings of the AMC's 2014 accreditation of the University of Queensland, School of Medicine

1. The context of the medical program	SUBSTANTIALLY MET
--	--------------------------

Standard 1.4 and 1.5 are substantially met.

2015 conditions

Ensure adequate medical education expertise to support the program in the areas of educational design, e-learning, assessment and evaluation (Standard 1.4).

Demonstrate the School has the ongoing financial resources and capacity to sustain the program (Standard 1.5).

2016 condition

Given the School's projected budget deficit to 2016, demonstrate the School has the ongoing financial resources and capacity to sustain the program (Standard 1.5).

2015 recommendation for improvement

Develop a succession management plan for key academic staff including curriculum leads, discipline and clinical school heads, and medical education experts (Standard 1.8).

2. The outcomes of the medical program	MET
---	------------

Commendations

The thorough and inclusive process by which the School has developed its new vision, purpose and core values (Standard 2.1).

The regular communication between the Ochsner staff and the School, that has contributed to comparable outcomes despite the geographic distance and differences in health-systems (Standard 2.2).

3. The medical curriculum	SUBSTANTIALLY MET
----------------------------------	--------------------------

Standard 3.2 is substantially met.

2014 condition

Finalise the MD Year 1 content by November 2014 (Standard 3.2).

2015 condition

Finalise the MD Year 2 content (Standard 3.2).

Complete the MD course structure, including the mapping of Phase 2 to the Graduate Outcome Statements, for the full MD program (Standard 3.2).

2015 recommendations for improvement

Develop a resourced plan to produce and implement the Adult Online Interactive Education (AOLIE) modules, to further integrate Phase 1 topics into Phase 2 (Standard 3.3).

Implement a mechanism to track students' competence in the required procedural and clinical skills (Standards 3.3 and 5.2).

Strengthen and further integrate the Indigenous health curriculum in the program (Standard 3.5).

4. Teaching and learning	MET
---------------------------------	------------

Standard 4.7 is substantially met.

2015 condition

Develop a curriculum strategy for interprofessional learning activities across all sites, to ensure all students have the opportunity to work with, and learn from and about, other health professionals (Standard 4.7).

Commendations

The transformed anatomy program has a focus on foundation knowledge, clinical context and safe practice, and is achieving high student satisfaction levels (Standard 4.1).

The development of a unified on-line curriculum for paediatrics, known as the Paediatric Online Learning Interactive Environment (POLIE) (Standard 4.1).

The high-quality student experience at Ochsner, which includes mentoring, one-on-one supervision, and students' increasing responsibility as a member of the healthcare team (Standard 4.4).

The Urban Longitudinal Integrated Community Care Project, an example of patient centred care and collaborative engagement (Standard 4.6).

5. The curriculum - assessment of student learning	MET
---	------------

Standard 5.2 is substantially met.

2015 condition

Produce a formal blueprint for each year or phase of the program to systematically guide assessment (Standard 5.2).

Commendations

The substantial progress in the area of assessment, the adoption of many recommendations of the Prideaux report, and the progress made in standardising assessment across the School's many clinical sites (Standards 5.1 and 5.2).

The assessment feedback method to students provided in Phase 1, where whole-of-class groups review recently completed exams, providing opportunity for students to consider their performance proximate to undertaking the assessment (Standard 5.3).

2015 recommendations for improvement

Monitor standard setting for multiple choice questions in Phase 2 to ensure the method is routinely and appropriately applied (Standard 5.2).

Minimise inter-rater variation in assessment outcomes through ongoing staff development and training (Standard 5.2).

Further develop methods for individualised student feedback from assessment (Standard 5.3).

6. The curriculum – monitoring	MET
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Commendations

The School's demonstrated willingness to seek and act upon student feedback (Standard 6.1).

The School's statistical analyses of the large cohort, and its close attention to Ochsner cohort outcomes (Standard 6.2).

2015 recommendation for improvement

Consider extending the more formal clinical teacher feedback process piloted in paediatrics and child health to other disciplines (Standard 6.1).

2016 reporting item

In 2016, report on evaluation of the 2015 MD cohort performance in Phase 1, including evaluation of any effect from curriculum change in the basic sciences (Standard 6.1).

7. Implementing the curriculum – students	MET
--	------------

Standard 7.3 and 7.4 are substantially met.

2015 conditions

Implement processes to ensure separation of student support from assessment and progression decision making (Standard 7.3.4).

Develop a School of Medicine Fitness to Practise policy specifically for medical students; and ensure adequate communication of this policy to clinical teachers and staff, to ensure effective identification and support of students who may be impaired (Standard 7.4).

Commendation

The efforts of the School in demonstrating its capacity to deliver a consistent teaching program to a significantly increased number of students (Standard 7.1).

8. Implementing the curriculum- learning environment	MET
---	------------

Standard 8.1 and 8.3 are substantially met.

2015 conditions

Demonstrate the School has the capacity to manage the full 2016 Year 1 cohort on main campus / Brisbane sites, including details regarding lecture, problem-based learning, lab, clinical skills and clinical coaching delivery, and availability of academic and clinical teaching staff (Standard 8.1).

Given the transfer of the Ipswich campus from UQ to the University of Southern Queensland, confirm arrangements for student and staff access to physical facilities, including teaching space allocation, from 2015 until the end of 2016 (Standard 8.1).

Given the withdrawal from Sunshine Coast Clinical School in 2015, confirm plans to accommodate these students at other clinical schools (Standard 8.3).

2016 conditions

Demonstrate the 2016 Year 1 students have adequate access to teaching and learning sites to achieve the outcomes of the program, including details regarding lecture, problem-based learning, lab, clinical skills and clinical coaching delivery, and availability of academic and clinical teaching staff (Standard 8.1).

Commendations

The physical facilities for students across all sites, in particular at the Ipswich campus, the Health Sciences building at Herston, teaching spaces at Greenslopes and Ochsner Clinical Schools and the Translational Research Institute (Standard 8.1).

The impressive clinical learning facilities at Ochsner Clinical School and Ochsner Health (Standard 8.3).

2015 reporting item

In addition to the 2015 conditions, demonstrate capacity to accommodate students in Phases 1 and 2 by reporting on current and projected student placement data for each course or rotation and every location (campus or clinical school) (Standards 8.1 and 8.3).

Report on the outstanding conditions

The following tables list the outstanding conditions and recommendations for improvement arising from the 2010 accreditation report. All conditions are now satisfied and closed. The recommendations for improvement which are progressing are included for reporting in the Key Findings Table of the 2014 accreditation report.

Standard 1 The context of the medical program

Standards cover: governance, leadership and autonomy, medical program management, educational expertise, educational budget and resource allocation, interaction with health sector and society, research and scholarship, staff resources and staff appointment, promotion and development.

By September 2014				
<ul style="list-style-type: none"> Evidence when the School has expanded to planned size and all clinical schools are operating at full capacity, the governance structure remains robust and appropriate (1.1). 				
2014 rating	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X
Team commentary				
This is satisfied and closed based on the findings in the report at Standard 1.1.				

Standard 5 The curriculum – assessment of student learning

Standards cover: assessment approach, assessment methods, assessment feedback and assessment quality.

Outstanding accreditation condition:				
<ul style="list-style-type: none"> Evidence the School has appropriate control over assessment in Years 1 and 2 to ensure integration of assessment and alignment of the assessment with learning objectives (5.1 and 5.2). 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
This condition was progressing (July 2013).				
This is satisfied and closed.				

Outstanding accreditation condition:				
<ul style="list-style-type: none"> Evidence the School has appropriate control over assessment in Years 3 and 4 to address the wide variation in the content and standards of assessment and their alignment to learning objectives (5.1 and 5.2). 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
<p>This condition was progressing (July 2013).</p> <p>This is satisfied and closed.</p>				

Outstanding accreditation condition:				
<ul style="list-style-type: none"> Evidence of an appropriate mechanism to ensure students' competence in critical specific procedural/ clinical skills in Years 3 and 4 (5.2). 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
<p>This condition was progressing (July 2013).</p> <p>This condition is satisfied. Based on the findings in the report, this has been modified as a 2015 recommendation for improvement, as stated in the Key Findings Table:</p> <ul style="list-style-type: none"> Implement a mechanism to track students' competence in the required procedural and clinical skills (3.3 and 5.2). 				

Outstanding accreditation condition:				
<ul style="list-style-type: none"> Evidence the School has reviewed its standard setting methods for Years 3 and 4 to address concerns about variability between Multi-Station Assessment Task stations; standard-setting for the multiple-choice question components in Years 3 and 4; quality assurance and training of examiners; and standardisation of the application of the seven-point Standards Reference Grading (5.4). 				
2014 rating	Unsatisfactory	Not Progressing	Progressing	Satisfied
				X

Team commentary
<p>This condition was progressing (July 2013)</p> <p>This condition is satisfied. Based on the findings in the report, this has been modified as a 2015 recommendation for improvement, as stated in the key findings table:</p> <ul style="list-style-type: none"> Monitor standard setting for multiple choice questions in Phase 2 to ensure the method is routinely and appropriately applied (5.2).

Outstanding accreditation condition:				
<ul style="list-style-type: none"> Evidence of mechanisms to review comparability of assessments across the ten clinical schools particularly to address inter-rater reliability of preceptor/consultant assessments (5.4). 				
Rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
<p>This condition was progressing (July 2013).</p> <p>This condition is satisfied. Based on the findings in the report, this has been modified as a 2015 recommendation for improvement, as stated in the Key Findings Table:</p> <ul style="list-style-type: none"> Minimise inter-rater variation in assessment outcomes through ongoing staff development and training (5.2). 				

Standard 7 Implementing the curriculum - students

Standards cover: student intake, admission policy and selection, student support, professionalism and fitness to practise, student representation and student indemnification and insurance.

By September 2014				
<ul style="list-style-type: none"> Evidence the School is monitoring the implications of the increased student load, and has measures to accommodate the resourcing of the various teaching sites to meet the needs of such a large student cohort, including facilities and teaching resources for nearly 550 students in each of Years 1 and 2 (7.1). 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
This is satisfied and closed based on the findings in the report at Standard 7.1.				

Report on the outstanding recommendations for improvement

Standard 1 The context of the medical program

Standards cover: governance, leadership and autonomy, medical program management, educational expertise, educational budget and resource allocation, interaction with health sector and society, research and scholarship, staff resources and staff appointment, promotion and development.

Outstanding recommendations for improvement				
<ul style="list-style-type: none"> Comment on the role for clinical school heads in the development of their local expenditure budget. 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
This is satisfied and closed.				

Outstanding recommendations for improvement				
<ul style="list-style-type: none"> Provide an update on the School's relationship with Queensland Health at the executive level. 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
This is satisfied and closed.				

Standard 3 The medical curriculum

Standards cover: duration of the medical program, the content of the curriculum, curriculum design, curriculum description, Indigenous health and opportunities for choice to promote breadth and diversity.

Outstanding recommendations for improvement				
<ul style="list-style-type: none"> Provide any updates on the levels of integration across and within the MBBS program. Reporting should also address any changes arising from work on the proposed renewal of the curriculum for the MD program. 				

2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
			X	
Team commentary				
<p>This is progressing, however as a revised recommendation for improvement for reporting in 2015, as stated in the Key Findings Table:</p> <p><i>2015 recommendation for improvement</i></p> <ul style="list-style-type: none"> o Develop a resourced plan to produce and implement the Adult Online Interactive Education (AOLIE) modules, to further integrate Phase 1 topics into Phase 2 (3.3). 				

Standard 4 Learning and teaching

New request for information				
<ul style="list-style-type: none"> • The organisational structure of the School of Biomedical Sciences is under review by the University and the outcomes of the review should be reported in the School's 2014 report (NB. This could be reported at Standard 1). 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
This is satisfied and closed.				

Outstanding recommendations for improvement				
<ul style="list-style-type: none"> • Provide an update on initiatives to improve the teaching of basic sciences for the benefit of students. 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
This is satisfied and closed.				

Outstanding recommendations for improvement				
<ul style="list-style-type: none"> Provide outcomes on efforts to strengthen the standardisation of teaching across sites. The School should include reporting on any evaluation of the effectiveness of these roles in the 2014 submission and if the funding of the roles will be ongoing. 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
This is satisfied and closed.				

Standard 7 Implementing the curriculum - students

Standards cover: student intake, admission policy and selection, student support, professionalism and fitness to practise, student representation and student indemnification and insurance.

Outstanding recommendations for improvement				
<ul style="list-style-type: none"> Provide an update on ensuring a core set of support services is available to students, irrespective of their campus or clinical school location. 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				
This is satisfied and closed.				

Standard 8 Implementing the curriculum - learning environment

Standards cover: physical facilities, information resources and library services, clinical learning environment and clinical supervision.

Outstanding recommendations for improvement				
<ul style="list-style-type: none"> Continue to report on access to information technology, specifically on the distribution of live lectures across all campuses. 				
2014 rating	Unsatisfactory	Not progressing	Progressing	Satisfied
				X
Team commentary				

This is satisfied and closed.

Introduction

The AMC accreditation process

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

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

The standards and procedures for accreditation are published in the AMC's *Assessment and Accreditation of Medical Schools: Standards and Procedures 2012*. 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 defines the educational framework, institutional processes, settings and resources necessary for successful medical education.

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

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 AMC Directors. The Directors make the final accreditation decision. The granting of accreditation may be subject to 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 program, 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 program changes to report annually.

The University, the Faculty and the School

The University

The University of Queensland (UQ) was founded in 1909. The University has campuses at St Lucia, Ipswich, Gatton and Herston, and operates at over 50 sites across Queensland. The University is involved in a further 118 centres and institutes.

UQ has more than 46,000 students from 134 countries; approximately 11,000 are international students, and almost 12,600 are postgraduate students. The University has more than 6,800 staff, including 2,800 academic staff.

In 2013 the University conducted a review of its faculty structure. In January 2014, the Faculty of Health Sciences was split into the Faculty of Medicine and Biomedical Sciences and the Faculty of Health and Behavioural Sciences. There are now six faculties within the University:

- Business, Economics and Law
- Engineering, Architecture and Information Technology
- Health and Behavioural Sciences
- Humanities and Social Sciences
- Medicine and Biomedical Sciences
- Science.

The Faculty of Medicine and Biomedical Sciences

The Faculty of Medicine and Biomedical Sciences comprises three schools:

- Medicine
- Population Health
- Biomedical Sciences.

The Faculty includes a number of research institutes:

- Diamantina Institute
- Mater Medical Research Institute
- University of Queensland Centre for Clinical Research
- Queensland Children's Medical Research Institute and
- Centre for Integrated Preclinical Drug Development.

The School of Medicine

The School of Medicine is the largest school within the Faculty of Medicine and Biomedical Sciences, and measured in total staff numbers is the largest school in the University. In addition to the 179 full-time equivalent staff, the School includes approximately 2,728 academic title holders. In 2014, the total medical student load was 1,800 equivalent full-time students.

The School of Medicine is complex and widely-dispersed. The School's programs are delivered across three campuses (Herston, St Lucia and Ipswich), and eleven clinical schools, two of which are located offshore: Northside, Princess Alexandra-Southside, Royal Brisbane, Sunshine Coast, Ipswich, Mater, Greenslopes, UnitingCare Health (commenced in 2012 as Wesley/St Andrews), Rural, Brunei, and Ochsner.

AMC consideration of major changes to the program

The School's Bachelor of Medicine/ Bachelor of Surgery (MBBS) program was first accredited in 1988. The School implemented a major change to its four-year graduate entry MBBS program in 1997. In 2005, the program was reaccredited and was granted the maximum period of six years' accreditation, until 31 December 2011, subject to conditions.

2010 major change assessment

In October 2008, the School notified the AMC that it proposed to provide for up to 120 fee-paying American students (citizens and permanent residents) to study the first two years of the program in Australia, and then undertake the majority of their clinical years training in the United States (US).

The AMC agreed this would be a major change that would require a new accreditation assessment. The AMC Medical School Accreditation Committee considered the plans in October 2008 and again in July 2009. The proposals included:

- Admission of up to 120 fee-paying students per year from the US (US citizens and US permanent residents) who would complete the first two years of the program at the University's Brisbane campuses, and then undertake the majority of their Years 3 and 4 clinical training through the School's Ochsner Clinical School in New Orleans, Louisiana.
- Delivering the first two years of the University of Queensland's four-year medical program at the University's Ipswich campus.
- With the addition of the Ochsner student cohort, a 50% increase in student intake since the last AMC program assessment in 2005.
- A medical program review in 2009, which the School described as a wide-ranging analysis of every feature of its education and governance arrangements.

The AMC policy, *Medical Courses Conducted Offshore by Australian and/or New Zealand Universities (Appendix Two)*, indicates the AMC will assess offshore program proposals that:

- are offered by AMC-accredited medical schools located in an Australian or New Zealand university, where the Australian/New Zealand university has developed the program and has responsibility for overseeing the academic standards; and
- result in the award of a recognised higher education qualification of the Australian or New Zealand university; and
- are essentially the same as the program accredited by the AMC for delivery in Australia or New Zealand, in terms of educational objectives, curriculum framework, educational process and assessment outcomes; and
- include adequate experience within the Australian/New Zealand health care system.

In August 2009, AMC Directors agreed the School had met the requirements of a Stage 1 submission, having demonstrated it had the capacity to implement the program and the program was likely to meet the accreditation standards. The AMC invited the School to proceed to a full assessment.

An AMC team completed the assessment in September 2010, following visits to the three University campuses associated with the MBBS program, and the then ten clinical schools, including the Rural Clinical School, Ochsner (New Orleans, Louisiana) and Brunei.

The AMC received helpful, general advice from the Liaison Committee on Medical Education (LCME), the US authority for accreditation of medical education programs leading to the MD degree, on its assessment processes and on the context of medical education delivery in the US. With the assistance of the LCME, the AMC appointed an independent adviser, Dr Cam Enarson, a former LCME member and LCME co-chair in 2007–2008, who provided advice regarding the challenges for medical education and training in the US; and helped the team assess the strengths of clinical training and experience available to students at the Ochsner Clinical School, and the differences and similarities between this experience and that available to students in the Queensland-based clinical setting. The AMC remains grateful to Dr Enarson for his contribution to understanding medical practice and health care delivery in the US during the 2010 assessment.

Following the 2010 assessment, AMC Directors, at their 10 November 2010 meeting, agreed the University of Queensland's medical programs met the accreditation standards, and agreed to approve the major changes by the School of Medicine, being the proposals to offer the medical program offshore through the Ochsner Clinical School; expanded student numbers to incorporate this cohort; and the implementation of Years 1 and 2 of the program at the University's Ipswich campus.

The AMC granted the School accreditation until 31 December 2016, subject to the submission of satisfactory progress reports, reports on conditions and a follow-up assessment in 2014 to review the School's progress in implementation of the major changes, and any changes that may follow from the School's internal 2009 MBBS review. The AMC set eleven conditions to be met by 2012 and two to be met by 2014. The Executive Summary of the 2010 assessment is at **Appendix One**.

After it has accredited a medical program, the AMC seeks regular progress reports. Accredited medical education providers are required to report any developments relevant to the accreditation standards and to address any conditions on their accreditation and recommendations for improvement made by the AMC. Reports are reviewed by an independent reviewer and by the Medical School Accreditation Committee.

In 2011 and 2012 the School submitted satisfactory progress reports. In reviewing the School's 2012 progress report, the Medical School Accreditation Committee found the School was making progress in addressing the conditions on its accreditation, and had satisfied conditions relating to Standard 1.2 (autonomy) and Standard 3 (curriculum).

The Committee considered the School's 2013 progress report and found the condition at Standard 5.4 regarding content validity was met, and the condition at Standard 8 regarding clinical teaching capacity was also met. Five of the six conditions at Standard 5 Assessment were found to not yet be met and required those to be addressed in the School's 2014 follow-up submission.

2012 notice of intent to introduce a Doctor of Medicine (MD)

In 2012, the School notified the AMC of its plans to introduce a Doctor of Medicine (MD) in place of its MBBS from 2015. The Medical School Accreditation Committee initially agreed this proposal did represent a major change. The School then amended its proposal to integrate the required research training into the first two years of the program by removing duplication in clinical science content, and provide opportunity for further research in Years 3 and 4. The Committee agreed in December 2013 the amended plans did not fit the AMC definition of a major change, however considered that assessment of the MD implementation plans should be part of the 2014 AMC follow-up assessment of the program.

In this report, the term 'medical program' or 'program' refers to the School's two programs: its four-year direct graduate entry Bachelor of Medicine/ Bachelor of Surgery program and its four-year Doctor of Medicine program. The final MBBS cohort commenced in 2014. The School will transition to the MD program in 2015 with a parallel teach-out phase of the MBBS program. MBBS students will not be able to transfer to the MD program or be awarded the MD on completion.

The AMC applies one set of accreditation standards for programs of study that lead to professional registration. It recognises 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.

Scope of the 2014 follow-up assessment

In 2010 the initial scope of the 2014 follow-up assessment included a review of the School's progress in implementation of the major changes, and any changes that may follow from the School's internal 2009 MBBS review.

In 2013, the Medical School Accreditation Committee agreed the scope would incorporate the 2010 accreditation decision along with changes since 2010:

- Review of the School's progress in implementation of the major changes, being the Ochsner program and the expanding student numbers to incorporate the Ochsner cohort; and delivery of Years 1 and 2 at the Ipswich campus.
- Any changes that may follow from the School's internal 2009 MBBS review.
- Review of the five remaining conditions on accreditation at Standard 5 (assessment); and the conditions to be met in 2014 at Standard 1 (governance structure) and Standard 7 (student load).
- Governance (including restructure and change of head of school).
- Curriculum change (MD program) and the implementation plans for the MD program.

The team was required to assess the School against all standards for both the MBBS and the MD program and report its findings to the Committee.

The accreditation decision that can be made by the AMC as a result of this assessment is:

- (a) confirm the accreditation decision made in 2010, being the maximum six-year

period of accreditation to 31 March 2017², subject to satisfactory progress reports

- (b) if the School is found not to meet all the standards, set conditions to ensure the standards are met in a reasonable timeframe.

If the School is found to not meet the standards, as outlined at Item 5.1 (iv) in the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2011* accreditation may be withdrawn where the education provider has not satisfied the AMC the complete program is or can be implemented and delivered at a level consistent with the accreditation standards.

The Committee will consider the team's report and decide on the final report and recommendations for accreditation. The Committee presents its recommendations to AMC Directors who make the final decision on accreditation.

If accreditation is confirmed to 2017, in 2016 the School will be required to submit a comprehensive report seeking a further period of up to four years of accreditation, before a reaccreditation assessment is required in 2020.

This report

This report details the findings of the 2010 and 2014 assessments, addressing the major change to the four-year graduate entry medical program offered by the School of Medicine, the University of Queensland. Each section of the accreditation report begins with the relevant AMC accreditation standards. The comments of the two AMC assessment teams are recorded under the standards in chronological order.

AMC accreditation standards review 2012

Since the 2010 UQ report was written, the AMC completed a review of the approved accreditation standards in 2011-2012. AMC Directors endorsed the revised accreditation standards and the Medical Board of Australia approved the accreditation standards for use from 2013. The approved standards are published in *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012*.

This report is prepared against the 2012 standards, and where changes have been made since the 2010 report was written, there are notes that indicate if a standard has been moved, subsumed by another, or if the standard is new.

The changes made in 2012 include revision of the statement of expectations of graduates with the standards. The graduate outcomes are organised into four domains:

- Science and Scholarship - the medical graduate as scientist and scholar
- Clinical Practice - the medical graduate as practitioner
- Health and Society - the medical graduate as a health advocate
- Professionalism and Leadership - the medical graduate as a professional and leader.

² The 2010 accreditation granted the program accreditation until 31 December 2016, however from 2014 at the time of an accreditation decision, AMC accreditation end dates will change from 31 December to 31 March (the following year).

There were minor revisions and updates at Standard 1: 'The Context of the Medical School'.

At Standard 2: 'The Outcomes of the Medical School' the new Graduate Outcome Statements are incorporated, and at Standard 3: 'The Medical Curriculum' and Standard 4: 'The Curriculum: Teaching and Learning', the Graduate Outcome Statements have been integrated and the standards revised.

Standard 5: 'Assessment of Student Learning' was strengthened in areas relating to assessment principles, practices and feedback to students.

Standard 6: 'Monitoring and Evaluation' includes more detail around standards related to the collaborative initiatives of medical programs in comparing outcomes, teaching and learning methods and other areas of common interest with other medical programs. At Standard 7: Implementing the Curriculum there is a new standard as students have specified the need for clear separation between student support and academic progression decisions, and procedures to manage medical students whose health or behaviour raises fitness-to-practise concerns.

Standard 8: 'Implementing the Curriculum: Educational Resources' has additional sub-standards in recognition of the greater focus on clinical teacher effectiveness. It also addresses the evaluation of clinical supervision including the quality of supervisors, the ability to undertake the role within clinical service requirements and the model of supervision to achieve effective learning.

The members of the 2010 and 2014 AMC teams are given at **Appendix Three**.

The groups met by the AMC in 2010 and 2014 are given at **Appendix Four**.

Appreciation

The AMC acknowledges the complex nature of this assessment, and the considerable work required of the University staff in Queensland, Louisiana and Brunei to prepare for the assessment.

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

1 The context of the medical program

1.1 Governance

- 1.1.1 *The medical education provider's governance structures and functions are defined and understood by those delivering the medical program, as relevant to each position. The definition encompasses the provider's relationships with internal units such as campuses and clinical schools and with the higher education institution.*
- 1.1.2 *The governance structures set out, for each committee, the composition, terms of reference, powers and reporting relationships, and allow relevant groups to be represented in decision-making.*
- 1.1.3 *The medical education provider consults relevant groups on key issues relating to its purpose, the curriculum, graduate outcomes and governance.*

2010 team findings

UQ's academic organisational structure has not changed significantly since an AMC team last assessed the University's medical program in 2005. As was the case then, the School of Medicine is one of seven schools in the Faculty of Health Sciences.

UQ has campuses at St Lucia and Herston in Brisbane, and Ipswich and Gatton in Queensland. The School of Medicine office is located at Herston, adjacent to the Royal Brisbane and Women's Hospital. The University designated this site a campus in 2009, and capital and service redevelopment is expected to result from this change. The School uses the St Lucia, Herston and Ipswich campuses.

The University has more than 39,000 students from 124 countries, with about 7,500 international students, and 10,000 postgraduate students. UQ has more than 6,000 staff, including 2,600 academic staff.

Since the last AMC assessment in 2005, major changes have required significant changes to the School governance. These changes include:

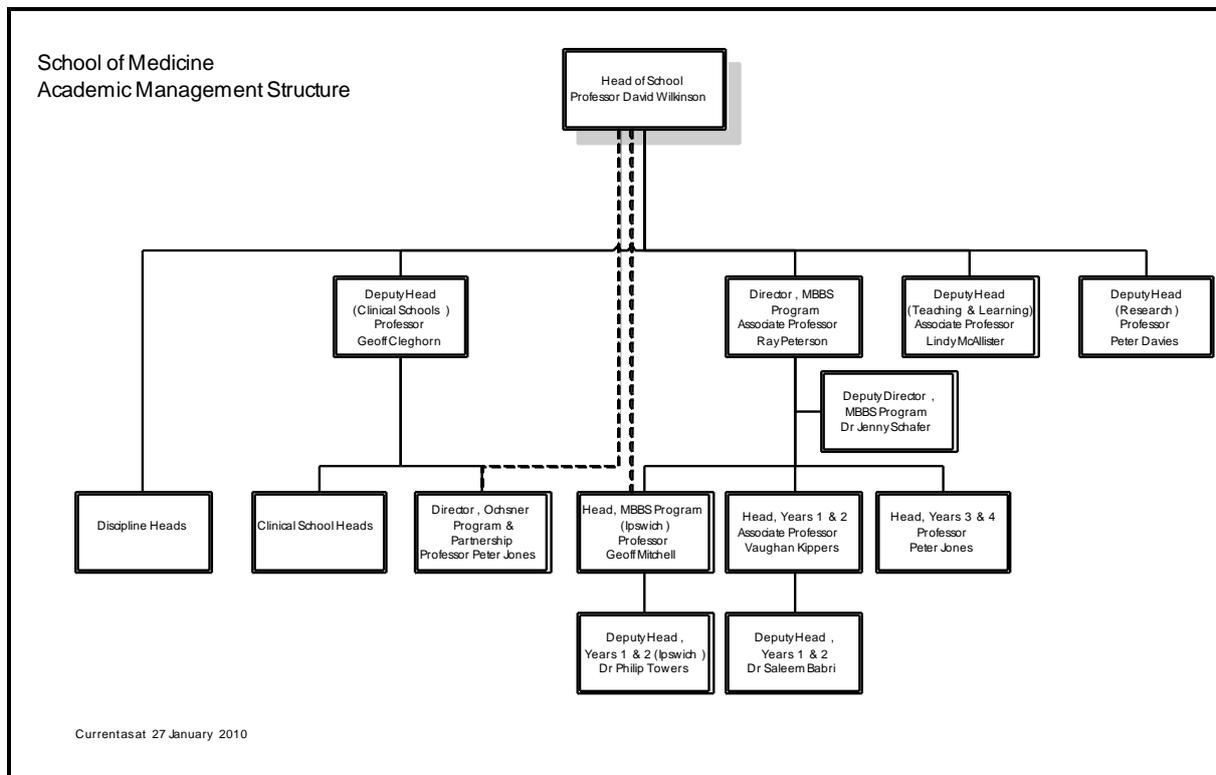
- The number of clinical sites the School uses for teaching has expanded. The School has established a clinical school structure replacing the previous four clinical divisions. The School now operates ten clinical schools, including two offshore in New Orleans and Brunei.
- From 2009, the School has delivered the first two years of the medical program at the Ipswich campus, building on the University's plans to make health sciences a focus of this new campus.
- In the MBBS program, the student intake has increased 50%.
- In line with the University's plan that 25% of its students have some form of international experience, the School has expanded its international partnerships, with 30–50% of its students having an international experience.

The School is a large, geographically dispersed school. It has introduced a revised governance structure to support its expanded operations.

The School's leadership has been enhanced and the Dean (who is also Head of School) is supported by a Deputy Head (Clinical); a Deputy Head (Teaching and Learning) and a

Deputy Head (Research). A new, full-time position (Director of MBBS program) has also been created. Figure 1 shows the School of Medicine academic management structure.

Figure 1 - Academic management structure



An Executive Committee chaired by the Head of School meets monthly and advises the Head on strategic direction. The Committee is the peak decision-making body within the School. It comprises the deputy heads of school, and representatives of the clinical schools, disciplines and the Head of the MBBS program at Ipswich.

This Committee is supported by an Executive Management Group and complemented by the Teaching and Learning Committee, and Research Committee. The structures and functions, compositions and terms of reference of these committees are well defined. The School also consults widely, both within the School through a six-monthly leaders' forum, and with external stakeholders through a School of Medicine Consultative Council, which meets annually. Figure 2 shows the School of Medicine academic governance structure.

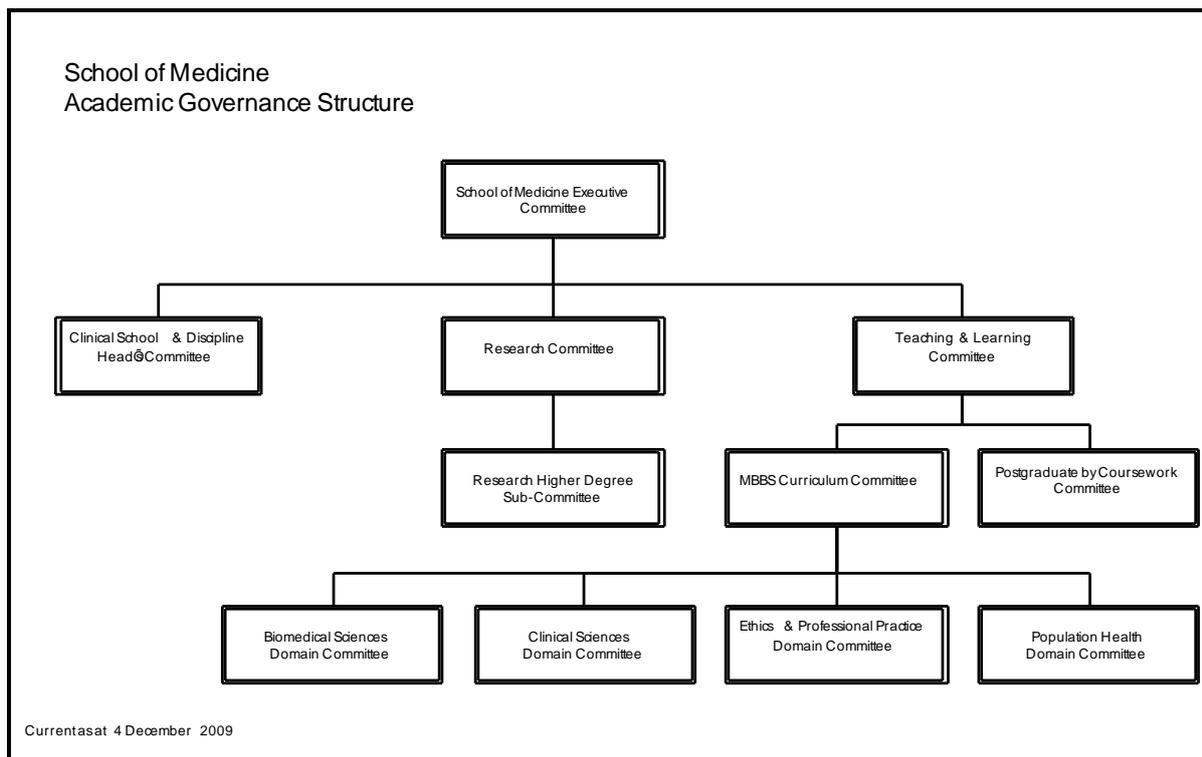
Geographically, the School is organised as ten clinical schools: eight in southeast Queensland, one in Brunei and one in the US. Each of the clinical schools covers a teaching hospital, or network of hospitals, and associated community health services. These are:

- Sunshine Coast Clinical School
- Northside Clinical School
- Royal Brisbane Clinical School
- Princess Alexandra-Southside Clinical School
- Mater Clinical School

- Greenslopes Clinical School
- Ipswich Clinical School
- Rural Clinical School
- Ochsner Clinical School in New Orleans
- Brunei Clinical School.

Each is led by a senior academic as clinical school head. In the case of the Rural Clinical School, this position is fully funded by the University. The positions of the other nine clinical school heads are funded in partnership with local hospitals or health services.

Figure 2 - Academic governance structure



Although the structure is relatively new, some of the clinical schools build on long-established clinical teaching relationships and well-established infrastructure. Some represent relatively new sites for the School and are still in the early development stages. The clinical teaching resources available to the School are discussed further at Standard 8.

The clinical schools are responsible for delivering the UQ MBBS curriculum in partnership with the academic disciplines.

The academic disciplines in place in 2005 remain, and a senior clinical academic leads each academic discipline. These leaders have school-wide responsibility for delivering teaching programs. Heads of discipline liaise with clinical school heads, and their staff, through quarterly meetings.

With the establishment of the clinical schools, a Heads of Clinical Schools and Disciplines Committee was developed. The Committee's terms of reference are clear.

The team was concerned there did not appear to be a parallel structure linking discipline representatives at each site with their respective head of discipline at School level. While this interaction has been good at some sites, notably the Ochsner Clinical School, it needs formalising. Although there are mechanisms for interaction between the Deputy Head of School (Clinical) and the clinical school heads, there was a clear wish for more communication, and the team considered this area would benefit from strengthening.

The Faculty of Health Sciences is establishing three Australian Government-funded Super Clinics, only one of which is already open. These clinics will be used for teaching in the MBBS program, and the Head of the School will be the Director of UQ Healthcare from 2011. Although each clinic is sited in association with clinical school health facilities, the governance of each clinic, its relationship to the clinical school, and the teaching model are yet to be tested.

The School has developed closer consultative relationships with groups who have a legitimate interest in the program. These relationships are to be commended, but are still developing.

The team recognises that substantial, important and positive management changes have occurred in the last few years. These changes have been essential to support the School's expansion in student numbers and geographic location.

The School will continue to experience expanding student numbers in the short-term, and to make change through academic initiatives, such as the 2009 Review of the MBBS Program. This denies the School any consolidation period. Careful management and significant resourcing of these two processes, of change and expansion, will be required, and will need close monitoring.

2014 team findings

The School has made changes to its governance structure at Faculty, committee and clinical school levels since 2010. In 2011 the School commissioned a governance review by Deloitte Touche Tohmatsu Ltd and in 2012 began making incremental changes to its governance and operating models. In 2013 it appointed a new head of school and further reviewed its academic management structure and its academic program organisation. The team acknowledges the efforts made by the School in this continuous renewal.

In 2013 the University conducted a review of its faculty structure. There are now six faculties within the University. In January 2014, the Faculty of Health Sciences was split into the Faculty of Medicine and Biomedical Sciences and the Faculty of Health and Behavioural Sciences.

The Faculty of Medicine and Biomedical Sciences comprises three schools:

- Medicine
- Population Health
- Biomedical Sciences.

The Faculty includes a number of research institutes:

- Diamantina Institute

- Mater Medical Research Institute
- University of Queensland Centre for Clinical Research
- Queensland Children’s Medical Research Institute, and
- Centre for Integrated Preclinical Drug Development.

The School of Chemistry and Molecular Biosciences remains in the Faculty of Science. The second health-related Faculty, Health and Behavioural Sciences (HABS), includes the Schools of Dentistry; Pharmacy; Health and Rehabilitation Sciences; Human Movement Studies; Nursing and Midwifery; Social Work and Human Services; and Psychology. The HABS research units include the National Research Centre for Environmental Toxicology and the Centre for Youth Substance Abuse.

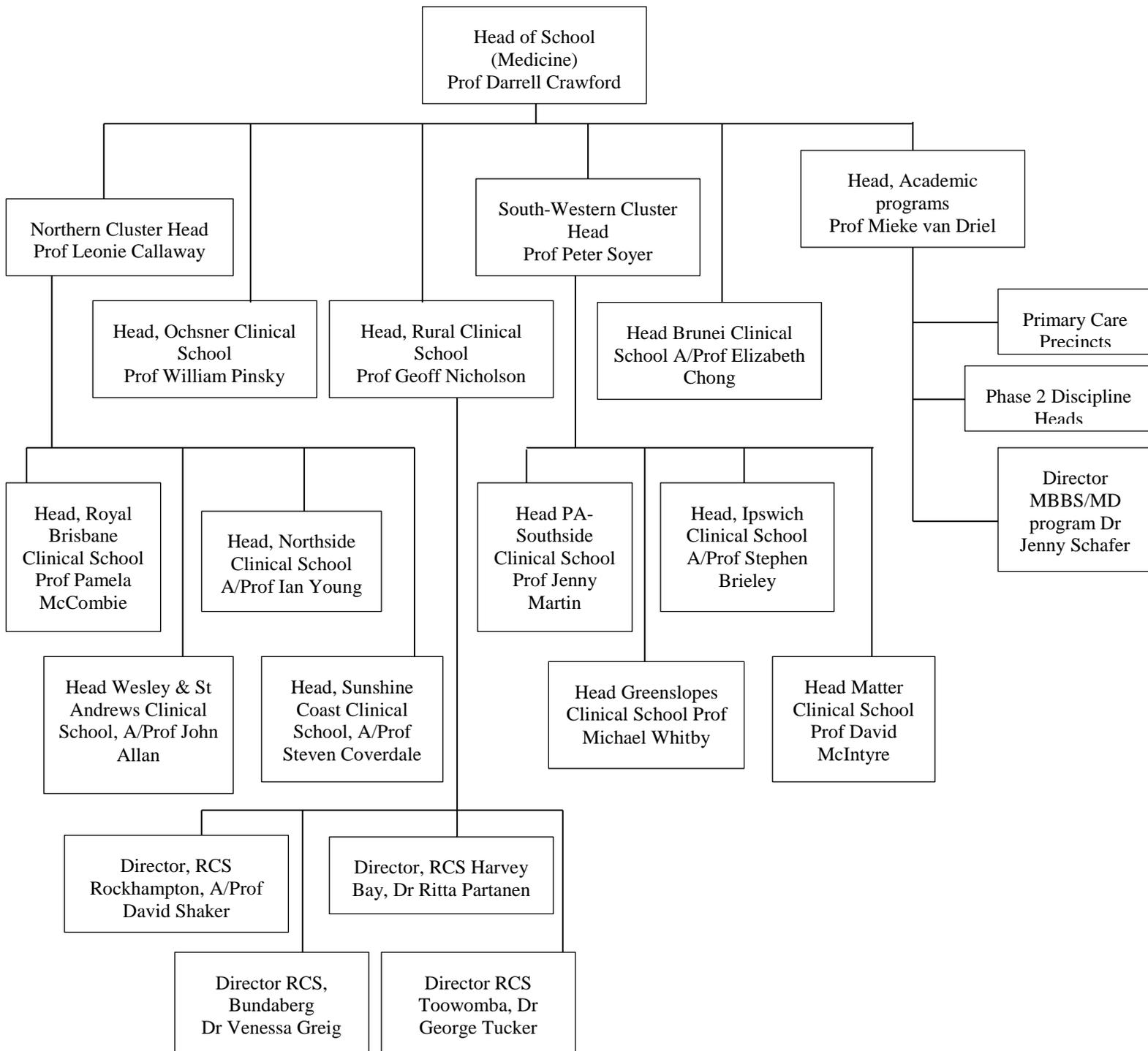
The School of Medicine is the largest school within the Faculty of Medicine and Biomedical Sciences, and measured in total staff numbers is the largest school in the University. In addition to the 179 full-time equivalent staff, the School includes approximately 2,728 academic title holders. In 2014, the total medical student load was 1,800 equivalent full-time students.

The School of Medicine is complex and widely-dispersed. The School’s programs are delivered across three campuses (Herston, St Lucia and Ipswich), and eleven clinical schools, two of which are located offshore: Northside, Princess Alexandra-Southside, Royal Brisbane, Sunshine Coast, Ipswich, Mater, Greenslopes, UnitingCare Health (commenced in 2012 as Wesley/St Andrews) , Rural, Brunei, and Ochsner.

The former Executive Dean of the Faculty of Health Sciences was confirmed as the Executive Dean, Faculty of Medicine and Biomedical Sciences.

As in 2010, the Head of School is supported by three Deputy Heads, although the 2010 positions of Deputy Head (Clinical) and Deputy Head (Research) are now two ‘Cluster Head’ positions (details below with clinical school governance). The functional and operational organisation of the School in 2014 is shown in Figure 3:

Figure 3 – Academic management structure 2014

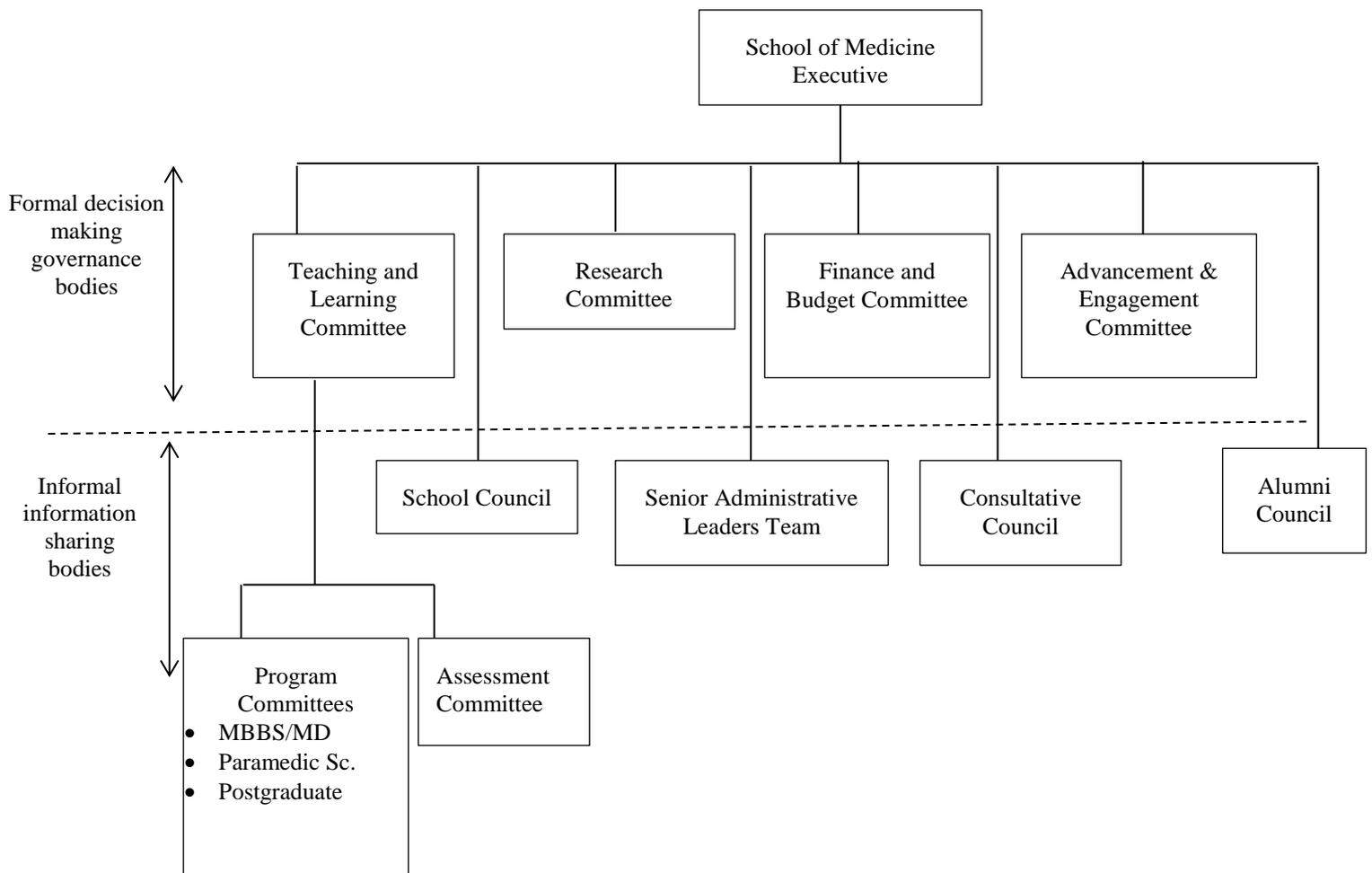


The Executive Committee membership was revised in late 2013 to align the leadership with the functions of the School. Prior to that there had been no representative from a teaching hospital, however the Committee now contains four teaching heads with hospital and primary care specialities.

The three-tier curriculum committee structure of 2010 has become flatter following the Deloitte review in 2011. In 2012, the School merged the Domain Committees, the Curriculum Committee and the Teaching and Learning Committee, before re-adjusting this model in 2013 to a two-tier structure in which the Teaching and Learning Committee sits above the Program Committees and the Assessment Subcommittee (see Figure 4).

The four formal decision-making governance bodies (excluding the Executive) for the program are the Teaching and Learning Committee; Research Committee; Finance and Budget Committee; and the Advancement and Engagement Committee. The School's 2014 committee structure is shown in Figure 4.

Figure 4 – Academic committee structure 2014



The 2010 Heads of Discipline and Clinical Schools Committee was extended into a Leaders' Caucus in 2013, and evolved into the School Council in 2014. The School Council meets monthly and its broad membership includes all discipline heads, clinical school heads, program committee chairs and staff managers. It ensures decisions made by program committees are implemented effectively and makes recommendations to the Executive Committee regarding change that requires further consideration. It is said to encourage open debate and feeds information from its meetings to clinical teachers and professional staff. Staff feedback regarding the School Council meetings was positive.

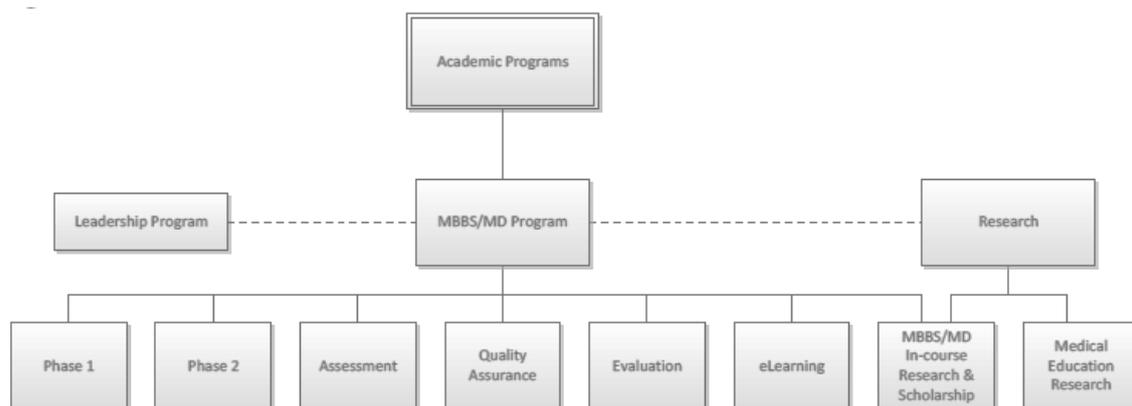
In June 2012, the University’s Academic Board endorsed the proposal to introduce a Doctor of Medicine (MD) in place of the four-year graduate entry program. The University formed an MD Working Party as the over-arching internal body, chaired by the Deputy Vice Chancellor (Academic) with representation from relevant parts of the University. The School’s Teaching and Learning Committee and MBBS/MD Program Committee have been responsible for the development of curriculum for the MBBS and MD Programs.

The Assessment Subcommittee was formed in 2012, following the AMC’s 2010 accreditation assessment and the subsequent Prideaux review of assessment. This subcommittee meets four to six times a year and reports to the Teaching and Learning Committee. Its role is to develop, monitor and evaluate the assessment of the program, but not to deliver assessment. Its membership includes the head of school, director of the program, Phase 1 (Years 1 and 2) representatives, heads of disciplines, academic course coordinators, and a student representative.

The team found the committee structures are well defined, appropriately documented and understood by most people. It noted the composition and function of the Teaching and Learning Committee and the MBBS/MD Program Committee have a significant degree of overlap. The committees function well together due to the cooperative practice of those involved, but in other circumstances tension could arise. The team is aware the governance structure is new and evolving and expects that, with time, the functions of these committees will change.

The School has revised the governance of its academic programs. The Deputy Head and Head, Academic Programs is a member of the School Executive, has primary oversight on matters related to medical education in the school, and chairs the Teaching and Learning Committee. Research fits into this governance in two strands as MBBS/MD in-course research and as medical education research. The structure of medical education within the School is shown in Figure 5.

Figure 5 – Structure of medical education 2014

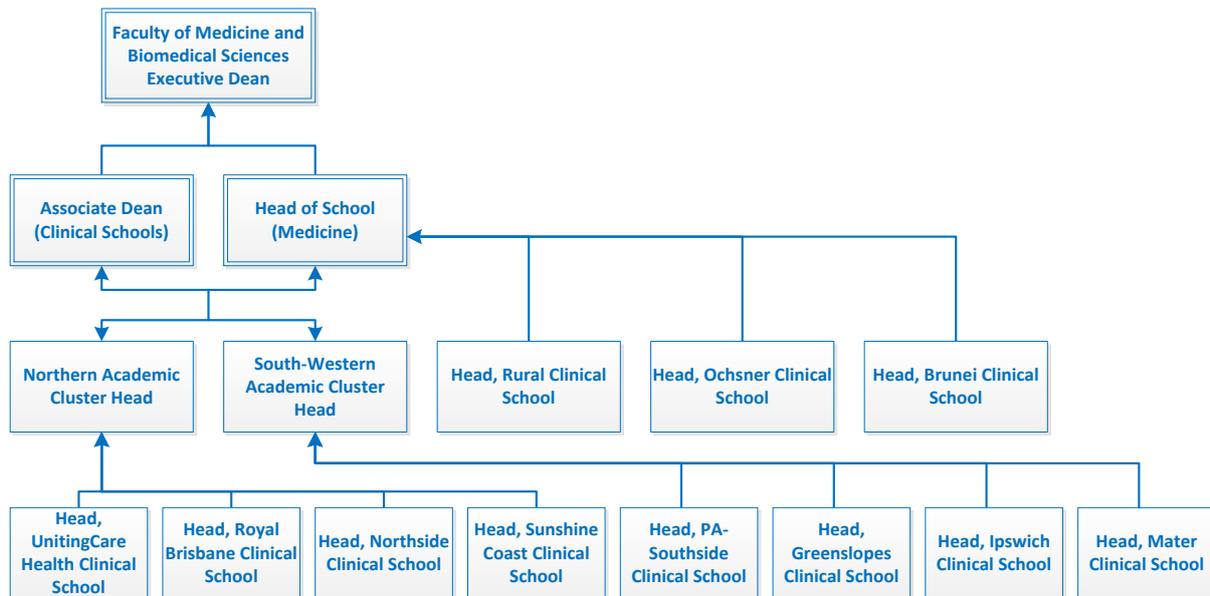


Current as at 1 February 2014

The Faculty conducted a review of its clinical school governance in 2012 with the recommendations arising introduced over 2012/2013. The review led to the creation of a new role of Associate Dean (Clinical) to provide leadership and direction across all clinical professions in the Faculty, and the creation of two academic clusters each with an academic leader. The formation of these two entities, being the Northern and the

South-Western academic clusters, aims to maximise the presence of the University in the clinical environment and to develop local staffing and budgetary allocation systems (although as discussed at Standard 1.5, the budget for the clinical schools is currently held centrally). The two cluster heads are intended to be multi-disciplinary and have dual reporting lines to the Associate Dean (Clinical) and the Head of School (Medicine). Figure 6 illustrates this governance structure.

Figure 6 – Clinical school governance structure 2014



The team found the role and purpose of the recently created positions of Associate Dean (Clinical) and the Cluster Heads are not widely understood, which led to confusion and concern among some staff and stakeholders. Further clarification of the organisational structure and a concerted communication effort by the School will be required in order to ensure that all interested parties appreciate the rationale of these new positions.

The leadership of the eleven clinical schools has been stable. At the time of the visit in June 2014, the future of the Ipswich campus and of the Sunshine Coast Clinical School was uncertain, with the pending transfer of the Ipswich campus to the University of Southern Queensland, and the expected loss of Sunshine Coast to another medical school. Contingency planning regarding these changes was underway: student cohort management is discussed at Standard 7.1, and clinical placements at Standard 8.3. The transfer of the Ipswich campus was confirmed by the University in July 2014.

The Ochsner Health Executive and Ochsner Clinical School continue as a single economic unit, with the clinical school embedded in Ochsner Health. Ochsner has its own committees and decision making functions for the clinical school, including its Education Committee, Personal and Professional Development Committee, and Administrative Management group. The Ochsner Clinical School continues to have representation on key School of Medicine governance committees, is involved in processes at the School and has consultation in the governance structure. The Ochsner leadership team described a strong partnership with the School and this relationship is demonstrated by its staff.

The eleven academic disciplines in the program remain as medicine; surgery; obstetrics and gynaecology; psychiatry; general practice; rural and remote medicine; molecular and cellular pathology; medical imaging; paediatrics and child health; anaesthesiology and critical care; and medical ethics, law and professional practice. The 2010 discipline heads are unchanged with one exception after the head of medicine was appointed head of school. In Phase 2 (Years 3 and 4), the discipline heads have a role in teaching, learning and assessment in their speciality. The team found the academic discipline governance structures and communication across sites were markedly stronger and more effective than had been the case in 2010.

The School reports that its structure and governance is appropriate to manage the MD program and it has no plans to further modify governance structures unless the need arises for improvements. The School reported use of multiple communication strategies to stakeholders regarding its MD program. The team recommends that this effort be maintained and communication with clinical teachers about the MD program enhanced.

Regarding consultation with relevant groups, the School has increased its engagement with Queensland Health at the executive level in health facilities, government and at ministerial level, and this appears to be effective. The Faculty has led a workshop on delivering better healthcare outcomes for the community, being the first step to develop a strategy for development of alliances with external stakeholders.

The team compliments the School on the steady improvements it has made to its governance. While complicated, the governance is robust and designed to align with the function and needs of the School and the program. As the School implements its MD program in the coming years, it would benefit from a period of stability to allow the opportunity for consolidation.

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.

2010 team findings

The School has overall responsibility for the design and development of the MBBS program. The responsibilities of the Dean of Medicine, and Head of School, are clearly stated. A new head of school was appointed at the end of 2006, and his term as Dean of Medicine and Head, School of Medicine, runs to March 2013.

As noted in the 2005 AMC accreditation report, the School of Population Health within the Faculty of Health Sciences and the Faculty of Science (through the School of Biomedical Sciences and the School of Chemistry and Molecular Biosciences) are responsible for delivering and assessing the majority of the course in Year 1 and a significant amount in Year 2. The team considered the lack of shared understanding between the School of Medicine and the Faculty of Science on their respective responsibilities for the program is affecting the quality and delivery of Years 1 and 2. Given that AMC standards require a medical school to have sufficient autonomy to design and develop its medical program, the team suggests this relationship needs

continued attention, and resolution, such that the School of Medicine is able to demonstrate explicit control of its entire curriculum.

2014 team findings

In September 2013 the Faculty confirmed the appointment of the new head of school, following the contract completion of the previous head in March 2013. The head's responsibilities for the program include oversight of the teaching and learning committee, admissions and cohort size, major academic issues and student welfare matters. The head is well supported by the School's senior academic and administrative leaders.

The School has autonomy to design and develop the program. The School has addressed the 2010 concerns regarding its autonomy over science teaching, and since the 2010 assessment, the co-operation of the School of Biomedical Sciences, the School of Chemistry and Molecular Biosciences, and the School of Population Health with the School of Medicine in the delivery of the program has increased markedly. The School of Medicine has clear oversight of the delivery of the program, including its design, content and assessment.

The 2014 restructure of the Faculty of Health Sciences has brought the Schools of Medicine, Biomedical Sciences and Population Health into the one Faculty. This has led to improvement in the quality of these relationships.

The School of Medicine has directed all the development work for the MD program. The Schools of Biomedical Sciences and Population Health will teach into the program although the financial arrangements are yet to be confirmed. The School of Chemistry and Molecular Biosciences in the Faculty of Science will still be required to teach into Year 1 of the MD program.

There is concern the proposed renegotiation of the financial arrangements with the School of Medicine may imperil the engagement of the Schools of Biomedical Sciences, Chemistry and Molecular Biosciences, and the School of Population Health in supporting the program. While the current heads of these schools do not regard this as being a material risk, the Schools' support of the program will require on-going monitoring.

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.

2010 team findings

The MBBS Curriculum Committee (a subcommittee of the Teaching and Learning Committee) is the peak body responsible for planning, implementing and developing the MBBS curriculum. Its terms of reference, responsibility and authority are clearly stated. It advises on all aspects of curriculum content, teaching, and learning activities related to the MBBS program.

Four subcommittees of the MBBS Curriculum Committee are responsible for the four domains of learning in the MBBS Program: biomedical sciences; clinical sciences; population health; and ethics and professional practice. Members of the schools in the Faculty of Science and the School of Population Health who deliver teaching into the MBBS program are represented on the relevant domain committees.

The day-to-day MBBS program management is the responsibility of the MBBS Program Director, who reports directly to the Dean. The Director also chairs the MBBS Curriculum Committee. Importantly, the Curriculum Committee membership includes six student representatives. The Curriculum Committee reports to the Teaching and Learning Committee, which has oversight of school-wide teaching and learning quality assurance, providing a conduit for changes to the program that require approval by the University-wide Education Committee. The team agreed the MBBS Curriculum Committee, with its associated committees, has the appropriate responsibility and authority to effectively manage the MBBS program.

Additional committees have been established at the Ochsner Clinical School in New Orleans and at the Ipswich campus to support implementing the program at these sites.

The leadership group within the Ochsner Clinical School meet as an Undergraduate Medical Education Committee, which is a subcommittee of the MBBS Curriculum Committee. The Undergraduate Medical Education Committee meets monthly, and provides oversight and consultation on key issues related to developing, delivering and assessing the MBBS program at the Ochsner Clinical School. Curriculum issues raised in the Ochsner School were discussed initially at the Undergraduate Medical Education Committee, before being raised with the MBBS Curriculum Committee. At present, the Curriculum Committee is focused on setting up the Year 3 core clinical rotations to mirror their delivery in Australia, as well as identifying needs of clinical teachers in New Orleans. The Undergraduate Medical Education Committee has three subcommittees: one that will oversee implementing the Year 3 and 4 curriculums; one that will provide guidance on students' personal and professional development; and an administrative management committee.

Bi-weekly joint management meetings are held using Skype between Ochsner Clinical School staff; the School's Director, Ochsner Program and Partnership; and the School's senior administrative staff to address issues concerning the program roll-out.

At the University's Ipswich campus, three committees have been established. The Ipswich Consultation Committee provides guidance and oversight of the MBBS program in Ipswich and is a forum to discuss strategic development. The MBBS Community Consultation Committee communicates issues relating to the Ipswich MBBS Program and importantly to the wider community, provides a point of first contact between the School and the community, and explores teaching opportunities for medical students within the community. The MBBS Ipswich Student Liaison Committee provides a forum for students and staff to discuss delivery of the MBBS program in Ipswich.

Academic staff at both these sites also hold the appropriate UQ program management committee membership, for example, the Deputy Head of the Ochsner Clinical School (Curriculum) is a member of the School MBBS Curriculum Committee and joins the monthly MBBS Curriculum Committee meetings by videoconference. The Deputy Head, Years 1 and 2 (Ipswich), is a member of the MBBS Curriculum Committee and the MBBS Operations Group.

In 2009, the MBBS Curriculum Committee and School of Medicine undertook a major review of the MBBS program, involving stakeholders, to determine the broad structure and content of the program for the next ten to twenty years. The review report contains 77 recommendations. The School is in the process of implementing a number of the recommended changes to the program. These changes are discussed further at Standard 3. The School will need to evaluate the effect of the changes.

2014 team findings

The Teaching and Learning Committee is chaired by the Head, Academic Programs and includes the head of school, chair of the assessment subcommittee, research coordinator, MBBS/MD program director and other program directors, heads of disciplines, representatives from the schools of population health, biomedical sciences, and chemistry and molecular biology, and the Associate Dean (Academic) of the Faculty. It is responsible for assuring quality in teaching and learning.

The MBBS/MD Program Committee is chaired by the Director, MBBS/MD program and includes the lead educators, course coordinators, discipline leads and their related administrative staff. Representatives of the previous domains remain as members of this committee. It is the peak body responsible for planning, implementing and reviewing the curriculum for the MBBS and MD programs. It is not a decision making committee; it develops proposals and makes recommendations to the Teaching and Learning Committee which has final approval authority.

The School advised that significant changes to the program must be approved by both the MBBS/MD Program Committee and the Teaching and Learning Committee. The process for the development of teaching and learning policies is consultative and iterative, and the clinical disciplines and other faculty members have opportunities for input via the committee structure that feeds proposals into the Teaching and Learning Committee.

There remains input into the program from the Ipswich campus and Ochsner Clinical School. The heads of each clinical school sit on the Executive Committee; and there is Ochsner representation on the Teaching and Learning Committee. Ochsner and Brisbane staff communicate frequently regarding program delivery and administration.

The level of qualification offered is assessed through the University's Academic Board, and the School advised the AMC in October 2013 the University had assessed the MBBS as a Level 7 bachelor degree and the MD as a Level 9 masters (extended) program in accordance with the Australian Qualifications Framework.

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.

2010 team findings

Since the last accreditation, the School has expanded its staff with specific educational experience and appointed a School Deputy Head (Teaching and Learning), who has a very strong scholastic record in this area. Similarly, the Director of the MBBS Program (and chair of the MBBS Curriculum Committee) also has considerable experience in

health sciences education. Several other staff members have significant expertise in health sciences education.

Within the past two years, the School has also appointed Indigenous Australians with expertise in Indigenous culture and who have developed the curriculum in Indigenous health and facilitated its teaching. The School has also appointed an Indigenous health professional to facilitate recruiting Indigenous Australians into the program. This has led to a substantial increase in Indigenous student numbers, for which the School and the Indigenous support team are congratulated.

2014 team findings

The School has a strong and committed, albeit small, cohort of staff with specific medical educational expertise involved in the development and management of the program. The School has two lecturers in medical education and has recently promoted two staff into part-time medical education roles, in addition to their existing roles.

There are a number of unfilled positions, including the medical education chair and the assessment lead. The team considers the current staffing is not sustainable long-term as the existing staff have a large workload with no capacity for junior staff development, staff training or personal scholarship. While the School does not plan to recruit to the medical education chair position in the near-future, it did identify a need for the key role of an academic lead in assessment.

The School has a broad base of staff across the program with educational expertise, in both Phase 1 and in the disciplines in Phase 2. The seven part-time Clinical Lead Educators in Phase 1 have been a successful evolution of the system-block coordinator role, and collaborate with content experts in the review and development of problem and case-based learning cases.

Ochsner has utilised the School's educational expertise, and in turn Ochsner's educational expertise benefits the School, for example the Ochsner Senior Deputy Head (Curriculum) sits on the Teaching & Learning Committee; and the heads of discipline (clerkship directors) all participate in discipline meetings. Ochsner staff have contributed in this way from the beginning of the partnership.

Areas in which there is room for developing the expertise available to the School include educational design and evaluation. The team believes that additional staff with expertise in assessment and psychometrics, and in educational design, including e-resource development, will be required for the School to achieve its goals in the online delivery of the curriculum.

The School has one Indigenous staff member with educational expertise in the Rural Clinical School, and also draws on the educational expertise of the Pro Vice Chancellor (Indigenous Education) on a regular basis. The extent to which the development of the Indigenous health curriculum makes use of all the expertise in this area is unclear, and this requires further attention by the School.

1.5 Educational budget and resource allocation

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

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

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

2010 team findings

The School has a well-defined budget for its teaching programs and support staff.

The University's processes for distributing revenue to faculties and schools remains effectively unchanged since the 2005 AMC accreditation assessment: the School receives about fifty per cent of the revenue it generates. Capital funds are provided for specific UQ-approved projects or from funding provided by the Australian or state governments.

Under University policy, the head of school has executive responsibility for, and authority over, the School budget. The School's overall budget is set by the Faculty of Health Sciences each year, and is handed to the School. This budgetary allocation is largely formula driven, but the executive dean exercises control over final components of the formula, and hence, allocation.

School physical infrastructure has undergone major expansion over the past two to three years to accommodate the substantial increase in medical student numbers, and further plans are noted. However, the very limited space for teaching at some of the smaller hospital sites needs to be addressed.

Although the overall teaching budget seems adequate, School staff expressed some concern about the funding method for teaching in Years 1 and 2 where the Faculty of Science administers a large part of the budget. The School and Faculty of Science need to attend to this issue.

Some of the heads of smaller clinical schools indicated they had little, if any, budgetary control or understanding for the funding supporting their schools. The team urges the School to engage the heads of all clinical schools in developing the expenditure budget relevant to their clinical school.

The Ochsner Clinical School funding is based on a specific agreement between UQ and Ochsner. The team found this agreement appropriate in its structure and terms. The UQ Vice-Chancellor has indicated that funding will be assured. UQ has budget mechanisms that allow new, strategic programs to develop without budgetary impact on the School's core operating funds. Developing the physician assistant program, medical students at the Ipswich campus, and Ochsner program are all funded in this fashion. The University allows the School to run the MBBS program at Ochsner Clinical School as a project with approved deficits. As a project, UQ permits a higher level of funding to flow through to the School than is the usual University formula. Any profit from the project will belong to the School.

Program income depends almost entirely on recruiting international students to the Ochsner program. The University has run a series of scenarios to assess the financial risk associated with the Ochsner program. The Ochsner initiative is anticipated to generate an operating surplus by 2012. The University will allow the School to manage the Ochsner budget outside of its main operating budget until a cumulative surplus has been achieved, in view of the significant investment required in the first few years.

Discussions with the Ochsner Health System senior management indicated strong support for the program, which they regard as an investment, allowing a partnership with a university of international standing, and that contributes to improved physician recruitment now and as students graduate. The required support from Ochsner, in terms of its overall budget, is not significant.

All parties in this collaboration have agreed to be responsible for their own costs. As detailed in the agreement and budget, from 2009, UQ is funding the university component of the clinical school head position in New Orleans. UQ is also funding administration and student administration posts. Ochsner will fund the teaching time of clinical academics in New Orleans, and there was clear evidence of commitment to funding infrastructure, information technology services and staff to establish the program successfully in line with the agreement.

The three partners (UQ, International Pathways Inc. and the Ochsner Health System) meet formally once per year to review the business plan.

2014 team findings

Since the 2010 assessment, the School's budgetary position has been affected in a number of ways.

In 2014, the model under which the School of Medicine receives central university funding was changed. Under the new model, all income, including income generated by the Ochsner program, is taxed by the central university at the rate of 54%, with the Faculty imposing an additional tax of 8.3% for teaching income and 4.1% for research income. This new funding model has given rise to concern within the School, as it overrides the previous agreement under which Ochsner generated income was only taxed at 15%. The School estimates the financial impact of this change is approximately \$2.5M in 2014.

The School's budget is also being negatively affected by increased salaries within the health system that is leading to increased payments for conjoint appointments.

The School has decided to discontinue the use of Mayne Bequest Funds to support ongoing teaching-related activities, preferring to use these funds to support research-related initiatives.

In response to these budgetary pressures, the School has continued to hold all School funds centrally and subject new funding requests to consideration by a Finance and Budget Committee that includes the head of school and the cluster heads.

In addition, the School is proposing to free-up funds by re-negotiating the financial arrangements with the Schools of Biomedical Sciences and Chemistry and Molecular Biosciences. The loss of the Ipswich campus for Phase 1 students and of the Sunshine Coast Clinical School for Phase 2 students will also release infrastructure funds.

The team considers these are rational responses to the financial pressures being reported by the School, however, they bring with them risks:

- Continuing to hold all funds centrally may lead to the disenfranchisement of the heads of clinical schools and reduce their ability to respond flexibly to issues as they arise within their clinical school.

- The absence of a performance-related formula for allocating funds among the units within the School may lead to an increasing disconnect between funding and activity at the various sites within the School.
- Imposition of a spending freeze may lead to loss of the capacity to innovate.
- Renegotiation of the financial arrangements with the Schools of Biomedical Sciences and Chemistry and Molecular Biosciences may lead to their disengagement from the program.
- Re-allocating students from Ipswich campus and the Sunshine Coast to other clinical schools may place strains on the capacity of the remaining clinical schools.

Of these risks, the team was informed the School of Biomedical Sciences is not currently concerned that the proposed budget renegotiation will adversely impact on its engagement with the program. The other risks, however, were raised by staff, titleholders and students with whom the team met. Avoiding them and ensuring continuing stakeholder support will require on-going attention by the School's senior management.

Discussions with the Ochsner Health System executive indicated continued strong support for the program, with the partnership remaining profitable for the School and Ochsner. The Ochsner contract with the University is current to 2019 and Ochsner cohort numbers will remain around 120 per year. Ochsner has autonomy in its executive management to direct resources to its campus.

Regarding the adequacy of the resources available to deliver and develop the program, few areas of clear deficiency were drawn to the team's attention. Deficiencies identified include: an additional educational designer, an assessment academic/co-ordinator and exam bank software, as well as an identified fund for educational innovation.

While the team was impressed by the quality of the human and physical resources committed to the program it considers that the deficiencies identified may affect the School's momentum to improve assessment and further implement online learning in Phase 2.

The School is projecting a progressively increasing budget deficit over the next few years. It is proposing a number of actions that will reduce but not eliminate this deficit. The human and physical resources are generally sufficient to sustain a quality program (aside from the few deficiencies identified by the team) but the School will need to pay on-going attention to ensure adequate support for the program in the next three to five years.

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.

2010 team findings

In the 2005 AMC assessment, the team commented on the relative lack of engagement with Queensland Health in teaching and research, and the need for a better relationship between the School and the teaching health services.

The relationship between Queensland hospitals and health services and the School has improved in recent years, and is commended. Clinical school heads are congratulated for their contribution to this process.

Establishing the clinical schools has facilitated stronger relationships between the health services and the School, especially at local levels. The clinical schools have improved engagement with local health service managers who support the program and value their association with the university. The heads of the clinical schools are also clinicians actively practicing in their respective health services. A conjoint (health services and School of Medicine) performance appraisal system for the heads of clinical schools would further strengthen the health services/School interaction.

Engagement with Queensland Health is now high, and it takes the lead on a number of initiatives that relate to medical education in Queensland, including convening the Queensland Medical Schools Liaison Committee, which comprises the four Queensland medical deans and several senior executives from Queensland Health. Given the importance of the relationship with Queensland Health, the School is encouraged to strengthen its ties at executive level.

The School has recognised the great importance of engaging health sector employees in the planning and providing the curriculum. Awarding honorary academic titles to non-UQ employees has been expanded and is valued by teachers. Work is required in training hospital and community practitioners who contribute to the teaching programs, so they are aware of the curriculum and are given appropriate training.

The developing Ochsner Clinical School promises to be highly successful. Ochsner Health System is a comprehensive health service with a strong commitment to, and track record in, teaching and research. The Ochsner Clinical School is integrated within the Ochsner Health System. An Executive Operating Committee, which includes all System executive vice-presidents, provides operational and strategic oversight for the System. The Head of the Ochsner Clinical School is Executive Vice-President Academic and a member of the Ochsner Executive Team. This relationship assists ongoing communication with the Ochsner medical community on issues such as curriculum, student performance, and graduate outcomes. The Clinical School Head is involved in decision making concerning physician goals and objectives, compensation, and employment, which the Ochsner Clinical School considers will help reduce potential conflicts between clinical service and academic pursuits.

The team was impressed by the extent of Ochsner's planning for its role as a major clinical school. The Clinical School has begun with a small number of UQ students undertaking core clinical rotations and elective rotations over the last eighteen months. While the team considers the delivery of the program at this site has strong success potential, the AMC will need to re-assess the capacity of Ochsner to train the planned full complement of 240 Year 3 and 4 students, together with additional students on elective placements within two or three years.

The Brunei Clinical School is a modest development. Since 2002, the School has placed small numbers of students in Brunei on electives and core clinical rotations in surgery, medicine, obstetrics and paediatrics. The relationship has changed over time, and an agreement to establish the Brunei Clinical School was formally ratified in February 2010, after negotiations with the Brunei government. Under the agreement, the Brunei government, the Universiti Brunei Darussalam School of Medicine, and Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital, support the clinical school's operation, and UQ provides financial support for administering and coordinating students in Brunei. The Head of UQ's Brunei Clinical School is also a senior staff member of the Universiti Brunei Darussalam School of Medicine.

2014 team findings

The School has strong links with its partners in the public and private healthcare sectors at every level of seniority. The efforts of the School in developing these linkages since 2010 were appreciated by its partners and the support of these partners for the educational and research objectives of the School was gratifying.

The ties at the executive level have been strengthened with the head of school on several external groups that relate to health service engagement, and a member of the Ministerial Advisory Board chaired by the Minister for Health. The new deputy head/cluster head roles have a mandate to engage with senior hospital leadership at a clinical school level and the team noted that the cluster heads were actively involved in this outward-facing role.

The School has been working with the Pro Vice Chancellor (Indigenous education) and the Rural Clinical School to build linkages with individuals and organisations active in the Indigenous healthcare sector. The collaboration with the Institute of Urban Indigenous Health is particularly noteworthy.

The team's meeting with representatives of Queensland Health confirmed a strong, collaborative and productive relationship with the School.

The Ochsner Clinical School remains embedded within the Ochsner Health System and its interaction with the health sector and society is impressive. Ochsner's partnerships with local communities and community outreach projects provide valuable student experiences.

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.

2010 team findings

The School has extensive research programs, many of national and international high standing, and has about 300 postgraduate research students. The uptake of combined MBBS/PhD program has been modest to date, although the MBBS/MPhil program may be more appealing to students. The School's strong research culture should have a significant influence on student understanding of how research underpins clinical medicine. However, the opportunities for all MBBS students to have some experience of research and its methodologies are limited, and this is disappointing in such a research-intensive School. The team notes the School is making efforts in this direction, including

a recent academic appointment with a remit that holds responsibility in resolving this concern, and encourages the School by these or other means to improve the level of research engagement for all students.

2014 team findings

The University is an outstanding research-intensive institution, and the School has improved opportunities for student participation in research since 2010. In 2012, out of all health-related institutes and schools in the University, the School had the highest *Excellence in Research for Australia* weighted publications and the highest number of research higher degree (RHD) students, and was awarded \$26M in research funding.

Since the 2010 assessment, the School has been the focus of an Academic Board review and it also commenced reviewing its centres in 2012. Outcomes have included a commitment to a significant reduction in the number of groups with the University organisational status of School research centres, with a focus on a small number of themes that can be internationally competitive.

The School deferred development of a strategic research structure until the Faculty restructure was complete in 2014, and it will now consider this in the broader context of health research in the University and its partner organisations, including Queensland Institute of Medical Research (QIMR) Berghofer, the Translational Research Institute, Diamantina Health Partners, and the proposed Academic Health Science Centres.

The School expects its research theme will be 'Observations to outcomes' with nine established themes in areas of community need that cover the majority of research in the school: mother and baby health; paediatrics; cancer; chronic disease; mental health; infection, immunology and transplantation; critical care; community health; and end of life and ethics. A portion of available research funds will be directed exclusively to support this strategic structure.

Ochsner has an active clinical, translational and population health research base and is enthusiastically working to build on this. There has been an increase in research collaborations between investigators at UQ and Ochsner. There is a UQ-Ochsner Seed Fund for Collaborative Research introduced in 2013, which funded four projects to the value of \$200K AU, and five projects in 2014 for \$50,000AU each. Two collaborative grant applications were made to the USA's National Institute of Health in 2014. A virtual UQ-Ochsner Research Institute is being established.

The School has a three-tiered framework of research learning for students in the program: foundation research training for all students; an 18 month MBBS Honours program for 30-40 Year 3 students; and the Clinician Scientist track introduced in 2013. The Clinician Scientist Track offers three pathways from as early as Year 2 for students to obtain a research higher degree in conjunction or intercalated with their MBBS. Since 2011 there are 42 MBBS-MPhil candidates with 90% upgrading to a PhD. There are over 420 RHD students and in 2013, one-third had a prior medical qualification or were current or recent UQ MBBS students.

The School advised the MD program's emphasis on research training in the first two years of the program will enable more students to be eligible for enrolment in the MPhil. The implementation of the MD program will cause little change regarding the existing Clinician Scientist Track.

The School views the MD as an opportunity to boost its research productivity and the research capacity of the School will be essential for the success of the MD program.

1.8 Staff resources

- 1.8.1 *The medical education provider has the staff necessary to deliver the medical program.*
- 1.8.2 *The medical education provider has an appropriate profile of administrative and technical staff to support the implementation of the medical program and other activities, and to manage and deploy its resources.*
- 1.8.3 *The medical education provider actively recruits, trains and supports Indigenous staff.*
- 1.8.4 *The medical education provider follows appropriate recruitment, support, and training processes for patients and community members formally engaged in planned learning and teaching activities.*
- 1.8.5 *The medical education provider ensures arrangements are in place for indemnification of staff with regard to their involvement in the development and delivery of the medical program.*

2010 team findings

(The responsibilities of hospital and community practitioners have been moved in the 2012 standards to Standard 8.4; and the 2010 Standard 1.10 Staff indemnification is subsumed here)

The academic and administrative staff establishment is well documented and overall, sufficient.

The University's submission identified a number of academic positions created since 2005 specifically to support the medical program. These include:

- Head and deputy head of Years 1 and 2
- Head of Years 3 and 4
- Director Ochsner Program and Partnership
- Head of the UQ MBBS program at Ipswich
- Deputy head of Years 1 and 2, Ipswich
- Nine new head of clinical school positions at professor or associate professor level.

Students reported some difficulties in accessing student support and other advice from the School, especially at the smaller clinical schools.

The team noted the relative dominance of more senior levels of academic appointments. Succession planning will require continued attention.

The School and the University have appropriate arrangements (including with Queensland Health) for indemnifying staff in regards to teaching and research.

2014 team findings

Since the 2010 assessment the School has invested in its staffing structure across academic and professional staff groups. Health Workforce Australia funds of almost \$5M were directed to additional positions over the last three years including the establishment of the UnitingCare Health Clinical School. The School created three senior administrative positions centrally and realigned administrative processes by business system. It reports that staff-to-student ratios across each clinical school are quite even, however, it states that non-critical administrative positions have been lost and the school is at efficient staffing levels. Academic positions are reported in 2014 as follows:

2014 UQ School of Medicine (University) funded positions

(Academic)

	University funded (FTE)	Jointly funded (FTE)	Externally funded (FTE)	Clinical titles etc.
In post	60.5	20.065	6.1	2728
Vacant	1.9	0.5	2	N/A

(Professional)

	University funded (FTE)	Jointly funded (FTE)	Externally funded (FTE)	Clinical titles etc.
In post	119.1	6.6	7.06	N/A
Vacant	1	0.8	N/A	N/A

*Does not include research professional staff

The delivery of the program is heavily dependent upon the use of clinical academic titleholders and junior medical staff who provide substantial amounts of teaching as part of their clinical appointment in all years of the program.

Although the university-funded academic profile is filled, academic full-time equivalents have been slimmed down since the 2010 assessment, despite the cohort growth. In some areas, such as medical education, paediatrics and psychiatry, there appears to be an insufficient allocation of academic staff. The team observed that coordination and delivery of the program was reliant on a small team of lead medical educators and teachers, with key persons taking on additional roles over time without release from existing responsibilities. While the staff expressed an admirable sense of being able to cope with significant shifts in student allocations and a possible continuation of the current student intake, the loss and non-replacement of academic positions in teaching and learning was being felt.

Areas which were particularly affected were timelines for curriculum improvements and innovation. For example the development and implementation of Adult Online Learning Interactive Education (AOLIEs), on which the integration of basic sciences and evidence-based medicine into Phase 2 depends, has an unspecified timeline. The staff also have limited time for scholarship and research as they are filling an increasing number of program delivery roles. Succession planning is also potentially hindered, with most appointments being at Levels D and E. A greater capacity to appoint and develop the lead educators of the future would have the added advantage of providing a pipeline for more sustainable teaching and research supervision for the future MD. Future reporting will be required on staffing, particularly regarding educational expertise roles and succession planning for the key curriculum leads.

There appears to be sufficient administrative and technical staff to achieve the goals of the program.

The School currently employs twelve Indigenous staff (three academic, seven professional and two self-identified academic title holders) and states that it is supportive of the University's Aboriginal and Torres Strait Islander Employment Strategy which is focused on the recruitment and retention via a range of activities.

There is evidence the School has an active program in the recruitment and training of academic staff. Academic staff are appropriately supported to deal with the challenges of their roles.

The School demonstrates appropriate engagement with patients and community members through the information and training provided by the Community Patient Volunteers program, Simulated Patient program and Teaching Associate's program for the intimate examination sessions.

At Ochsner, there are adequate staff to deliver the program, and each discipline has plans to deliver the program to the full cohort by using existing capacity or adding clinical sites. Staff were enthusiastic about taking students, and training of new staff was conducted. Ochsner has eight student administrators who work closely with the Brisbane staff, and plans to add further staff as student numbers increase. Ochsner has a qualified, trained cohort of standardised patients. Many are Ochsner Health System staff who value this as demonstrating 'engagement with community' on their Ochsner performance review.

The School has appropriate indemnity for its staff and this extends to staff and students in the US. Ochsner staff and its standardised patients are also indemnified by Ochsner Health System.

1.9 Staff appointment, promotion & development

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

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

2010 team findings

The School has a well-documented appointment and promotion policy for academic staff that recognises not only research achievements, but also excellence in teaching and learning, and service to the broader health services and general communities.

Given the large remuneration disparity between university-employed clinical academics and health-service employed clinicians, the School now employs most clinical academics on a fractional basis, with health service employment (or private practice) for their remaining time. The team has no concern about this but suggests that joint appointment processes and annual performance reviews underpin such arrangements. Over the past five years, the School and the health service have established joint performance reviews for senior clinical academic staff who are employed by both Queensland Health and UQ.

The team noted the excellent engagement of clinician/tutors in the problem-based learning (PBL) and clinical skills programs in Year 1. The team was concerned about the use of busy hospital clinicians, mainly medical and surgical registrars, for PBL and clinical coaching program in Year 2, noting that service requirements were affecting clinician availability.

The School has a well-documented process for the annual staff appraisal. Currently, the process is quite limited for adjunct clinical academic staff but the School plans to extend the process.

The School has created the School of Medicine Professional Development program, which is comprehensive and includes a program to enhance teaching skills. The teaching skills program is available to adjunct clinical academics, but uptake to date has been minimal.

2014 team findings

The University has appropriate policies and practices to appoint, promote and develop its staff. The University has staffing categories of teaching and research, teaching-only, research-only and clinical academic (introduced in 2011). There are clear criteria and standards for appointment and promotion. Teachers are able to upgrade their skills via University training or graduate certificates in clinical education for example. Professional development is managed by supervisors and their staff. The School has identified that there are no centrally available reporting processes that monitor, at the School level, the uptake of University professional development opportunities.

Ochsner follows the University appointment and promotion policy. Academic promotion is subject to University standards and this high standard has assisted with recruitment of academic staff and given credibility to the program overall. Title holders are funded through Ochsner Clinical School. Ochsner awards a teaching prize to staff and five recent winners will visit Brisbane in October.

The School continues to use the University's annual performance appraisal process for staff and promotes joint annual appraisal between the University and relevant hospitals for jointly-appointed staff.

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.

2010 team findings

The School has an appropriate statement of strategic intent that includes its vision, mission, value proposition, strategy, tactics and strategic priorities. This statement addresses teaching, research, and social and community responsibilities, but does not explicitly address Indigenous peoples and their health. Despite this omission, the team notes the School is actively committed to training a significant number of Indigenous doctors. The School has a specific focus on improving performance in Indigenous health.

The vision of the School is:

- to be recognised as Australia's leading medical school, and to establish a global reputation in medical education and medical research
- to strengthen its position as Australia's 'global medical school'.

The School indicates that when it uses the term 'global', it means 'not limited or provincial' in scope.

The UQ-Ochsner medical program mission, provided to prospective students, is 'to address the United States' shortage of physicians by providing a global medical education in which students have the opportunity to take part in cutting-edge medical research and learn in a fully integrated health system'. The team noted the mission of the Ochsner Health System to 'serve, heal, lead, educate and innovate' and was impressed by the high level of awareness and commitment to this mission demonstrated by the Ochsner Clinical School staff and the Ochsner Health System clinical and administrative staff.

The team was impressed with the stakeholder engagement level in Louisiana, with strong local awareness and support for the UQ-Ochsner medical program mission.

The School's mission has changed since the AMC assessment in 2005. Formal interaction with key external stakeholders, aimed at developing the mission, was limited until the 2009 MBBS review. The review provided the opportunity for engagement, consultation and debate with the School's stakeholders. The review appears to have successfully engaged academic staff and clinicians, as review awareness and process engagement was reported by many teachers across the clinical schools.

The School reports having strong engagement with alumni, and is successful in receiving bequests from alumni to support advances in teaching. However, the team

noted that similar strong engagement is not as apparent with the wider community. A Community Consultation Committee has been convened in 2010 to support the MBBS program at the Ipswich campus.

2014 team findings

Since the 2010 assessment, the School has revised its purpose, which is now:

‘To lead and inspire the development of people and knowledge that will transform healthcare.’

Underlying this purpose are the School’s core values of social commitment, inspiring passion, the collective pursuit of excellence, integrity and professionalism, valuing the school community, and innovation. The School has mapped its core values to the proposed MD program.

The School’s submission documents the mechanisms by which the School’s commitment to its core value of social commitment underpins its efforts in the recruitment and support of Indigenous students, and in the development of the Indigenous health curriculum.

The School conducted the review of its purpose as part of its preparation for its 2011 Academic Board School review. The School Executive’s strategic plan included a range of stakeholder consultation events to involve the School community and key stakeholders in the process. The team commends the thorough and inclusive process by which the School has developed its new vision, purpose and core values, and was impressed by the strong engagement with the School’s objectives of the stakeholders with whom it met. In 2013, the School’s purpose was reviewed by School Council and some modifications were recommended regarding aligning its vision with the University’s 2014 strategic plan and vision ‘Knowledge leadership for a better world’.

The close relationship between the teaching and service activities of the School and the health care needs of the communities in which it operates was evident to the team from the documentation provided and from the stakeholder input gained during site visits. The School’s decision to re-align its research activities to the theme of ‘Observations to Outcomes’, aims to produce outcomes that have demonstrable social impact in areas of community need.

The Ochsner purpose is unchanged and the team remains impressed with the high level of awareness and commitment to this purpose demonstrated by the Ochsner Clinical School staff and the Ochsner Health System clinical and administrative staff. There continues to be excellent stakeholder engagement with the purpose of the program.

During discussions with university staff about the optimal size of the medical student cohort, the team noted a shift in focus from producing graduates to meet medical workforce needs, to producing high-quality graduates who attain leadership positions in health and research institutions around the world. This shift in focus is consistent with the School’s decision to develop the MD program, and its vision that the MD will ‘make the most of the world-class research opportunities at UQ and the University’s expanding global footprint’.

The School aims to achieve a global reputation in medical education and research. The Ochsner model of trans-national medical education has exceeded the School’s

expectations in outcomes, particularly in its *United States Medical Licensing Examination* performance and first year United States residency matches.

2.2 Medical program outcomes

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

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

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

2010 team findings

The School has defined graduate outcomes and these relate to the four curriculum domains. The outcomes are consistent with the AMC's goal for medical education.

In its April 2010 submission to the AMC, the School outlined a list of its core values. However, how each core value is incorporated into the curriculum was not clear. Examples of such values are commitment to social justice and eradication of health inequalities, and interprofessional learning.

The 2009 MBBS review identified important curriculum gaps in patient safety and aspects of communication and professional behaviour. The AMC will need to monitor the School's plans to correct these deficiencies.

The team examined whether all graduates are truly ready to work under supervision as interns in Australia and New Zealand. This was seen as one of the challenges facing the Ochsner Clinical School student cohort. The overall clinical experience quality available at the Ochsner Clinical School is impressive, but it does not represent experience in the Australian health care system. The plan at Ochsner to explore differences between the US and Australian health systems, as a response to this situation, is educationally innovative and appropriate. The School's plans to provide the Ochsner cohort with Australian clinical experience are considered at Standard 3.2.

2014 team findings

The MBBS program curriculum has three aims, seven goals and thirty-five outcomes. The program's outcomes have not changed since 2010, although since the release of the AMC graduate outcome statements (GOS), the School has re-organised the outcomes into four groups:

- 1 Graduates must be humane and committed to the ethos of medicine, personal development and life-long learning (fourteen outcomes).
- 2 Graduates must be knowledgeable and understand the scientific basis of medicine (six outcomes).
- 3 Graduates must be highly-skilled in providing care to patients (nine outcomes).

4 Graduates must have an understanding of evidence-based population and preventative health (six outcomes).

The School has formally mapped its thirty-five graduate outcomes to the 2012 AMC GOS and these are consistent with the AMC requirements.

The AMC graduate outcome domains have been used as the basis of the themes of the program: Biomedical Sciences, Clinical Sciences, Population and Preventive Health and Ethics and Professional Practice. Within the four domains, the School identifies fourteen disciplines: six of which relate to the biomedical sciences contribution to Phase 1, and eight of which relate to the core clinical rotations in Phase 2. Population Health, and Ethics and Professional Practice are both vertically integrated within the curriculum.

The School will phase out its three aims, seven goals and thirty-five outcomes with its MBBS teach-out.

The School has adopted the AMC Graduate Outcome Statements as the MD program outcomes commencing in 2015.

The outcomes formally adopted by the School are consistent with the School's graduates being able to practise safely under supervision as interns and provide an appropriate foundation for life-long learning and further training. Importantly, the team met clinicians who teach the School's students and supervise its graduates who were unanimous in affirming that the School's graduates are safe and competent junior doctors.

Since 2010, the School has undertaken a number of initiatives to ensure its students have comparable educational experiences and undergo equivalent methods of assessment across all clinical sites. In particular, the School is progressively placing more formal learning activities on-line in order to broaden student access to formal educational sessions (discussed at Standard 4).

The regular communication between the Ochsner staff and the School is commended, with the aim of maintaining comparability despite the geographic distance and differences in health systems. The team found that at Ochsner, staff make exceptional efforts to ensure the comparability of student outcomes, experiences and assessment. These efforts include regular meetings between Ochsner staff and the clerkship leads, regular interactions with the discipline heads, ongoing communication of staff with the School, consistent adherence to the curriculum and the use of the School's slides and resources.

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.

2010 team findings

The four-year graduate entry, integrated, problem-based medical program, introduced in 1997 and AMC-reviewed in 2005, has been retained. The MBBS program has three aims, linked to seven goals and then further broken down in to thirty-five outcomes in four groups. These have not changed significantly since the 2005 AMC assessment, although the School now presents its previous fitness to practise principles as outcomes. The School has developed program aims, goals and outcomes linked to individual learning objectives across the program by year and/or domain. The outcomes form the basis for specific learning objectives for each system module in Years 1 and 2 and for each of the ten core clinical rotations in Years 3 and 4. Organising Years 1 and 2 into system modules covering the four domains, each with a designated clinical lead educator responsible for designing and coordinating curriculum, is new. Years 3 and 4 are organised into 10 core clinical rotations: Medicine, Surgery, General Practice, Medicine In Society and Mental Health in Year 3, and Obstetrics And Gynaecology, Paediatrics, Medical Specialty, Surgical Specialty and Elective in Year 4. The four domains cover each rotation. All four domains of the curriculum have a strong core program with learning objectives organised by domain.

2014 team findings

The MBBS program continues to be delivered over four years and is of sufficient duration to cover the School's graduate outcomes.

The School's medical program will be offered as an MD for cohorts commencing from 2015. The AMC's Medical School Accreditation Committee in December 2013 advised the School that it did not consider the proposed changes as a major change.

The implementation of the MD program will not alter the duration of the four-year program. In Phase 1 of the MD, four units will be removed from the sixteen units of medical / clinical science courses in the MBBS and four units will be added to research training to ensure AQF Level 9 compliance. The School has managed the loss of four units of science by eliminating duplication in course content and expecting a higher standard of student knowledge on entry to the program. In Phase 1, the School will emphasise the teaching of basic sciences in the clinical context.

Students come to the program primarily from a science undergraduate background, and for non-science students the School provides additional resources as refresher content and targeted support for students to utilise. Students reported that new students receive science resources with their offer letter. The student body also organises peer coaching for non-science students. While the School is confident the MD program will continue to meet the science and scholarship outcomes, it will need to monitor the outcomes of non-science students in the MD.

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.

2010 team findings

The overall program structure, with two preclinical years and two clinical years, remains unchanged from 2005. The 2009 MBBS review recommended reorganising Years 1 and 2 into two-unit courses to comply with the preferred UQ program structure, to make course content more explicit, and to increase course coordinator accountability. The proposed unitisation will introduce four courses in Year 1 (biomedical sciences, clinical education, population health/ethics, and an elective) and five courses in Year 2 (clinical sciences including pathology, clinical education, case-based tutorials, population health, and ethics). The Curriculum Committee is considering the change and its effects. These are yet to be determined; in particular, the implications of unitising for progression rules. Detailed updates on this restructure will be required.

Basic biomedical sciences teaching, focussed in Years 1 and 2, is coordinated and delivered by the Faculty of Science, which provides sixty-seven per cent of teaching in Year 1 and five per cent in Year 2. Two joint appointments between the School and the Faculty of Science, including the Head of Years 1 and 2, have facilitated coordination of biomedical science teaching. The School acknowledged the need to improve anatomy and pharmacology teaching, and appropriate work is underway. The significant improvement in providing the physiology course is commended.

The School recognised the need to extend biomedical science teaching into the clinical Years 3 and 4 to form a 'linked' curriculum. Plans to develop a weekly half-day 'release' from clinical teaching, to allow focus on key unifying biomedical sciences concepts, are commendable, but remain at an early stage. In this regard, Ochsner academics have developed impressive materials for radiology teaching that allow anatomy to be taught in a clinical context. This commendable enthusiasm is an indicator of the strength of engagement with the Ochsner teachers.

The four-domain curriculum framework—biomedical sciences; clinical sciences; population and preventive health; and ethics, personal and professional development—does not appear to inform the curriculum offered by the academic clinical disciplines. The School does not yet have an effective mechanism to ensure disciplines contribute to the Years 1 and 2 curriculum, resulting in program separation into two sections: Years 1 and 2, and Years 3 and 4. The discipline heads responsible for Years 3 and 4 do not have sufficient knowledge of or input into the program's first two years. There are exceptions to this, such as Saturday morning anatomy dissection tutorials for Years 3 and 4 students, taught by surgical trainees through the surgery discipline, although these are extracurricular.

Major changes in Years 3 and 4 since the 2005 AMC assessment include removing the intern traineeship and introducing the Medicine in Society core clinical rotation in 2010. This rotation allows students to choose one of four streams: rural and remote communities, refugee and migrant health, Indigenous and other minority group health, and palliative health and rehabilitation. Each stream provides a structured clinical placement, giving students the opportunity to experience and understand the challenges of clinical practice in disadvantaged populations or communities.

The School is commended for its efforts in strengthening the area of Indigenous health, identified in the 2009 MBBS review. The School is mapping the curriculum to the Medical Deans Australia and New Zealand Indigenous Health Curriculum Framework.

The School has reviewed available data on demographics, vital statistics, health status and health service use, comparing Queensland and Louisiana. There are similarities in health and disease patterns, but there are also identifiable differences in clinical practice. Examples include resuscitation protocols, diagnosis and management approaches to melanoma, and the management of cervical dysplasia in pregnancy. The School has designed learning activities to encourage students to document and explore the implications for these differences, as a platform for developing lifelong learning skills. Cultural diversity is recognised within the context of rural setting placements, including experiences in Indigenous health care facilities and in Brunei and New Orleans. The new course, Medicine in Society, introduced in 2010, provides opportunities for preceptor-supervised student placements in a clinical practice amongst a disadvantaged/minority community/population group.

To ensure Ochsner students meet the AMC requirements of work readiness as interns in Australia, the School is intending students complete the following:

- a four-week elective at the end of Year 1 in the Australian health care setting
- a four-week placement in the Australian health care setting in South-East Queensland, including an Indigenous placement. At the time of the team's assessment, the School planned four weeks in South-East Queensland on a general practice/rural/Indigenous placement, but this changed in response to the AMC's advice (see next paragraph)
- one of the Year 4 eight-week hospital-based core clinical rotations in Australia in place of the elective.

This will give Ochsner students a total of sixteen weeks clinical experience in Australia. The team considered this an appropriate response to the AMC's accreditation requirements. The team acknowledges the differences in rural practice in Australia and

Louisiana, including contextual differences such as degree of rurality and distance from large tertiary referral centres. There are also many similarities. While the team acknowledges the School's intention to provide Ochsner students with Australian experience as preparation for possible Australian practise a substantial number of Australian UQ MBBS students have very limited opportunities for rural clinical experience. The large increase in medical student numbers in Queensland has placed significant pressure on rural places. The School should consider carefully how it can best use available resources to provide students with high-quality rural medical practice experience, and the potential role of Ochsner Health System rural hospitals and health facilities in meeting program objectives.

As part of the Faculty of Health Sciences, the School is represented on the Faculty Interprofessional Education Committee. An audit of interprofessional education teaching in the program identified existing activities and further opportunities. In Year 1, in groups of ten, all medical students and students from all health disciplines participate in a full day of activities linked to charitable organisations. The School has also piloted a ward-based scenario in collaboration with the School of Nursing and the Queensland Health Skills Development Centre to increase competencies in professional communication, collaborative decision-making, recognising knowledge limitations, and identifying sources for assistance. The team was shown examples of interprofessional learning, using scenario-based teaching with simulation, at both Sunshine Coast Clinical School (Nambour) and at Toowoomba. The team encourages the School to build on its established relationships and integrate learning of safe clinical practise and quality improvement into these learning models.

2010 team findings

(Previously 2010 Standard 3.4 'Research in the curriculum'.)

The School introduced an MBBS/PhD program in 2000 and subsequently the MBBS/MPhil in 2008. In 2009, a total of nineteen candidates were enrolled; four have graduated, nine are continuing and six have withdrawn. A 2007 review of the research higher degree programs associated with the MBBS found the low enrolment number and high withdrawal rates could be attributed to the demanding nature and length of the program, aggravated by the withdrawal of financial support provided through the School's Mayne scholarship. Other sources of scholarship support are available from the School, but uptake remains low.

The School must continue its efforts to provide MBBS program students with opportunities to undertake research, including scholarship and financial support. While opportunities have been identified through combined programs such as the MBBS/PhD and the MPhil, uptake of these programs has been low, and research exposure is not high despite UQ's rich research environment. The School needs to reinvigorate and explore research project opportunities across the curriculum.

2014 team findings

The MBBS curriculum is informed by a well-described and defined set of three aims, seven goals and thirty-five outcomes. These align to learning objectives that map to the AMC Graduate Outcome Statements.

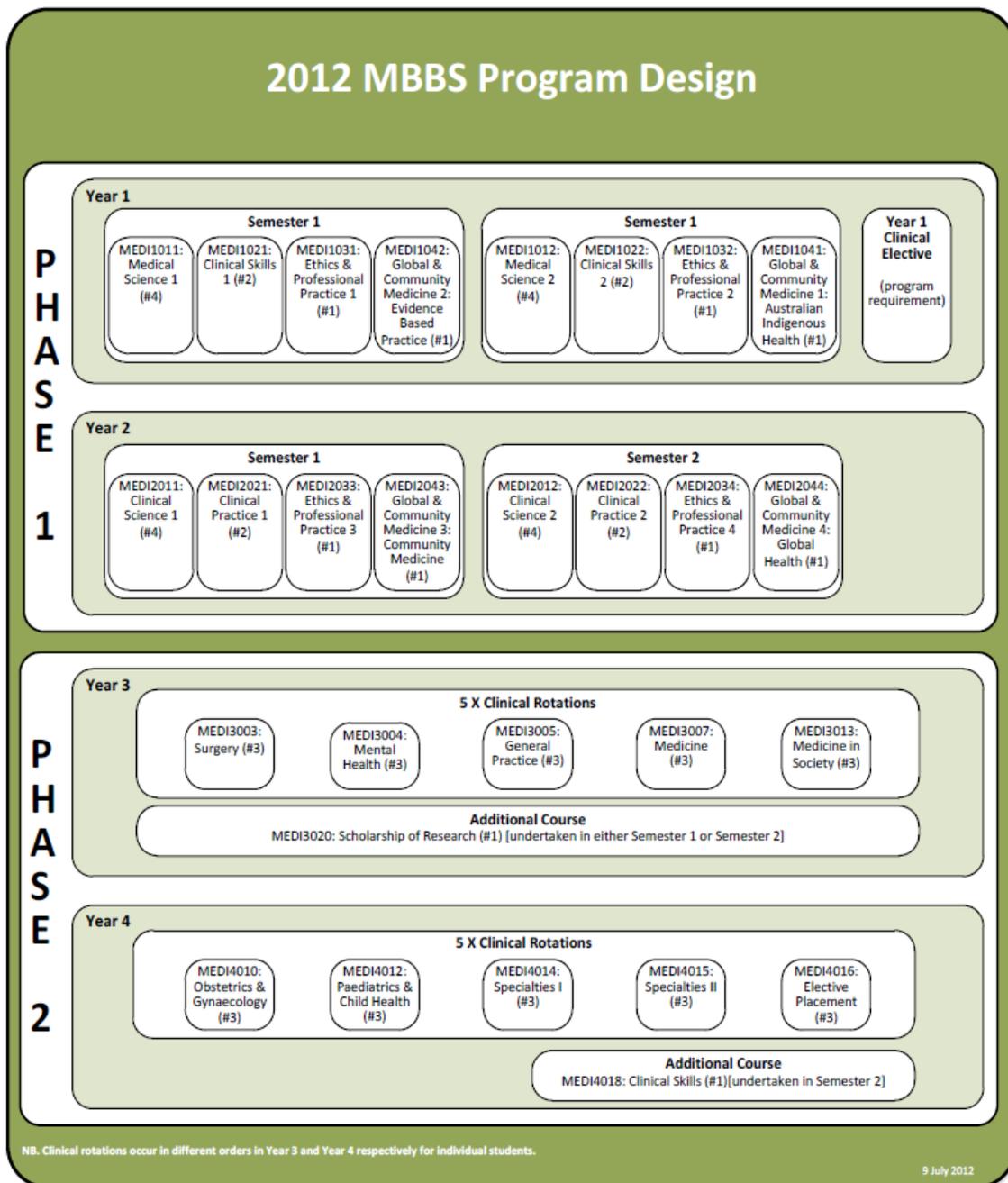
During Phase 1 the curriculum remains organised within four domains: Biomedical Sciences, Clinical Sciences, Population and Preventive Health and Ethics and Professional Practice. Since the 2010 assessment, the School has enhanced the Phase 1 basic science teaching in anatomy and microbiology, and in the areas of population health and ethics. In anatomy especially, the content has been revised with clear learning objectives and an enhanced clinical focus, and there is a stronger correlation between content and assessment with addition of practical-based examinations, which include gross anatomy and histology.

During Phase 2 the separation of the curriculum into domains is less obvious with the curriculum being delivered by clinical specialties. The ten rotations in Phase 2 that the disciplines teach into are: Year 3 – Surgery, Mental Health, General Practice, Medicine, Medicine in Society. Year 4 – Obstetrics & Gynaecology, Paediatrics & Child Health, Critical Care, Specialties I, Surgical Specialties.

It is apparent from review of the curriculum content and discussion with staff and students, that students are exposed to content sufficient to satisfy this standard.

Figure 7 represents the structure of the MBBS program.

Figure 7 – MBBS program design



The Phase 2 rotations have been altered since 2010 with the Year 4 eight-week Specialties 2 rotation being replaced by Surgical Specialties (eight weeks) and Critical Care (eight weeks including emergency, intensive care and anaesthetics). These changes were possible with the removal of an elective block which can be taken optionally in between Years 2 and 3, or 3 and 4. Assessment of clinical skills competency is now a program requirement instead of a course-based assessment. The team heard positive feedback from students and staff regarding this change.

At Ochsner, there was evidence the health and society curriculum was relevant to the local context, with examples provided including the Haiti rotation, and primary care of low socioeconomic status patients. Students commented that the Indigenous health

teaching they received in Phase 1 was transferable to areas of the community in Louisiana. Ochsner staff indicated students demonstrate evidence of appropriate instruction in professional behaviour and could apply this to the clinical context.

In 2010, the team assessed graduate readiness to practise in an Australian health care setting noting the Ochsner cohort would spend sixteen weeks in an Australian clinical setting across the program. Ochsner students complete the Year 1 elective (minimum eight weeks) in an Australian healthcare setting, in Year 2 the clinical coaching sessions are delivered in the Queensland healthcare setting, and they are required to return to Australia in Year 4 to complete one eight-week clinical rotation of their choice. The team is satisfied that the arrangement meets the requirement of this standard.

During the visit to Ochsner, the School commented that the return eight-week clinical rotation to Queensland in Phase 2 placed a financial burden on students, and given the similarities in clinical practise between Australia and the US, the School queried whether it delivered any additional benefit beyond that achieved in Phase 1. The School advised that it may consider teaching and learning strategies in place of the Phase 2 return rotation to ensure graduates are able to practise in the Australian healthcare setting. If the school were to progress these plans, it should submit a proposal to the AMC that demonstrates the Ochsner graduates would continue to be able to practise as safe and competent interns in Australia.

The MD program will commence in 2015 and the team assessed the changes that will be made. The structure of the program will not change. The MD program structure is shown in Figure 8.

an increased research workload for students. The impact of these changes has been anticipated. The bioscience content has been revised to ensure all learning objectives are covered with the loss of units and that Phase 1 topics are vertically integrated; and the School plans to move from problem-based learning to case-based learning in Year 1 to reflect the content change. Staff development needs have been identified and training of CBL tutors is underway. The team considers the bioscience content in the MD will be adequate. The impact of these changes on preparedness for transition to Phase 2 should be monitored.

The School expects Phase 2 in the MD will evolve but not change significantly. The University rules encourage semesterisation and the School is discussing how best to integrate five rotations into a semester model.

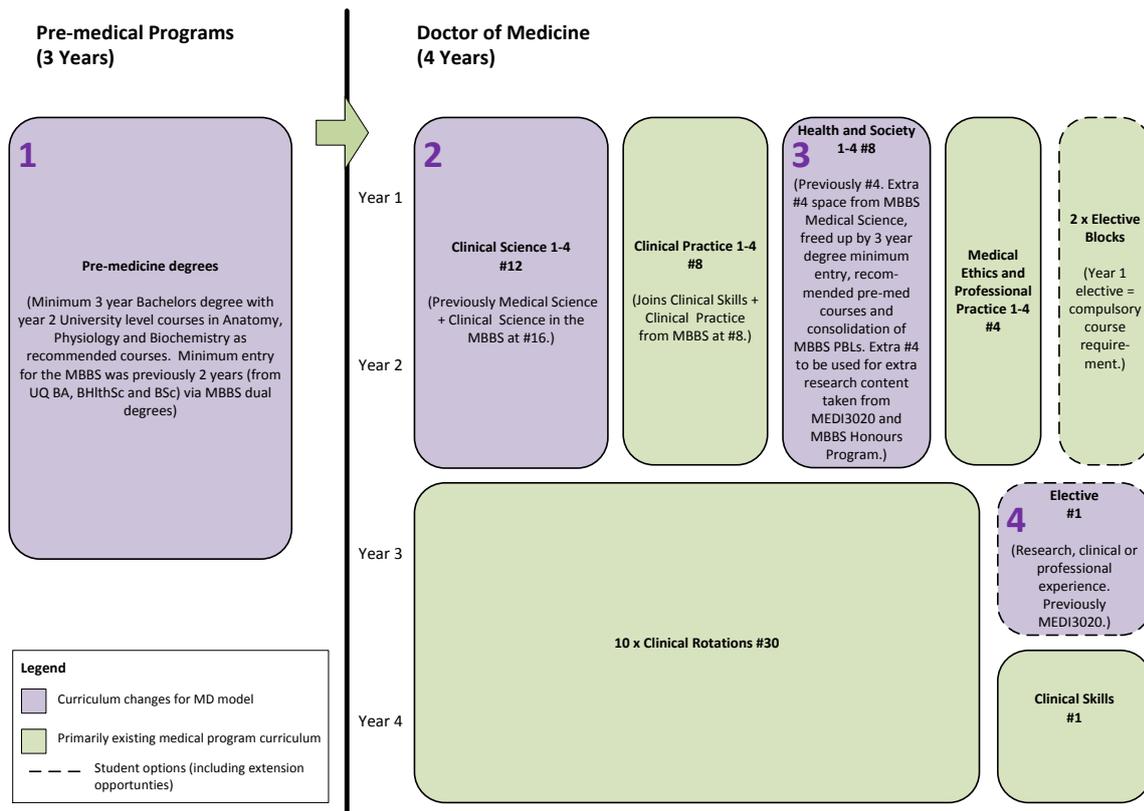
The School, through the Program Committee, has reviewed and refreshed elements of the curriculum in designing the MD, mainly in the science and research elements. For the sciences, the School is planning a foundation week for each system block. Semesters 1 - 3 will be system-based, and Semester 4 will be integrated and relevant to the Australian Junior Doctors Curriculum Framework.

There are course descriptions for each of the four Phase 1 Health, Society and Research courses though the content is still being finalised. The addition of research in Phase 1 will allow enhanced research opportunities in Phase 2, and will prepare those students with an interest in clinical research for extension opportunities.

In Phase 2 (specifically Year 3) options for several types of research projects are being planned. Some students will conduct a supervised project and the remainder will complete a 'sample' project that will involve secondary analysis of data or a clinical audit that has been scoped for the students. Approved high-performing students will be able to join supervisors on new or existing projects and use these projects for assignments in Semester 2 of Year 2. All other students will be given access to the 'sample' database described before. The number of research supervisors, the type of and access to datasets, and the provision of statistical and other methodological support tailored to each project will be defined on a case basis.

Figure 9 outlines the areas of curriculum change in the MD program.

Figure 9 – Areas of curriculum change in the MD



The student representatives on the MBBS/MD Program Committee were positive about the MD curriculum changes, advising that they had been fully involved in the review process and were benefiting from the content improvements that were being implemented in the MBBS program now in readiness for the MD.

The School was yet to finalise the MD curriculum and Phase 1 courses at the time of the team’s visit in June. As stated above, the School has mapped the Phase 1 courses of the MD program to the AMC Graduate Outcome Statements. Mapping of Phase 2 of the MD courses to the AMC Graduate Outcome Statements should also occur once curriculum plans are finalised. These MD curriculum and Phase 1 documents will need to be completed in reasonable time for the 2015 MD program commencement. The School was confident this would occur and the team considered this to be achievable.

It is recommended that the School monitor, and include in progress reports, information on the range of research projects, including parameters such as topics, supervisors, and methodologies, after implementation of the MD program.

The team recommends the impact of the proposed curriculum change on Phase 1 exam outcomes and perceived readiness for Phase 2 be reported on in the first relevant progress report to the AMC after implementation of the MD (also noted at Standard 6.1).

3.3 Curriculum design

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

2010 team findings

Horizontal integration continues across Years 1 and 2 of the program, centred around the weekly PBL case and associated lectures, tutorials and practical classes. The School acknowledges a number of difficulties in maintaining a logical learning sequence. These difficulties include: changes in staff and lecturer availability that may shift learning activity sequence; unclear ownership and responsibility for parts of the curriculum, making regular, effective material revision difficult; and, finally, vertical elements running through the four years, such as population health and ethics which fragments otherwise connected curricula in the program.

To address these concerns, the School is reorganising the Years 1 and 2 courses into units with clearly designated course coordinators responsible for each unit. The Head of Years 1 and 2 will continue to oversee integration across the program in Years 1 and 2.

The School has identified vertical integration as an area requiring attention. Teachers responsible for vertical elements running through all four years, such as the population health and ethics domain, are developing their own curriculum statements and aligning their teaching with the system modules in Years 1 and 2. The School is developing plans to integrate basic sciences teaching in Years 3 and 4 using a program of weekly half-day releases linking basic sciences with clinical practice. The School is expected to report to the AMC within the next one or two years on progress with curriculum integration.

2010 team findings

(In 2010 these findings were presented at Standard 3.6 'The continuum of learning'; subsumed in 2012 at Standard 3.3.)

To ensure explicit integration of the program with postgraduate medical education and training, representatives from Queensland Health's ClinEdQ are members of the MBBS Curriculum Committee. (ClinEdQ was established to ensure a more coordinated approach to clinical education and training across the health professions in Queensland.) The School is auditing the curriculum to review its alignment with the Australian Curriculum Framework for Junior Doctors.

When applying for program entry, international students are provided full and explicit information regarding the conditions of intern allocation and placements in Australia. Queensland Health guarantees intern positions for all local medical graduates of Queensland medical schools and was able to place international graduates of local medical schools in 2010. This is unlikely to continue, given the increased number of medical graduates over the next five years. Although sufficient places are available in postgraduate Years 2 and 3, there are insufficient places for internship. The Head of School is actively involved, through the Medical Deans of Australia and New Zealand, in lobbying for sufficient intern placement numbers for all UQ graduates.

To be eligible to apply for residency in the United States, Ochsner students must first pass Steps 1 and 2 of the United States Medical Licensing Examination (USMLE), and then pass Step 3 within twenty-four months of completing their medical degree.

Louisiana is experiencing serious medical workforce shortages, with up to sixty per cent of the current medical workforce supplied by international medical graduates and locums. Its health authorities are therefore supportive of the UQ–Ochsner Clinical School as a means of supplying well-trained doctors. Ochsner students will be able to select an advisor in Year 4 to counsel them on career options and residency preparation. Ochsner students will be provided support programs to help them prepare for Steps 1 and 2 of the USMLE, including tutoring sessions by paid tutors, access to question banks, review books and practice examinations. Since residency placements in the United States are based in part on student placements and referee reports, Ochsner students are well placed compared to American students from other overseas medical schools.

Up to eight international students per year from Brunei are sponsored by the Bruneian government. The team met students from three year-cohorts, all of whom returned to Brunei for their foundation year and subsequent residency. These students had all completed two core clinical rotations plus an elective in Brunei—in medicine, obstetrics and gynaecology, paediatrics, or accident and emergency—and felt well prepared for their subsequent postgraduate training and work in Brunei.

The School has developed effective support mechanisms for teaching in rural and remote medicine, resulting in a continuous stream of students undertaking these placements in Year 4, and proceeding to the Prevocational General Practice Placements Program in postgraduate Year 1. The team’s visits to rural clinical schools highlighted the importance of student exposure to rural generalist experience in attracting and retaining rural students. The team met a number of recent UQ graduates who had elected to return to their rural clinical hospitals as interns and residents.

2014 team findings

Phase 1 is described by the School as having a spiral curriculum and it has a scaffolded approach to content complexity. The medical and clinical sciences are taught at a foundation, system-based level in Year 1 and revisited in Year 2 as symptom-based presentations. Likewise, communication skills and clinical skills move from normal scenarios in Year 1 to more clinically complex scenarios in Year 2.

There is good horizontal integration within Phase 1 by virtue of the problem- and case-based learning model, and the Phase 1 management team meet regularly to ensure this integration is maintained.

There has been good vertical integration of the Phase 2 clinical subjects into the Phase 1 program, however there remains opportunity for further integration of Phase 1 topics into Phase 2. The School plans to address these issues through the development of Adult Online Interactive Education (AOLIE). As neither a detailed timetable for implementation, nor a dedicated budget to provide the resources required, was available, there is a risk of this development not progressing.

Horizontal integration in Phase 2 is less well-defined as the program is being organised largely along discipline-focused lines. The integration of the domains in the disciplines in Phase 2 can appear ad-hoc as opposed to being driven by a strategic curriculum map. The team did not see this as a major weakness as the tutorial program and PBLs ensure some integration of learning, and there are many benefits from the strong discipline structure in the clinical schools that could be at-risk if broken down. The School is encouraged to consider a more purposeful approach to integration in Phase 2.

The e-Portfolio discussed in 2010 was planned to improve integration in the program through the longitudinal tracking of clinical skills development. This project is yet to be realised due to the difficulty of identifying an appropriate longitudinal software platform, and in the interim, a clinical skills competency checklist is being developed.

The team was satisfied the program prepared graduates for internship in Australia. To work as a doctor in America, the Ochsner students must sit three USMLE exams: the first at the end of Year 2, the second at the end of the program, and the third at the end of the graduate year. Students receive study support and mentoring, and the USMLE Step 1 and 2 results have been good, as have the residency matching results. The Ochsner graduates are recognised in all American states, except for New York, where the School's recognition application is pending.

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.

2010 team findings

(In 2010 these findings were presented at Standard 3.1.)

Since the 2005 AMC assessment, the University has implemented the electronic course profile, an integrated and distributed web-based system for developing, delivering and archiving all course profiles. This system has allowed curriculum mapping to guide course design, review and implementation, and student learning across the program. The School has devoted considerable attention to providing a complex and extensive list of learning objectives. However, the level of detail in these learning objectives lacks consistency. Neither teachers nor students found them relevant or helpful in guiding learning and teaching. Students who met the team repeatedly commented on the overwhelming number of learning objectives. The team remains unconvinced that the School is providing clear direction to the students about what should be learned. Given the complexities of delivering a uniform curriculum across ten clinical schools, the team strongly encourages the School's plan to retain the aims, goals and outcomes, but to review the wording and substantially reduce the number of learning objectives.

2014 team findings

As described above, the MBBS curriculum is underpinned by a well-defined set of three aims, seven goals and thirty-five outcomes, and these align to learning objectives that map to the AMC Graduate Outcome Statements. The AMC Graduate Outcome Statements have been adopted as the outcomes of the MD program.

The learning objectives have measurable outcomes aligned to each of these which are available electronically, and are readily available in each course outline. Students and discipline leaders are aware of the learning outcomes and the methods of assessment related to these. Students commented the learning objectives have been improved in recent years: for example the case-based learning sessions have clear objectives that guide learning and provide clarity for tutors and students, and students download the learning objectives to guide their study. The Ochsner students reported that they understood what the curriculum objectives were and found these easy to access online.

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).

2014 team findings

The main teaching in Indigenous health occurs in Phase 1 through a dedicated core subject which forms part of the Health and Society domain and is based on the Medical Deans Australia New Zealand curriculum framework. Students examine Indigenous health in a cultural and historical setting. The aim is to provide students with an understanding of the practice of healthcare within diverse Indigenous Australian communities, and to understand how issues such as culture, history, education, location, employment, and family structure adversely effects health and doctor-patient relationships.

In Year 3 there is a further three-hour module for domestic students prior to commencement in the rural placement during the Medicine in Society rotation, when students have the opportunity to be involved in Indigenous health settings. This module is run concurrently across sites, and has a high level of integrity between sites. There is a session in the General Practice rotation on Indigenous health which is offered to all students and there is also opportunity within the General Practice rotation for students to spend time in urban Indigenous Health Centres. As such, all students have access to clinically-focused Indigenous health content prior to Medicine in Society and General Practice rotations.

There are opportunities for Indigenous health issues to be further integrated into the teaching in both Phase 1 and Phase 2 with better inclusion of Indigenous health issues into case- and problem-based learning as well as lectures and the planned Adult Online Interactive Education system.

In the MD program the Australian Indigenous Health course will be expanded to a two unit course and will include research modules. Specific research modules will cover the ethics of research with a specific focus on designing and conducting research in Indigenous and other vulnerable populations.

The responsibility for the content of the Indigenous health curriculum currently lies with the MBBS/MD Program Committee, with expert content input from the University's Aboriginal and Torres Strait Islander Studies (ATSIS) Unit. The team considers there is opportunity to strengthen and further embed the Indigenous health curriculum by means of improved collaboration between the School and ATSIS. Future progress reports should comment on the progress of integrated learning opportunities within the MD curriculum.

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.

2010 team findings

The School offers two elective periods: four weeks at the end of Year 1, and eight weeks during Year 4. Students are encouraged to explore new settings and, in keeping with the

School's positioning as a 'global medical school', thirty to fifty per cent travel internationally for their electives. Ochsner students will be required to undertake these electives in Australia. Additional choice is available in Year 3, when all students can choose one of four streams for the Medicine in Society rotation.

Students in Years 3 and 4 may spend up to two core clinical rotations plus an elective offshore with one of the School's clinical partners: Brunei, IMU (International Medical University) or Ochsner, following the same curriculum and sitting the same examinations as their peers. To complete a rotation overseas, students must have the term approved prospectively and, for a core clinical rotation in Year 3 or 4, must be eligible to complete an overseas rotation. The minimum rotation length a student is allowed to study overseas is four weeks. The School indicated it was also developing opportunities for medical student electives with a small number of partners in India and in China.

The School's Elective Coordinator, supervised by the Head of Year 3 and 4, approves students' elective choices. Students are required to submit a signed supervisor's agreement and an elective description to the Elective Coordinator for approval.

2014 team findings

There are multiple opportunities for students to pursue studies of their choice. Examples include: an elective program at the end of Year 1; the option of spending a significant amount of time in a rural location through the rural clinical school; spending Year 3 immersed in a rural community or to sequentially spend the Medicine in Society and General Practice rotations in a rural community. There are also opportunities for students to seek approval to undertake up to two core rotations offshore or in alternative locations in Year 4. The minimum duration of a clinical placement at an international or non UQ affiliated location is four weeks.

There is a strong research culture at UQ and this reflects the amount of research training and opportunities that are provided through the Honours, MPhil and PhD streams. This will serve as a good platform for the MD program.

Australian-stream (non-Ochsner) students have the choice to rotate to Ochsner Clinical School for up to two rotations, which many of the international fee-paying students rely on to gain American healthcare experience. This opportunity may become limited from 2015 when the Ochsner cohort is at capacity with 120 students enrolled in each of Years 3 and 4. Ochsner students can choose their compulsory Year 4 rotation in Australia.

4 Learning and teaching

4.1 Learning and teaching methods

2010 team findings

The program learning model includes lectures, which in Year 1 are given mainly by Faculty of Science lecturers and limited to nine hours per week. In Year 2, lectures are limited to eight hours per week and mainly delivered by practicing clinicians. In keeping with the horizontal integration of learning, a panel of clinicians, basic scientists, and in some cases patients/carers present two-hour, whole cohort symposia in Years 1 and 2.

Evidence-based medicine and physiology topics are taught in larger tutorial sessions. Practical lab classes in anatomy, histology and physiology are taught for up to forty students with a tutor–student ratio of 1:10–15.

A substantial amount of teaching continues to be provided in small groups, including problem-based learning (PBL) sessions, where groups of ten students meet for two hours each week, discussing seventy PBL cases across Years 1 and 2. Overall, the School has maintained a high standard in its PBL, clinical skills and bedside teaching. It was pleasing to note that PBL teaching in Year 1, predominantly by clinicians, is well resourced and supported, with students benefiting from a ten-week period with the same tutor. PBL cases are reviewed regularly and systematically.

Significant changes have been made to the clinical coaching program since the 2005 AMC review. The former traditional format of weekly clinician-taught, 1.5-hour bedside sessions at the hospital has been replaced with a more structured program. This is delivered during clinical visits, preferentially scheduled in nursing homes and retirement villages, and closely linked to the system modules in Years 1 and 2. The team met the community-based medical practitioners recruited and trained as dedicated tutors; students and teachers strongly endorsed the Year 1 clinical coaching program, which has been recognised with a UQ Award for the Enhancement of Student Learning. The team commends the work achieved to date. The School is encouraged to review clinical teaching in Year 2 with appropriate support of clinical teachers.

For logistical reasons, clinical coaching tutorials in Ipswich alternate weekly between sessions in the Ipswich General Hospital rehabilitation ward and campus-based tutorials with patients from the ‘community patient volunteer’ program. The team encourages the School to continue to work with Ipswich General Hospital staff so that students have appropriate access to inpatients.

The physiology teaching offered at Herston campus is impressive. Recruiting a medically qualified full-time lecturer at Ipswich is a positive move. Teaching staff are now travelling regularly to the Ipswich Clinical School, although students do not have regular access to some key lectures, and have had to attend classes or examinations in physiology, microbiology, anatomy and clinical symposia on the St Lucia campus about fifteen times in Year 1.

The School is congratulated for developing the new, interactive pathology teaching material and environment at the Herston campus. The team was pleased to note the pathology discipline is increasing its workforce and planning to increase the level of

pathology teaching in Years 3 and 4, introducing clinico-pathological conferences during core clinical rotations.

The team is concerned about the style and extent of anatomy teaching and access for all students. Students based at Ipswich campus attend complete cadaver classes at St Lucia, supplementing the tutorials based on plasticised anatomic models at Ipswich. The School has acknowledged a lack of adequate wet lab access for Ipswich students. The team is pleased to note, in conjunction with the Faculty of Science, the School has obtained permission for cadavers to be loaned to the Ipswich Clinical School for teaching purposes, and plans are underway for building a major facility for preserving anatomical specimens at Ipswich campus. Relying on students as anatomy teachers is undesirable.

In Years 3 and 4, students undertaking rotations in peripheral hospitals expressed concerns about access to core lectures and tutorials provided at large teaching hospitals. Electronic access to these materials would be invaluable to these students.

2014 team findings

The program offers a good range of learning and teaching opportunities across all teaching sites. In Phase 1, teaching methods include: lectures and problem-based learning (PBL) or case-based learning (CBL) tutorials, clinical coaching, workshops for communications skills and practicals in anatomy, histology, physiology and microbiology. In Phase 2, the core teaching is clinical immersion supplemented with direct teaching, including bedside tutorials, lectures, clinical skills training and e-learning with on-line cases.

The central role of the seven Clinical Lead Educators in developing the Phase 1 curriculum and liaising with relevant biomedical and clinical colleagues has proved to be highly effective. The team is pleased that the Year 1 clinical skills teaching and supervision ('clinical coaching') has been extended to Year 2.

The team noted that the size of the teaching groups at some clinical sites in both phases has increased over the last two years, with Year 1 clinical coaching groups at some sites doubling since 2013 from five to ten students. This potentially makes bedside teaching less interactive and has led to students and teaching clinicians expressing dissatisfaction. The School advised it has not noted a change in remediation numbers or re-sits with the increased size of the groups. In Phase 1, PBL group sizes have increased from ten to twelve students and communication skills workshop groups have increased to twenty-four per group, reducing opportunities for direct supervision, interaction and feedback. The team suggests the School should continue to monitor group size against student learning outcomes.

The School is commended on the transformation of its anatomy program. The learning is scaffolded from easy to more challenging concepts with increased focus on important foundational knowledge, application to clinical context and safe practice information. There is high student satisfaction of the anatomy teaching which is now viewed by students and staff as outstanding.

Drawing on the success of the revised anatomy teaching, the pharmacology program would benefit from redesign and the identification of a champion in this field. Core concepts in pharmacology may be better placed at the beginning of Year 2. In each

system block there is some updated pharmacology but confusion between pharmacology and therapeutics was observed.

The team commends the School on the development of its unified on-line curriculum for paediatrics. The Paediatric Online Interactive Education (POLIE) modules have improved consistency in paediatric teaching, and are an exemplar of the high quality e-learning material that the School is developing as part of its Adult Online Interactive Education (AOLIE) modules to improve access to learning. As stated at Standards 1.4 and 3.3, a resourced plan to further develop and maintain e-learning materials is recommended.

Evaluation of the student experience in relation to the POLIE modules and flipped classroom delivery indicates positive results and good student engagement. It would be valuable for this evaluation process to be expanded with larger sample sizes, and extended as more cases are developed.

4.2 Self directed and lifelong learning

2014 team findings

Throughout the program the blended learning model promotes enquiry-oriented learning that encourages students to take responsibility for their learning. Students report there is a good culture for teaching and learning that encourages them to be self-directed.

4.3 Clinical skill development

2014 team findings

Phase 1 biomedical science teaching develops clinical reasoning and provides a link between science and clinical skills. Core concepts are mapped to align with the clinical skills program. Year 1 is taught predominantly on campus and in Year 2 clinical coaching, problem-based learning / case-based learning and workshops are held at the clinical sites.

There is ongoing discussion and good collaboration between the Phase 1 clinical lead educators and clinicians from Phase 1 to Phase 2. There are some outstanding faculty members who have fully integrated scientific and clinical skills and knowledge. Clinical coaching sessions use blended learning for an active learning experience and the clinical coaches introduce students to core skills and liaise with the basic scientists in a collegial and collaborative way.

Clinicians, particularly those in Ochsner, report UQ students have good clinical skills when they enter Phase 2, and are ahead in clinical practice skills when compared with United States medical students. However, some Ochsner staff have observed that student knowledge of pharmacology and anatomy in Phase 2 was at times weak in comparison with their United States counterparts.

4.4 Increasing degree of independence

2014 team findings

In Year 1, students practise their clinical skills in simulation, and participate in an elective experience at the end of the year for a minimum of four weeks. In Year 2, there is weekly supervised interaction with patients in the clinical coaching session. The clinical simulation sessions and the Clinical Teaching Associates program, which uses standardised patients, are good examples of the strong focus on clinical learning. Students have independent time in the clinical environment and are required to examine patients and participate in daily ward activities.

In Phase 2, teaching and learning methods are comprehensive, with increased emphasis on development of clinical skills under the supervision of clinicians through clinical simulation and small group case-based learning.

The team commends the School on the student experience at Ochsner which includes mentoring, one-on-one supervision and increasing responsibility as a member of the medical team.

4.5 Role modelling

2014 team findings

In Phase 1 problem and case-based learning tutors act as role models and students are introduced to clinical coaches and clinicians. The clinical coaching program instils a respect and appreciation of the role of clinicians in different contexts.

In Phase 2 clinicians are thoroughly engaged in role modelling in each discipline and across the various sites. The high level of clinician engagement promotes role modelling and there are some outstanding young role models, both junior and experienced clinicians, in a wide variety of health services, including those who work in challenging contexts such as refugee and rural health and other socially disadvantaged areas. Students enjoy the hands-on learning opportunities and this is reciprocated as the clinicians view the students as highly motivated learners.

Research role models are available to students interested in gaining this experience outside the MBBS program including summer scholarships and formal research projects. The MD program should develop this experience.

4.6 Patient centred care and collaborative engagement

2014 team findings

The School requires all students to sign a *Commitment to Professionalism in the MBBS Program*, which is a set of clear standards for professional behaviour, incorporating patient centred care and collaborative engagement principles. An extensive range of methods is used to facilitate learning about patient centred care, to assist students develop their clinical skills and reinforce professional standards. These include a wide variety of clinical simulation scenarios, case-based learning and bedside teaching. Patient centred care is assessed through the professional behaviour component in each clinical course.

A commendable example of patient centred care and collaborative engagement is the Urban Longitudinal Integrated Community Care Project, where students have an opportunity to undertake a longitudinal experience in primary care.

4.7 Interprofessional learning

2014 team findings

While several interprofessional learning activities have been developed at various sites, interprofessional learning is not comprehensively offered throughout the curriculum, and some of the existing activities were delivered with short term funding from Health Workforce Australia.

In Phase 1, multidisciplinary symposia showcase interprofessional care, with topic areas such as stroke and spinal injuries. In the MD program, these will be remodelled into the regular wrap-up sessions. The Healthfusion team challenge is an annual event, where groups of Phase 1 students from different healthcare fields work together on projects and presentations.

In Phase 2, students are exposed to clinical teams and gain an understanding of the interaction involved in providing optimal care.

Where interprofessional learning does exist it is high quality and appreciated by the students. The Silver Q project in the Rural Clinical School is one outstanding example of interprofessional learning. Silver Q is a simulated learning project which gives students the opportunity to work together as part of a collaborative health care team prior to transitioning into the health care workforce. In the General Practice discipline, students reported they felt like part of a team that showed a genuine respect for their knowledge and suggestions. The students felt they learned about teamwork and also refined their understanding of the health system.

The team considers that the design and incorporation of further activities of this type would benefit the program.

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.*

2010 team findings

The School has a clearly written and well-defined assessment policy, outlined in the UQ submission and, in more detail, in the Staff Assessment Guide 2010. The latter refers to key aspects of assessment such as reliability, validity, standard-setting, importance of referencing the answer source for each written question, balancing formative and summative assessments, and clear guidance on how to write multiple-choice questions (MCQs). The guide is written mainly for assessments in Years 1 and 2. An equivalent document for Years 3 and 4 is necessary. The assessment processes currently in place are not fully compliant with the stated assessment policy. This is particularly evident in Years 3 and 4.

There is no obvious central control over the assessment across all four years. Overall, it was stated the responsibility resides with the Director of the MBBS Program; policy issues reside with the MBBS Curriculum Committee, and implementing is devolved to the heads of years. On the administrative side, the overall program management also includes an examinations unit, which is responsible for preparing the written exams and MSATs, and a senior assessment officer responsible for the results. There is a process in place for managing the end of year assessments, but there is a greater issue around managing the end of attachment assessments.

Assessment is clearly divided into two halves: Years 1 and 2; and Years 3 and 4. Each of those involved in setting assessments have clearly defined roles for Years 1 and 2, but roles are much more opaque in Years 3 and 4. Moreover, control over Years 3 and 4 is devolved to the individual discipline leads. This results in a disjointed assessment package with each discipline creating its own assessment style. Even when the same assessment tool is used by more than one discipline, there is unnecessary variation, which leads to confusion among students. This wide variation in assessment style results from lack of central control of all Year 3 and 4 assessments. The team acknowledges the School is aware of this issue and is trying to address it through strong leadership from the Head of Years 3 and 4. The issue is a concern to the team and the AMC will need to monitor improvements in central oversight of the Years 3 and 4 assessment.

Assessments in Years 1 and 2 are more consistent, with a clear progression between Years 1 and 2. A number of significant changes have taken place in response to student feedback:

- A designated individual is now responsible for each assessment.

- In-course assessments have been introduced in Semesters 1 and 2 in the form of 'quizzes'. These mainly cover imaging and anatomy in direct response to student complaints about the paucity of examination questions in these two disciplines.
- The percentage of in-course assessment now conforms to University requirements.
- Substantial formative assessments have been introduced.

The Faculty of Science carries out a substantial part of the Year 1 teaching and, to a lesser extent, contributes to teaching in Year 2. While the Faculty senior management expressed the view that there was disconnect between teaching and assessment, the Biomedical Science Domain Committee, which sets the examination questions, did not support this view. They clearly stated staff members who teach the course set the questions. The Committee is appropriately made up of a mix of scientists and clinicians, ensuring that the biomedical science questions set are relevant to clinical practice.

There is an ongoing discussion about breaking the Year 1 and Year 2 assessments into assessment units; there is a risk this will lead to some disintegration of assessment. Having taken care to produce assessment that is contextualised and integrated across all disciplines, the proposed fragmentation could be a backwards step. The Director of the MBBS Program stated he had confidence in the current domain group's ability to create a management structure ensuring this does not happen when unitisation occurs. The team stresses the importance of retaining an integrative approach to assessment.

Since the majority of the Year 1 biomedical science is taught through the Faculty of Science, which Faculty actually controls the biomedical sciences domain assessment is an issue. The Dean of the School of Medicine clearly stated responsibility for the final agreed assessments lies exclusively under the School of Medicine, and this is stated in the memorandum of understanding that governs the high-level program management. Since the senior managers in the Faculty of Science did not hold this view, the team is concerned about the apparent mismatch in understanding and strongly supports the School of Medicine retaining full control over all its assessments.

Year 1 and Year 2 assessments are largely based on published learning objectives. The link between objectives and assessment is much less clear in many of the Year 3 and Year 4 assessments. For example, in surgery rotations, students receive objectives that bear little resemblance to the highly 'fact-based' end of block assessment. Students spend most of their time on rotations working closely with patients, but there is no clinical assessment component to the examination.

2010 team findings

(In 2010 these findings were presented at Standard 5.3 Assessment rules and progression, subsumed in 2012 at Standard 5.1.)

Progression rules are clear in Years 1 and 2, but are less so for Years 3 and 4, particularly on supplementary assessments. In Years 1 and 2, students are required to complete all pieces of summative assessment, achieve an overall mark that is greater than (or equal to) the overall pass mark, pass written and clinical skills assessments separately, and meet all course requirements, including attendance, and personal and professional development. In addition, Year 1 students have to satisfactorily complete their elective and elective project report. The School has chosen to move away from requiring a pass in each assessment domain.

Students who fail their Year 1 or Year 2 assessments are allowed to sit a supplementary assessment. The type of supplementary assessment is 'at the discretion of the executive dean'. Clear pre-written rules would be preferable. The peer-tutoring program for students in Year 1 who are in the bottom ten per cent of their mid-term assessment is an example of good practice.

In Years 3 and 4, the progression rules are simpler: students are required to pass each rotation independently. Students who fail one rotation assessment in Year 3 or 4 are given a supplementary assessment which they must pass to proceed to Year 4 or graduation (in addition to the final examination). The rules for being granted a supplementary assessment are not completely transparent; the rules state that students may be allowed a supplementary assessment but at the discretion of the Board of Examiners, who make a recommendation to the executive dean. The documentation does not state what happens to students who fail the final rotation of the year, and more particularly, students who fail more than one rotation assessment during the year.

Another concern about progression in Years 3 and 4 is that the individual disciplines set and mark the various rotation assessments, as discussed in Section 5.2. Assessments cannot be regarded as equivalent to each other because of the assessment variability, and the question of reliability was raised in an earlier section. Furthermore, the assessment components for each rotation are equally weighted and the marks are simply combined to reach an overall rotation assessment mark. Knowledge, skills and professional behaviour are treated the same. In addition, the pass mark for these assessments is arbitrarily set at fifty per cent.

In summary, while progression rules are clear for Years 1 and 2, the School needs to make the rules more explicit in Years 3 and 4.

The School states students are made fully aware of assessment policies through the electronic course profile and the MBBS guide. In addition, heads of year reiterate the information at appropriate and relevant opportunities. Students have not raised this as an issue.

2014 team findings

The team was impressed by the substantial improvements in assessment achieved since 2010. The School engaged Professor David Prideaux to review its assessment during 2011/12 and developed an assessment implementation plan. The Assessment Subcommittee was formed in 2011 and provides central control over assessment across all four years of the program. Other responses to the Prideaux review have included the discontinuation of the standards distribution rule, improvements in the quality of assessment including the use of new assessment methods, attention to standard setting, and improved examiner training and calibration.

The Assessment subcommittee's clear terms of reference include development, monitoring and evaluation of assessment. Its policy generation and strategic engagement of members of the School have been critical in achieving a number of significant improvements. The Assessment subcommittee has developed a clear assessment policy, and the principles of assessment alignment, objectivity, fairness and transparency underpin the policy. In 2014 the School confirmed a commitment to a programmatic approach to assessment.

The assessment and progression requirements for each individual course and rotation are readily available online on the School's website. Electronic course profiles for every course are available publicly online, with enrolled students able to access further details on assessment. The electronic course profile documents the alignment of course assessment with learning outcomes, and is the single source of information on course assessment tasks. All electronic course profiles were updated at the start of the 2014 academic year.

Following a program-wide Audit of Summative Assessment presented to the Assessment subcommittee in 2013, the School provides appropriate access to formative assessments and a balanced approach to summative assessment. A 2014 Audit has also been completed.

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.

2010 team findings

The School uses a wide range of assessment formats appropriate for each domain being tested. In Years 1 and 2, knowledge is tested using a mixture of problem-based exercises, short answer questions (SAQs) and single best answer questions (SBAs). The problem-based exercises test factual recall and reasoning around specific presentations. They cover a wide range of issues within the specific initial presentation. The SAQs cover a wider range of topics, including evidence-based medicine, public health, ethics and sociology, as well as the basic sciences. The SBAs address a much wider range of topics, but more superficially. Many of the questions are set in a clinical context and accompanied by a clinical scenario. Some SBAs are still not contextualised and not in the correct format. The addition of anatomy quizzes, and perhaps an increase in pharmacology questions, will create a better balance among the basic sciences. It is noted that these changes have only just been introduced in 2010.

Overall, the knowledge papers are impressive, testing a wide range of topics in a clinically relevant way. It is hoped the School will continue to set such comprehensive papers when unitisation takes place.

In both Year 1 and Year 2, clinical skills are assessed. In Year 1, progressive summative assessment of clinical skills is the format, and students must pass. The assessment is progressive in the sense that it depends on acquiring skills throughout the year. The skills are taught and assessed mainly by GPs in the highly-rated clinical coaching course. The student's regular tutor undertakes formative assessment, but a different tutor conducts summative assessment.

In Year 2, clinical skills assessment takes the form of a Multi-Station Assessment Task (MSAT), a five-station Objective Structured Clinical Examination (OSCE)-type examination. Passing this assessment is essential for progression to Year 3 of the

course. Using such a small number of stations for a high-stakes examination is a concern, especially considering the wide range of skills being tested (history taking, examination, clinical reasoning, ethics, communication skills and procedural skills). The team noted that no reliability data was presented for this assessment, nor was the team shown any blueprint for such data. Reliability might be improved by increasing the number of stations.

The clinical part of the course over-emphasises assessment of knowledge at the expense of clinical assessment in many of the Year 3 and 4 rotations. The extent and type of clinical assessment varies from rotation to rotation. The widely varied nature and weighting of components in each rotation assessment suggests greater central control of all Year 3 and 4 assessments is desirable. Some rotations include personal and professional development domain assessment, but students have complained about inconsistencies in the way such assessments are carried out.

Students have expressed concern about the variable application of the UQ seven-point assessment scale. Although descriptors are provided—in the assessment handbook and in some rotation assessment advice to staff—for each of the scale's seven points, they are inconsistent. It is also clear that a number of assessors have not seen the descriptors and are applying their own values to rate the students. Improved assessor training is needed in this area.

At the end of the four-year program, students must pass an exit MSAT/OSCE exam. This exam lasts three hours and has nine, nine-minute stations. As with the corresponding Year 2 assessment, more stations would provide improved reliability. The MSAT is, however, well-structured and tests many of the skills an intern requires when beginning medical practice. There is a mixture of history taking, examination, assessment, management, and explanation stations, often in combination. Each station is subdivided into several specific content areas, the content of each area being clearly specified. Examiners give a global rating for each area using the scale described above.

The singular omission from this barrier examination is the assessment of procedural skills. Summative assessment of procedural skills does not appear to be in any formal examination. The demise of 'The Orange Book' has not helped. This book, albeit out of date and in need of substantial revision, indicated to both students and staff which skills students were expected to acquire during their program. It is slowly being updated and replaced by an online portfolio. This needs to be completed as soon as possible as both students and staff feel poorly informed on what skills the School expects, and staff are using their own initiative as a stopgap.

Prescribing skills are also part of the core competences junior doctors require. These are minimally assessed summatively at present (included in one or two OSCE stations). Increasing prescribing skills assessment in OSCEs would easily resolve this deficit, although the team noted students have to complete and pass online prescribing tests during their final year.

2014 team findings

The School assesses students regularly throughout the program and, with minor exceptions, uses appropriate methods for the assessment of students.

The School has appropriate control over assessment in Phase 1 to ensure integration of assessment and alignment of the assessment with learning outcomes. The engagement

of the Clinical Lead Educators in Phase 1 assessments; the strengthened relationships between the School of Biomedical Sciences and School of Medicine, and the representation of Phase 1 teachers on the Assessment Subcommittee have ensured that Phase 1 assessments are well within the control of the School. Draft examinations are reviewed for content and construction by a panel of clinical- and science-based academic staff. At times, multiple choice formats are used, for reasons of feasibility and resourcing, to assess content that may be better suited to written assessment formats.

The School has appropriate control over assessment in Phase 2 to address the wide variation in the content and standards of assessment and its alignment to learning objectives. It has implemented a clear assessment policy and requires individual clinical disciplines to report regarding their assessment regimes. Course assessment is subject to uniform criteria and standards across all assessment sites. Disciplines liaise with representatives from each clinical school to ensure standardisation of the teaching, learning and assessment of their respective courses. Clinical examiners rotate between teaching sites in some discipline-based clinical assessments, including Ochsner, and simulated or recorded clinical examinations of students of different standards are available for calibration.

In Phase 2, the students are thoroughly assessed, arguably even over-assessed, with the emphasis on assessments at the end of each block. This approach is not as appropriate for the admittedly small group of students undertaking a longitudinal rural year. The School is considering introducing a semesterised system for Phase 2 that may decrease the overall assessment burden, and the team encourages the School to look to the most educationally appropriate regime of assessment.

The School has progressed in its work to ensure students' competence in critical specific procedural and clinical skills. It has undertaken considerable work to identify specific competencies that its graduates should achieve, using the Medical Deans Australia New Zealand (MDANZ) Competencies and the Australian Curriculum Framework for Junior Doctors. In Phase 1, a broad range of clinical and procedural skills are assessed by direct observation. In the Year 4 Critical Care rotation, competence in critical care skills is assessed by way of consultant assessment. Additional procedural and clinical skills are assessed in the Phase 2 discipline exams and the end of program barrier OSCE. Final decisions regarding exactly how competence in procedural and clinical skills should be recorded and its precise contribution to assessment are still being elucidated. Once implemented, the e-Portfolio may offer a solution. In the interim, an electronic log that mirrors the MDANZ list is being piloted to track progressive student learning of skills.

Work is underway to produce a detailed curriculum map for Phase 1 of the MD, with aligned assessment blueprinting. Decisions regarding blueprinting and content of assessment in Phase 1 courses are the responsibility of the course coordinators in collaboration with the clinical lead educators. In Phase 2 courses, these decisions are the responsibility of the heads of discipline / course coordinators in collaboration with the clinical teachers. This has led to considerable transparency in assessment, and the appropriate mix of assessment methodologies to assess individual disciplines. Specific alignment of activities to learning outcomes can be achieved by this approach. While examples of within-course or rotation application of blueprinting methods were evident, there is no overall, formal blueprint for each year or phase of the program to guide assessment as is required by the accreditation standard.

The School has adopted appropriate methods for standard setting of multiple choice assessments (Hofstee method) and OSCE assessments (borderline groups' method). The Phase 1 representative moderates each course and the School reports that most courses in Phase 1 are satisfied with the method. In Phase 2, there appears to be incomplete adoption of the Hofstee method, and in some instances, incorrect application of the technique. Standard setting for all assessments is detailed in the electronic course profile.

At Ochsner, staff reported they communicate regularly with their counterparts at main campus to ensure comparability, and have opportunity to review assessment items in advance to ensure relevance to the American clinical context. Exams are sometimes required to be held at the same time as Queensland, so Ochsner students sit the exam in the evening. The students the team met did not see this as an issue. Ochsner staff commented that there are small discrepancies in assessment nomenclature between America and Australia, for example a long case is a 'history and physical' and a short case is a 'focused physical exam on a system'. Delivery of these assessments was similar and clinicians are familiar with the terms and are trained in assessment delivery.

The team commends the progress made in standardising assessment across the School's many clinical sites. It recommends the School consolidate and build on this work, notably in blueprinting, standard setting, staff development and the clinical skills log.

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.*

2010 team findings

(Standard 5.3 Assessment rules and progression has been subsumed into Standard 5.1.)

2014 team findings

There is good identification of poorly performing students, and appropriate support provided to these students. Supervisors and teachers report receiving information about the performance of cohorts of students, but there is not extensive feedback provided about the performance of individual students. This becomes important in a distributed system, where, especially in the clinical environment, individual clinicians provide input to a relatively small number of students.

In Phase 1 feedback to students includes: individual feedback to all students with unsatisfactory portfolios; peer and tutor feedback on oral case presentations in small groups; and written generic feedback based on common errors posted on Blackboard. The team commends the exemplary method for feedback provided in Phase 1, where whole-of-class groups review recently completed exams, providing opportunity for students to consider their performance proximate to undertaking the assessment.

In Phase 2 feedback is regularly provided to students by medical staff in the clinical environment. Feedback is also provided in formative assessment nodes. Individual face-to-face feedback with senior academic staff is offered to students who have failed courses or individual assessment tasks. This may include opportunities to review marking sheets and written examination answers, or video-recorded clinical assessments. Students commented that feedback from some disciplines was slow.

Students at risk of failing to progress in the program are identified summatively through performance in assessments, and formatively through performance and behaviour in learning activities, such as PBL tutorials, clinical coaching sessions and clinical placements. Students who fail one unit are asked to meet with the Course Coordinator in Phase 1 or Discipline Head in Phase 2 to review their progress. Students who fail two units are asked to 'show cause' in a meeting with the Director MBBS.

It is clear students are provided with opportunities for feedback, though often this needs to be student initiated. In general terms, the student cohort reports that it does not receive enough feedback information to be able to accurately assess their individual areas of strength and weakness. The team recommends the School investigate how to provide this feedback routinely.

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.

2010 team findings

The School has made progress towards improving assessment quality through all four years of the program, and the team encourages the School to continue working on this important process.

Content validity requires further progress. The course objectives are often unclear, vague and inconsistent, as previously noted. Students often find it difficult to understand what they need to know to pass assessments. Some clinical teachers are familiar with the assessment content and teach to it; others have no link with those setting the assessments and teach what they think students need to know.

Medicine and surgery assessments represent the two extremes. In medicine, students spend most of their time with patients, learning to take histories, carrying out physical examinations, making diagnoses and proposing management plans. Medicine is assessed through long and short cases only; there is no separate knowledge assessment. By contrast, surgery is only assessed through written reports and knowledge tests of variable quality.

The final OSCE tests appropriate skills for a graduating student, with the exception of procedural skills assessment, which is lacking. While it is recognised the School intends to assess procedural skills throughout the four-year course as part of an e-portfolio, for patient safety, an assessment of sample key intern-required procedural skills needs to occur in the exit examination.

Blueprinting is one means to ensure objectives are clearly linked to assessment. The School states that it has 'an explicit curriculum and assessment blueprinting mechanism to ensure quality of assessment items'. This may be true in Years 1 and 2, and probably for the final OSCE, but is not true for the end-of-rotation assessments. The team encourages the School to institute blueprinting for all summative assessments.

The School is using questions from the International Database for Enhanced Assessments and Learning (IDEAL) consortium and is planning to link up with Monash University (as part of a benchmarking exercise) and possibly with the US National Board of Medical Examiners. Questions will need to be carefully selected to match the UQ curriculum.

The School states 'reliability is calculated routinely for all examinations and is reported to the Board of Examiners'. The Office of Teaching and Learning has very recently taken over this responsibility. Cronbach's Alpha has been calculated for a number of assessments throughout Years 1 to 4 and shows most values above 0.8. These values have been calculated for the overall assessments, rather than the individual components of each assessment. It would have been interesting to see the individual scores for each component, which may have shown a very different picture. The School is encouraged to carry out a range of statistical analyses for all summative assessments, for example, point biserial correlation coefficient, discrimination index, facility index, and inter-rater reliability.

While the School has clear rules in place for passing the final MSAT/OSCE assessment (passing six out of nine stations), there is no attempt to address the issue of variability between stations; some stations are easier than others and should therefore have a higher pass mark; other more difficult stations should have a lower pass mark. This aspect of standard-setting needs to be put in place (and was highlighted at the 2005 AMC visit). The Hoftsee Method is used for MCQs standard-setting in Years 1 and 2, which is appropriate, though not generally used for high-stakes examinations. However, the MCQ components in Years 3 and 4 that have a declared pass mark of 50%, have no standard-setting in place.

For clinical assessments, the School stated it uses standard-setting similar to the AMC's approach when assessing international medical graduates. For example, to establish whether a student has passed or failed an MSAT where there are four to five assessment domains per station, a student will fail if they are unsatisfactory in two out of five domains, or if they make a critical error. Quality assurance and training are then the issues that arise. It is important that all examiners undergo face-to-face training prior to being accepted. It is understood that general practitioners do undergo intensive training, but this needs to occur across all specialties.

Students have complained vigorously about a lack of standardisation in applying the seven-point Standards Reference Grading (SRG). A wide range of people, from preceptors to consultants, carry out this subjective assessment. Students are particularly vexed about ratings from preceptors who clearly have widely differing and inconsistent views about how to interpret the seven grades. The assessors lack a reference point to interpret the grading descriptors and translate them into grades. Again, this is a training issue.

The School's processes for reviewing the educational impact and usefulness of assessment items largely occur through the Head of Years 1 and 2 (in discussion with

the domain committees and the clinical leads), and through the Year 3 and 4 discipline leads (supervised by the Head of Years 3 and 4 and with the support of the MBBS Program Director). Post-examination statistical analysis is carried out, but is not detailed enough to make decisions about removing questions or MSAT stations. Removals may be carried out following feedback from question and station markers, but no rigorous procedure is described. The School is encouraged to set clear rules in this area.

The School reports the standard of assessments on the St Lucia and Ipswich sites is directly comparable, in that students take precisely the same written and MSAT assessments on both sites. There are minor variations in teaching across the two campuses, which the School is addressing, but this does not appear to affect the student assessment performance.

There is a concern about the comparability of assessment across the 10 clinical schools, particularly with respect to inter-rater reliability of the preceptor/consultant assessments. Students report considerable inconsistencies across the clinical schools and within any one clinical school. Some schools are proud that they have 'tough' markers who rarely, if ever, award a grade of seven, whereas at other sites, the examiners are more generous. This has potential consequences with the introduction of honours cum laude.

Ochsner Clinical School, although it has not received any Year 3 or Year 4 students from the Ochsner cohort, has received regular UQ students on electives or core attachments. Written end-of-rotation assessments, and the final MSAT assessment, will be carried out simultaneously in UQ and Ochsner, albeit at different times of the day. Staff have been trained in how to grade students, with some UQ staff running training workshops in Louisiana and some Ochsner staff visiting UQ to observe and partake in assessments in Queensland. Checking appropriateness of MCQ questions for the practice of medicine in Louisiana will be necessary. Some questions may have to be 'tweaked' or 'Ochsnerised'. Possibly, the same may apply to some items on the OSCE checklist.

The Brunei Clinical School takes only a few students and only some components of the assessment are carried out there. For much of the assessment, students return to Queensland to sit assessments. Those assessments carried out in Brunei are comparable in quality and in student performance to those in Australia. Numbers are small, however, and comparability will need monitoring over time. Few Brunei staff have visited UQ to observe the assessment process first hand, though UQ staff have conducted limited visits to carry out some assessment training.

The remaining eight clinical schools in Queensland all have comparable outcomes in student performance in rotations. Those clinical sites that do not yet have students will require adequate training to carry out assessments. Some staff have never assessed students before.

2014 team findings

Since 2010 the School has reviewed its program of assessment, made many valuable changes and plans to continue improvements in areas such as blueprinting. These changes will translate to the MD program.

It is clear that the adoption of robust policies has led to a culture where those directly involved in the delivery of the curriculum take ownership of assessment. These groups

generate reports regarding major assessment events that are carefully scrutinised by the Assessment Subcommittee to assist program improvement.

The Assessment Subcommittee has considered at length the seven-point Standard Reference Grading used to assign course grades in accordance with University policy. Despite efforts to improve assessor application of the seven-point grading, some students believe that grades can be somewhat arbitrary, especially across grades five to seven. This is an issue for students in the honours stream and international students where the score contributes to a grade point average. Feedback to the team indicated that this variation occurs as much within a single clinical site (e.g. hawk and dove effect), as between sites. The team noted the data presented does not suggest that this is an issue but considers the School should monitor inter-rater reliability and student satisfaction with clinical assessments.

The School has adopted a simplified and transparent four-grade scale (unsatisfactory, borderline, satisfactory, proficient) in the Clinical Participation Assessment in all disciplines from 2014 which indicates considerable progress towards standardising assessment outcomes in clinical placements. Communication with students about the variability of assessment outcomes in Phase 2 rotations will be important.

Assessment practices are largely consistent across sites. Considerable effort has been put into ensuring the standardisation of examiners, with examiner training and/or moderation of examiner judgments in all Phase 2 courses, although strategies vary between disciplines. The Assessment subcommittee has oversight of each discipline through annual discipline assessment reports that are tabled at its meetings. An examiner calibration tool using online marking and examiner discussion is being piloted.

There is evidence of mechanisms to review comparability of assessments across the eleven clinical schools particularly to address the inter-rater reliability of preceptor/consultant assessments. In addition to the methods implemented to create standardised assessment, the disciplines are required to consider and report on inter-site variability of assessment outcomes. While some individual inter-rater differences may remain, inter-site differences appear to have been dealt with adequately.

The team was impressed with the School's efforts at Ochsner to ensure consistency with the program's assessment practices, including review of assessment items, marking of some exams in Brisbane, assessor training, monitoring of results and regular communication and travel.

The Brunei Clinical School has not increased its student placement numbers from 2010. Assessment conducted in the clinical rotations of surgery, paediatrics, general practice and obstetrics and gynaecology at Brunei is comparable with the School other clinical sites.

The team notes there does not appear to be specific assessment expertise in the School (also referred to at Standard 1.4) to promote best practice in standard setting and blueprinting and provide leadership with staff development and training. An effective exam question banking capacity would also greatly enhance assessment quality.

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.

2010 team findings

The School recognises the scale of its operations and its dispersed teaching delivery structures require a comprehensive quality assurance program.

The School is commended for the significant progress made in establishing systems to monitor and evaluate the medical program quality, and in developing a culture of data-driven quality improvement. The recently established Office of Teaching and Learning, and the Teaching and Learning Committee, manage the School's quality assurance program. A range of data are collected, reported on, and used to drive improvement in the MBBS Program structure, content and delivery.

The School uses the University's Curriculum and Teaching Quality Appraisal system to assess core teaching and learning indicators, which are aggregated from a range of data collection systems each year. Data are aggregated in a Dashboard format to provide variable access (depending on a person's role within the University) to indicators such as:

- student load by category (domestic, international, undergraduate, postgraduate)
- admission numbers and trends
- student retention
- student progress
- student satisfaction (assessed for each course in preclinical years and, in Years 3 and 4, across all disciplines in rotations 1 and 4)
- graduate satisfaction and destinations.

The 2009 MBBS Review highlighted some weaknesses in areas including unclear learning objectives, assessment methods and poor administration. The School has outlined how these will be addressed.

Within the Office of Teaching and Learning, the School has established an evaluation unit that has developed a comprehensive evaluation plan for all stages of the program. The plan outlines a yearly timetable for surveying, analysing, reporting and distributing results to stakeholders. In addition to the evaluations coordinated through the Office of

Teaching and Learning, the disciplines conduct their own evaluations (except in rotations 1 and 4, which are coordinated centrally).

In 2010 these evaluations were managed within the disciplines. However, to facilitate a comprehensive overview of program quality and student satisfaction across all the disciplines, it would be desirable for all evaluations to be centrally coordinated.

The Office of Teaching and Learning prepares specific reports for each of the disciplines and clinical schools on student evaluations of clinical rotations 1 and 4. These reports are accompanied by a template highlighting strengths and improvement areas, and seeks a formal response from each clinical school.

Feedback and evaluation from teachers only occurs sporadically, mainly through staff raising issues at the regular meetings for different components of the program. For example, weekly PBL tutor meetings, discipline-specific preceptor surveys in Medicine in Society, and informal feedback through email. The School has identified this as a gap and, from 2011, the Office of Teaching and Learning will implement a formal survey and evaluation system that seeks the views of teachers within the medical program.

2010 team findings

(In 2010 these findings were presented under Standard 6.4 Educational Changes, subsumed in 2012 at Standard 6.1.3.)

In the area of assessment, the School collaborates with other educational institutions through the Australian Medical Schools Assessment Consortium, along with University of Sydney, University of Western Sydney and Monash University. The participating medical schools have conducted a joint blueprinting exercise and developed a set of common MCQ questions. A comparative analysis will be undertaken to assess each university's student performance for these questions.

The School also has a collaborative partnership with the University of Notre Dame Australia. The initial focus of the partnership is to develop common MCQ questions to be used in the first year of the program. Sharing teaching and learning content (UQ Clinical Skills Program) is also being discussed through the partnership.

As part of its mission to be a global medical school, UQ has established a number of international partnerships. These partnerships follow UQ policies on overseas collaboration and are formalised through written exchange agreements.

The School's primary partners are the Ochsner Health System, IMU Malaysia, and the Ministry of Health and Universiti Brunei Darussalam, Brunei. These partnerships involve staff and student exchanges, shared research activities and joint education programs.

The School has a number of developing partners in Europe and Asia. Developing partners provide elective experiences and a small number of clinical rotations. The School is currently developing new partnerships in China for student electives, and in Canada to facilitate UQ Canadian students' entry into Canada's health care system.

The UQ partnership with the Ochsner Health System will be the School's largest in terms of proposed student numbers. While the School does not intend to have any substantive relationships with other US medical schools or hospital groups, Ochsner provides clinical placements for medical students from Tulane University and Louisiana State

University. UQ students at Ochsner currently share clinical teaching with medical students from these schools. UQ/Ochsner have an opportunity to develop further relationships with Tulane and Louisiana State Universities to maintain the positive learning environment for all students, especially during the Ochsner Clinical School expansion over the next five years. A more formalised collaborative relationship with Tulane and Louisiana State Universities could offer significant benefits for staff and Ochsner UQ students through, for example, shared clinical teaching programs, activities and facilities, as well as benchmarking opportunities.

2014 team findings

There has been no significant change in the processes by which the School reviews the program. The Teaching and Learning Committee has clear responsibility for these processes which include five-yearly academic program review; annual curriculum and teaching quality appraisal.

The School plans to develop a monitoring plan and the team encourages specific evaluation of the effect of the change to an MD program upon student performance and graduate outcomes.

The School continues to collect and evaluate student feedback from all stages of the program. This involves a combination of a standardised University questionnaire (now called SECaT - Student Evaluation of Course and Teacher), and discipline-specific instruments. Although the educational support available for evaluation has decreased since 2010, there is still a full-time evaluation officer, and it is pleasing to see that evaluation by disciplines is now beginning to be developed in association with, and coordinated by, this individual.

Students at all sites indicate the School is responsive to feedback and evaluations, and gave numerous examples of situations where changes had been made to content, delivery, assessment and administration of the program, in response to their feedback. Change also results from communication with students outside the formal evaluation process, such as regular student meetings with staff. Information regarding the changes made is disseminated to students and staff, thus closing the loop: for example Phase 1 coordinators post on Blackboard the changes that have been made, and describe these in the course outlines. The School is to be commended upon this demonstrated willingness to seek and act upon student feedback.

As noted in 2010, evaluation from teachers is only sought sporadically, and largely by informal means. Discipline meetings, problem and case-based learning tutor meetings provide a forum for such feedback. However, particularly among the highly distributed and numerous clinical teaching workforce, this may not act as a highly functional mechanism. The team found that clinical teachers consistently reported they had not received any feedback on the quality of their teaching and were keen to do so. The School has piloted a more formal feedback process in the discipline of Paediatrics and Child Health, and the team encourages the School to extend this evaluation to other areas.

The international partnership with Ochsner Health System is a successful example of a global medical collaboration. In 2010, the team considered a more formalised collaborative relationship with Tulane and Louisiana State Universities would be valuable, and Ochsner staff advised this remains an area of opportunity.

The School actively collaborates with a number of other Australian and international universities, most particularly in the sphere of assessment benchmarking. It is a party to the following consortia: International Database for Enhanced Assessments and Learning, the Australian Medical Assessment Collaboration, the Australian Medical School Assessment Collaboration (AMSAC), and the Australian Collaboration for Clinical Assessment in Medicine. The School's AMSAC data indicate that UQ students performed consistently well from 2009 – 2013 with no apparent adverse effect from an increasing student cohort size.

The School also participates in the International Foundations of Medicine (IFOM) benchmarking exercise with the Group of Eight, which is aimed at aligning curriculum with the United States Medical Licensing Examination (USMLE) and supporting the UQ students sitting these exams. Future reporting on the tangible outcomes of these collaborations would be of interest.

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.

2010 team findings

The School is commended on the considerable body of research into student and graduate outcomes published over recent years. The head of school initiated a major research program in 2006 entitled 'Training Tomorrow's Doctors'. Through this project, the School has established a robust mechanism to analyse the performance of student cohorts in terms of student background, student selection policies and student demographics. Performance data include student assessment, and personal and professional development.

The School has analysed student performance in terms of student background and entrance qualifications. Academic performance is also analysed across clinical schools and these analyses reported to relevant committees. For example, the Board of Examiners, relevant discipline staff and the head of year review any significant variations in performance of the clinical school cohorts in particular disciplines.

The School has initiated a range of activities to assess graduate outcomes in terms of performance, career choice and career satisfaction. These include the Rural Clinical School Tracking Project, a rural intern study, an analysis of Medical Board complaints data, the Graduate Destination Survey, analysis of intern supervisor evaluations, and college exam results.

Outcomes data have been used in the 2009 MBBS Review to guide recommendations for change.

The School intends to track the performance of Ochsner students in the USMLE exams, and employment outcomes through the US residency matching process.

2014 team findings

Although the educational research activity of the School has diminished since 2010, there are ongoing projects to monitor outcomes: studies of the usefulness of GAMSAT as a predictor of student performance; the Training Tomorrow's Doctors (TTD) project looking at associations between student characteristics and a wide range of outcomes; and the Rural Clinical School tracking project. Further information resulting from these projects should be included in future progress reports.

Phase 1 performance across St Lucia and Ipswich campuses is monitored. The results of grade distributions between 2009 and 2013 indicate no systematic differences between the two campuses.

Consistency of student performance between the clinical schools is also closely monitored by the School. Comparative data on student results in each discipline at each clinical school are generated, and these are considered within each discipline and at the assessment and program committees. Data for Phase 2 rotations is comparable overall. If discrepancies are found, these would be reviewed by the committees. The large cohort permits statistically significant analyses and the team commends the School on this informative work.

The School is commended on the analysis of the performance of the Ochsner cohort. The School closely monitors the performance of these students in the USMLE examinations, and the USA residency matching process and the outcomes have been highly satisfactory. The steady improvement with each cohort in the USMLE Step 1 scores is a significant external validation of the School's Phase 1 program.

The School monitors graduate outcomes through the generic Australian Graduate Survey, but also tracks performance of its alumni in College examinations and intern assessments. Post-graduation progress is also an element of the TTD project. Continued focus on graduate outcome monitoring is recommended.

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.

2010 team findings

The School distributes evaluation results through its committee structures (domain committees, MBBS Curriculum Committee, and the Teaching and Learning Committee).

Students access data through their representatives on curriculum committees. Other mechanisms for disseminating results include staff, student and alumni newsletters.

2014 team findings

The Evaluation Officer receives SECaT (Student Evaluation of Course and Teacher) data from the University's Teaching and Educational Development Institute, and distributes it to relevant disciplines and committees. This process appears to function robustly,

with all appropriate committees and unit coordinators indicating that they have received such information. Within disciplines, dissemination of the evaluation data beyond the level of unit coordinator, to clinical schools and individual teachers, is variable. A systematic mechanism for providing this information to all interested parties would be desirable.

Evaluation data are discussed at the Queensland Medical Schools Liaison Committee, and are also disseminated via various newsletters distributed by the School to its stakeholders and alumni.

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.*

2010 team findings

The student intake has been defined for domestic and international students. Total domestic student intake has increased by twenty-three per cent since 2005. The domestic student intake from 2011 onwards is set at 298 students with no further growth planned. The international full fee-paying student intake has increased from 54 students in 2005 to 165 students in 2010. Over the next five years, the international student intake will increase to 250 students (120 in the Ochsner cohort and 130 other international students), taking the overall student intake to 548 students. This represents a seventy-five per cent increase in student intake from 2005 (314 students).

The increasing student intake is undoubtedly the major challenge facing the School, with the need for increased teaching capacity, and adequate resourcing for the various teaching sites to meet the needs of such a large student cohort. The UQMS (University of Queensland Medical Society) submission makes it clear that the current student body has concerns.

The projected growth in the Ochsner cohort from 35 students in 2010 to 120 students by 2013 will place additional demands on Years 1 and 2 as the Ochsner students spend their preclinical years in Brisbane. The School intends to manage the growth in Years 1 and 2 by phasing the Ochsner cohort increase, employing additional PBL and clinical skills tutors, and building additional teaching space. There is a commitment to maintaining PBL ratios at one tutor for ten students, and clinical skills ratios at one tutor for every five students.

It is relevant to question whether the facilities and teaching resources are adequate to teach nearly 550 students in Years 1 and 2, especially in practical classes (e.g. anatomy), clinical skills, PBL tutorials, and GP attachments for the Ochsner students. Although reassurance has been given about clinical skills and PBL tutor availability, students expressed concerns about the ability to access practical classes once numbers have reached the maximum stated.

In Year 2, clinical skills are further developed by clinical coaching, but the model may not be ideal for such a large cohort due to problems with tutor availability, and perhaps the Year 1 program could be extended into Year 2. However, this change implies significant resource implications. For clinical teaching, Year 3 and 4 onshore placements are projected to increase eleven per cent from 2010 to 2013 (n= 808 to n=895) and thereafter remain constant. The School has provided data showing there are enough

clinical placements to meet future demand. It appears there is some untapped capacity within some clinical schools, and a clear plan for how increased numbers will be distributed across them. Indeed, a significant strength is the way the clinical schools have been structured and resourced. It may be that some specific pressure-points, such as paediatrics may cause problems. This will require close monitoring.

The offshore clinical schools in Brunei and New Orleans have sufficient capacity to accommodate clinical placements. However, Ochsner students will be required to complete one Year 4 clinical rotation in Queensland. The School intends to accommodate the Year 4 Ochsner students through exchanges with domestic UQ students (who will complete their rotations at Ochsner) and, from 2012, by reducing the number of IMU transfer students from 25 to 10, freeing 15 additional places. The full Ochsner cohort in 2014, and the needs of other Queensland medical schools, will challenge the rural teaching capacity at the end of Year 2.

The nature of the student cohort is clearly defined, including quotas for subgroups such as Indigenous and rural students, and those from a low socioeconomic status background. It is unclear how the School plans to ensure a mix of rural and low SES students in the Ochsner cohort, but this is not an essential requirement. The team encourages the School to seek this information once several years of intake into the Ochsner program have occurred.

The principal sources of support for rural students are the Rural Clinical School and Discipline of Rural Medicine. The Rural Clinical School is well resourced and is able to provide an appropriate level of care to its students. The Rural Clinical School runs a high school program to promote careers in rural medicine and keeps in contact with interested students. There is a community/social support program for rural students to welcome and help integrate students into the local community.

The School is developing infrastructure and support mechanisms for its growing Indigenous student cohort; an Indigenous Recruitment Manager and Support Officer have recently been appointed.

2014 team findings

Since 2010, the program's student intake has risen from 485 to 560. The projected student intake from 2015 to 2019 is 520-530 per annum. Data regarding the enrolment types of the Year 1 student cohorts from 2010 to 2014 are shown:

	2010	2011	2012	2013	2014*
CSP	236	221	216	220	220
MRBSS	12	13	11	11	10
BMP	71	70	71	74	81
DFFP	1	1	4	3	1
Total Domestic	320	305	302	308	312
IFFP (Onshore)	130	108	137	113	110

	2010	2011	2012	2013	2014*
IFFP (Ochsner)	35	34	88	105	138
Total International	165	142	225	218	248
TOTAL	485	447	527	526	560

Key:

CSP Commonwealth Supported Place

MRBSS Medical Rural Bonded Scholarship Scheme

BMP Bonded Medical Place

DFFP Domestic Full Fee Place

IFFP International Full Fee Place

*2014 is pre-census date data

The School is commended for delivering a consistent teaching program to a significantly increased number of students. In particular, the noted the efforts of teachers in the basic sciences to deliver an equivalent Phase 1 program on the Ipswich campus, the teaching clinicians at clinical sites, and the commitment of the Ochsner Clinical School to clinical education.

Nonetheless, the effect of the increased intake has placed additional demands on limited academic staff resources, has increased small group teaching sizes and has placed pressure on clinical placements.

The optimal size of the student intake is a subject of considered and open discussion at the School. Many clinical teachers expressed concern that clinical placements were at capacity and staff are acutely aware of the financial impact of even small reductions in student numbers. In the current atmosphere of uncertainty regarding fee de-regulation, it is not possible to determine whether the School's projected small decrease in student numbers to an intake of 520-530 in 2019 is realistic.

Of immediate concern are plans to transfer the Ipswich campus, which was described in 2010 as the School's main strategy to meet increased numbers of Phase 1 students from Ochsner, to the University of Southern Queensland. This campus accommodates approximately 100 students per year. The School has commenced contingency planning for additional Phase 1 students to be accommodated at the St Lucia campus and the Princess Alexandra-Southside, Royal Brisbane and Mater Clinical Schools.

Of further concern is the pending withdrawal in 2015 of Phase 2 from the Sunshine Coast Clinical School. The School has planned for the 57 Sunshine Coast Phase 2 students to be absorbed into other clinical schools. Clinical school heads and clinical teachers, however, reported that only small increases in their clinical placement numbers were possible, with some reporting that no further expansion is possible.

The Ochsner Clinical School expressed confidence that it could place its planned full cohort of 240 Phase 2 students, an increase from 120 in 2014. Brunei Clinical School reported that expansion in its student numbers is possible. While some students, particularly international students, would value the opportunity for clinical rotations at

these sites, it is not known whether this option could be implemented with substantial numbers of students. Accordingly, further reporting on how the Phase 2 students are being accommodated will be required.

There are no targets for Aboriginal and Torres Strait Islander students, and numbers remain low in this cohort. Since 2011, with the loss of a dedicated Aboriginal and Torres Strait Islander officer in the School, selection and support of these students have been managed by the Aboriginal and Torres Strait Islander Studies Unit. This Unit provides infrastructure and support for the Aboriginal and Torres Strait Islander access scheme, and ongoing support to the cohort. This arrangement arose after the School Indigenous Recruitment Manager and Support Officer was not replaced after attrition. The Head of School and the Director of the Aboriginal and Torres Strait Islander Studies Unit have expressed a desire to work more collaboratively to improve the recruitment and support of these students.

The target of twenty-five per cent rural origin students was met in 2014 (twenty-eight per cent achieved), and was nearly met in 2013. Efforts continue through the Rural Clinical School with a range of school engagement activities to boost enrolments in this sub-quota. The Rural Clinical School provides infrastructure and high quality student support. However, there were some reports that vulnerable students may be at risk if placed in more remote regions. In this regard, effective communication, particularly concerning students who have been identified as being vulnerable, is paramount to minimise the potential for students to become isolated or distressed.

There are no targets or preferential selection criteria for other under-represented groups. The percentage of under-represented groups in the international cohort was not described, although the Ochsner Clinical School reported that recruitment of African American students is encouraged. There is no published target for international students, with the maximum size of this group being determined by the University.

Although recruitment of international students is not traditionally considered a targeted access scheme, international students are a large cohort with a distinctive recruitment process. The separate resources include two International Student officers in the School, and the University International Student Services office. It was reported that an international student mentoring scheme is planned.

The School has adopted a scholarly approach to the monitoring of changes in the student cohort as changes in selection processes have occurred, and this is appreciated by the team.

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.

2010 team findings

Student selection policies and processes have been defined and published; they are available to prospective students on the School's website. Since 2005, significant changes have occurred to the way in which students are admitted into UQ's MBBS Program. The student intake is now evenly balanced between the graduate entry stream and the school leaver entry stream, and there are no student interviews.

The school leaver stream is open to students who complete Year 12 with an OP1 (overall position 1 in the Queensland Year 12 marking system), or equivalent, and who have an acceptable UMAT (Undergraduate Medicine & Health Sciences Admission Test) ranking. Eligible students are required to complete an undergraduate program at UQ, or one of the three dual MBBS (two plus four year) degree programs, and maintain a minimum grade point average (GPA) (see below). There is some confusion about the GPA required for the school leaver stream (UQ student representatives raised this discrepancy). The information on the UQ website indicates a GPA of four is required, but the School's submission to the AMC states a GPA of five is required for all applicants. Clarifying this matter would help address student concerns about fairness and equity in student selection across the various sub-groups (school leaver, graduate entry, domestic and international) and the team understands the School has such clarification in process.

For the graduate entry stream, GPA (five or higher) and ranked GAMSAT (Graduate Australian Medical Schools Admission Test) scores are combined to determine whether applicants receive an offer. International students are required to achieve a threshold GAMSAT or Medical College Admission Test (USA) score, and have a GPA equivalent of five or higher.

The admission processes, including the mechanism for appeals, are published. The School follows the UQ grievance and appeals policies.

The policies for admission and recruitment of Australian Aboriginal and Torres Strait Islander students are well defined. There is a separate admission pathway for Aboriginal and Torres Strait Islander students. The School has targeted Indigenous students as a priority for admission; there is no upper limit on the number of Indigenous students admitted to the program in any one year. A suitability assessment is made by the School's Indigenous Medical Student Selection Committee using a range of documentation and an interview. Successful applicants for the school leaver pathway are required to complete the Bachelor of Health Sciences/MBBS Program. The School ensures the desired mix of under-represented groups using quotas for Indigenous, rural and low SES students.

In contrast to domestic students offers, which are based on merit ranking, all international student offers are made on a 'first come, first served' basis until the quotas are reached. However, the School will leave places unfilled if applicants do not meet the standard (e.g. only thirty-six Ochsner places were filled this year instead of forty), ensuring all students admitted have the capacity to complete the program.

The School's rationale for student admission is to offer places to applicants from any background with sufficient academic ability, as indicated by the minimum entry requirements. The School considers academic merit to be the key determinant of

successfully completing the UQ MBBS Program. The only 'selection' process used by the School is for the rural and Indigenous pathways.

The School's stated mission is that it is a large school, with a social responsibility to meet the needs of the community, rather than an elite school with a small number of graduates. There is a desire to produce a cohort of graduates largely representative of the local community. The mix of the student intake, determined by the different entry pathways, should ensure this is achieved.

2014 team findings

The University thoroughly reviewed its medical admission processes and procedures in 2013. Entry to the program is now governed by the University Admission Rules available on the University website. There are specific sections pertaining to program entry, suggesting greater centralised oversight of the medical student selection process. The team considers that the selection policy and processes are clearly defined and consistently applied.

In 2009, a decision was made to cease selection interviews. This was largely due to the feasibility and sustainability of conducting sufficient interviews for a student intake of over 500, supported by poor statistical association between interview results and subsequent performance in the early years of the program. A consistent gender bias has since emerged; that of a significant increase in males in the direct graduate entry pathway. The School community is debating this situation and further work is planned to better understand the reasons why fewer females apply to UQ as a first preference, and the better performance of males in sections of the GAMSAT. There was no analysis provided on the gender balance of subgroups such as international and rural origin students.

Recruitment of international students is brokered by separate external companies. The School intends to interview Ochsner applicants from 2015 (pending University approval) using a standardised evaluation tool. Interview results will be presented to the School, with the University making the final selection decision.

There are no preferential criteria nor selection processes to attract more students from low socio-economic backgrounds or under-represented groups, other than rural and Aboriginal and Torres Strait Islander background students.

The School follows the University's anti-discrimination policy with regards to admission of students with disabilities, including infection with blood borne viruses.

There is little public information for potential applicants on the effect of disabilities on future ability to practise. A brief reference to inherent requirements to practise is linked to the Faculty of Medicine and Biomedical Sciences webpages for all health students. The School could consider providing more specific information for potential applicants to the medical program.

Since 2011, the Aboriginal and Torres Strait Islander Studies Unit has managed Aboriginal and Torres Strait Islander student entry. Total student enrolments have remained low (six students in Year 1, 2014), particularly in relation to the total student intake. Retention rates have been improved through learning and student support (see Standard 7.3) and more rigorous academic criteria, focusing on prior learning in science. A member of the School sits on the selection panel for Aboriginal and Torres

Strait Islander students, and both the School and the Aboriginal and Torres Strait Islander Studies Unit expressed a desire to work more closely to improve the recruitment and retention of these students.

The MD program will commence its first cohort in 2015 and remains a graduate entry program with a provisional school-leaver entry pathway. Admissions remain as for the MBBS: graduate entry applicants require a grade point average (GPA) of five in a key degree and GAMSAT (or MCAT for international students); and provisional school-leaver entry applicants sit the UMAT while in their final year of secondary school and must complete their first degree at UQ within the minimum time specified with a program GPA of five to progress to the MD. The School anticipates no negative impact on Aboriginal and Torres Strait Islander and rural student enrolments. The School has no immediate plans to revise the program's selection criteria. Selection information is available on various School, Faculty and University websites, although these webpages are not necessarily linked nor the provider relationships clearly explained. The School should review these sources of key information for potential applicants.

7.3 Student support

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

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

- o students with disabilities and students with infectious diseases, including blood-borne viruses*
- o students with mental health needs*
- o 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.

2010 team findings

In general, the School offers a high level of support, backed by University support services. The UQ Union (the student union) has historically offered a comprehensive welfare service for students. There are some student concerns that there may not be enough (visible) support in the first two years, especially for such a large group and for those at the Ipswich campus.

Students consistently praised the quality and responsiveness of the administrative staff located at the School's campuses and clinical schools.

Now that Herston, the site of the Medical School office, has been designated a campus, improved on-site students support services are predicted, reducing the need for students to travel to the main campus in St Lucia.

Some attention could be given to methods of engaging the group of students in the first two years of the dual degree, to ensure they feel a connection with medicine and to integrate them quickly into the medical program.

Support for Year 3 and Year 4 students is based in the clinical schools and varies. The School acknowledges the importance of ensuring a core set of support services is available to all students, no matter their location. The support provided by the Rural Clinical School has been put forward as a model for the other clinical schools. All clinical schools should comprehensively document student support services available locally and have a referral mechanism for students with various needs including academic issues, physical and mental health problems, professional behaviour issues, and peer/cultural support for under-represented groups.

The current Ochsner student cohort is made up of thirteen students from the initial 2009 intake, and thirty-four students from the 2010 intake. By 2013, the annual student intake will increase to 120, and by 2016, there will be 480 Ochsner UQ students across Years 1 to 4. The team had the opportunity to meet with a number of Ochsner students based in Brisbane. Overall, the students were positive about their experience to date, and about the prospects of their clinical placements at the Ochsner Clinical School in New Orleans. Students appreciated the special welcome event at the beginning of the academic year and the opportunity to meet with the Ochsner staff members. They also welcomed the study resources UQ provided to assist students prepare for the USMLE part 1.

The team also had the opportunity to meet, in New Orleans, students from the main UQ cohort who were completing a core clinical rotation or elective rotation at the Ochsner Clinical School. Students indicated there was good local support, which had included assistance in securing accommodation for their short stay in New Orleans. Transport was a common student concern, given the limited public transport options available. The team encourages the School to continue to consider ways it can assist students to address these difficulties.

At the Ochsner Clinical School, a Deputy Head for Students has been appointed to develop and lead a local student support program, building on existing expertise and experience. The School is working with Student Services at UQ to define the types of student services that will be required, and expects to fully establish these in 2010, ahead of the anticipated first Ochsner cohort arriving in New Orleans in early 2011.

The key issues of concern for Ochsner cohort students were:

- variation and transparency in tuition fees – these have now been set in US dollars to avoid increases due to currency fluctuations
- changes to the program requirements – students are now required to complete their Year 1 electives in Australia and will be required to return to Australia for one clinical rotation in Year 4
- the projected lack of intern places available in Australia – this is now understood by students.

The School has acknowledged these early implementation issues and moved to address concerns. It is important that prospective Ochsner students receive comprehensive written information on the MBBS Program requirements and support available through

the recruitment agency, MedEd Pathways. Students would also welcome early contact with a UQ-based staff member to answer any queries before they enrol in the program.

The team recognises the financial impost the Year 4 return to Australia represents for the Ochsner cohort of students. It may be appropriate for the School to consider supporting this process, for example, by providing short-term accommodation for the returning cohort.

The assessment processes are very intensive and would clearly identify any student not performing well academically. There are appropriate support mechanisms in place to help students with difficulty.

The School's policies and procedures on the admission and support of students with disabilities and students with infectious diseases are adequate. It is unclear, however, if the clinical schools have a robust mechanism for ensuring students have complied with Queensland Health policies on immunisation before commencing clinical work.

Mechanisms are in place for addressing students with needs related to mental health or professional behaviour. New national legislation covering the registration of medical practitioners in Australia provides for the registration of medical students, and has requirements for education providers to notify the Medical Board of Australia of student impairment that may place the public at substantial risk of harm. It is unclear how the newly formed Medical Board of Australia will respond to registration of offshore students and what level of involvement they will require in the case of such issues.

Although the School has appropriate support for students with special support needs, including those coming from under-represented groups or admitted through widening-access schemes, it may be that these facilities are not sufficiently advertised. The School is in the process of appointing a dedicated GP counsellor (0.8 FTE). The students believe that identifying someone who has special skills in responding to the needs of North American students sitting the USMLE would be valuable.

The MBBS Program includes large numbers of international students, which will increase as the School moves to 120 students per year in the Ochsner Clinical School. The team discussed with School and University staff the particular support required for these students, and was assured that appropriate processes exist to deal with individual requests for financial assistance, as well as financial and counselling support for groups of students affected by disaster in their home country. The team noted that eligible US citizens studying at appropriately-accredited international medical schools are able to access US federal loans, and the AMC accreditation of the UQ medical school presently meets these requirements.

2014 team findings

Medical students have access to the University student services in learning support, disability, counselling and welfare on the St Lucia and Ipswich campuses. These are supplemented by additional site-specific activities, such as the events organised by the library on Ipswich campus. Offshore Ochsner students are supported by their Deputy Head for students in a similar way to onshore students in Phase 2.

Access to this range and type of services in all clinical school sites was less well documented, although staff expressed confidence in their ability to identify struggling

students and as necessary report their concerns. Students generally agreed with this, and appreciated the personalised service and strong sense of connection offered by Student Coordinators at these sites. The School has appointed, on a permanent basis, two new Student Coordinators to the Disciplines, to act as a point of first contact for students in Phase 2 rotations.

Herston campus staff expressed a high level of commitment to identify and support struggling students in Phase 1. Issues with individual students are discussed in weekly meetings of the Director, MBBS/MD Program; Head, Ipswich Campus; Deputy Heads; Manager, Operations; and Manager, Student & Academic Administration. The Director, MBBS/MD program has primary responsibility for advising and managing students requiring ongoing support, with the assistance of the Deputy Heads. Both Phase 1 senior academic staff and students identified PBL/CBL tutors as the key staff members for providing student support.

International students reported experiencing a significant period of adjustment, and appreciated the School's efforts to orient them to life in Australia through social events organised by the School's International Office, and practical support, for example financial advice from University Student Support Services. Students noted that peers were essential to adjusting to living in Australia, fostered by a strong sense of community in sites which were relatively isolated from main campus and smaller in size.

The team was impressed with the strong culture of peer support in the University of Queensland Medical Society (UQMS) and Ochsner student associations. Examples include student representatives acting as first point of contact and triaging student concerns to appropriate services; peer-led teaching, including Year 2 coaching sessions for Year 1 in basic sciences, anatomy, and clinical skills; and developing a list of independent clinicians with an interest in medical student mental health so that students could seek support outside the University.

The team acknowledges the considerable efforts to identify and support students in need of assistance. Nevertheless, student support does appear to some extent reliant on informal pathways and on a relatively small number of staff with responsibility across a large and dispersed cohort. The training of front-line staff to carry out support roles is unclear. Accordingly, there is a risk of students with significant concerns remaining unidentified or lost in the system. In addition to continuing to promote the range of services available at each site to students and staff who may identify struggling students, the team recommends that the School continue to develop and train a wider range of staff in identifying and supporting students in need.

Students with disabilities are supported primarily through the University's disability services, consistent with anti-discrimination legislation to provide reasonable adjustments. Students with disabilities are primarily identified through self-disclosure. The requirement for self-disclosure with regards to blood-borne viruses, and the requirement to complete an approved immunisation schedule is stated in the Program Rules and public information for all intending and newly enrolled students. All students are required to provide evidence of their immune status with regards to blood-borne viruses and diseases covered in the immunisation schedule, with a designated staff member to check student-provided documentation at Year 1 Orientation.

The University policy *Alternative Academic Arrangements for Students with a Disability* includes specific consideration of blood-borne viruses, invasive, and exposure-prone procedures.

As with students with disabilities, students with mental health concerns are encouraged to seek advice from the Director, MBBS/MD program, who may recommend a range of supports, including university counselling, independent medical advice, leave of absence or reasonable adjustments. It is noted that UQMS are developing, with the assistance of a senior academic, a list of independent clinicians from whom medical students can seek help for mental health problems.

A generic mechanism for identifying students with health and academic concerns is the online Notice of Concern. This appears to function as a back-up process, to supplement a range of more informal and less easily documented processes such as self-disclosure, and reporting by various tutors, coaches and academics, to Course Coordinators (including the Deputy Heads), Discipline Heads and in the main, the Director, MBBS/MD program. At Ochsner Clinical School, the Deputy Head of Students has a similar role.

The Aboriginal and Torres Strait Islander Studies Unit provides support for Aboriginal and Torres Strait Islander students using a case management approach with a designated staff member for students in the medical program. Indigenous Tutorial Assistance Scheme tutoring is provided although it was noted this had not been wholly successful. Between 2011-2013 a third of the Aboriginal and Torres Strait students enrolled in Year 1 (eight of twenty-three total in three cohorts) either failed, or were repeating or suspended or withdrew. This rate of attrition causes concern. The team supports continued monitoring to improve the effectiveness of support to these students.

Several senior academic staff members have multiple roles and responsibilities in student support, assessment and progression decision making. These include the:

- Director, MBBS/MD program, who has formal responsibility for students requiring assistance with mental health, health, welfare and academic issues, and is identified as such by clinical teachers, academics and students. Students who fail two Units are asked to meet with the Director, MBBS/MD program and show cause for continuing in the program.
- Student Integrity Officer, who is also Discipline Head, Medical Ethics, and thus responsible for assessment in the Medical Ethics, Law and Professional Practice curriculum.
- Head, Ipswich campus, who moderates assessments and assists the Director, MBBS/MD program by providing academic advice and learning support for struggling students across all sites.
- The Deputy Directors, who are also Course Coordinators for the Clinical Sciences units. Students who fail one unit are asked to meet with the Course Coordinator to review their academic progress.

Additionally, the Director, MBBS/MD program and Deputy Heads are members of the Board of Examiners. The team consider the formal mechanisms to ensure separation of student support from assessment and progression decision making are insufficient. Informally, potential conflicts of interest were reliant on individual staff withdrawing from or otherwise self-managing the decision making process.

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.

(Standard 7.4 is new in 2012.)

2014 team findings

There appear to be multiple formal and informal processes for identifying and managing students with impairments and/or professional behaviours which raise concern about the student's fitness to practise. The School does not have a fitness to practise policy specifically for medical students; since 2011 the School has adopted the university misconduct and student integrity policy for addressing serious concerns about student behaviour. There are several possible pathways for dealing with welfare, impairment and competence issues.

The key formal pathway for staff, students or community members to notify the School about significant concerns is the online Notice of Concern form.

Notifications are directed to the School Integrity Officer who may triage according to:

- Academic, health and mental health problems; referred to the Director, MBBS/MD Program and/or Deputy Heads. Welfare problems may be referred to the appropriate university service.
- Professionalism concerns are dealt with by the School Integrity Officer according to University policy (see above).

There is a formal feedback process whereby the outcome of the referral is communicated to the referrer. Verbal accounts of the process of referral and management differed in detail from the written submission. This most likely reflects the fact that key staff hold multiple roles and responsibilities in student learning and support, as well as responsibility for curriculum, and that there are multiple informal processes operating in parallel. A strength of the School processes is the experience and expertise of the School Integrity Officer/Head of Medical Ethics. It is also noted discussions about impaired students have occurred with the state health department through the Medical Schools Liaison Committee, with the Director MBBS/MD Program representing the School.

The School reported there are approximately 40 referrals per year through the online Notice of Concern form, which given the size of the cohort and scope of intended referrals, is likely to represent a small proportion of student issues. The form requires the notifier to identify themselves, which is likely to deter vexatious complainants, but may also deter genuinely concerned persons who are reluctant to make a formal complaint.

Clinical school and teaching site staff appear to regard using the Notice of Concern as a last resort, and report a variety of informal identification and management processes for concerning student behaviours. These included direct telephone referral to the

Director, MBBS/MD program, direct referral to the clinical school head or the clinical school professional staff, or to the discipline head. Meetings with the student and the lead academic may then be held.

For Ochsner students, there is direct liaison between the Deputy Head and the Student Integrity Officer. Students with unacceptable behaviour may be withdrawn from Ochsner clinical placements.

Clinical teachers at several sites voiced concerns about the capacity of the School to deal with serious concerns. In particular, they raised significant concerns about not receiving relevant advice from staff on main campus about students with known impairments or ongoing health problems, which had resulted in otherwise avoidable situations of at risk students being placed in settings with less supervision. While information privacy has been a concern, the School confirmed it is acceptable to pass on information about the students which affects their education, and for which the student has given consent. However, it appears this process is yet to bed-down and be understood by clinical teachers and staff, resulting in a failure to pass on important information.

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.

2010 team findings

(In 2010 these findings were presented at Standard 7.4.)

The team is impressed by the range and quality of student representation at the UQ School of Medicine. The University of Queensland Medical Society (UQMS) is the formal body responsible for medical student representation and engagement in the School's academic and other committees. Through the UQMS, students are represented on key committees including domain committees, the MBBS Curriculum Committee, and the Teaching and Learning Committee.

The UQMS has established robust mechanisms to ensure student leaders (President, Vice-President) are able to represent student feedback and interests to the Dean and Head of the School of Medicine. The main mechanism is through regular meetings with the student representatives for each academic year and clinical school. Year 1 and 2 focus groups are used to gather information and obtain student feedback.

The UQMS has also established subcommittees including an International Students Subcommittee, an Anatomical and Surgical Interest Subcommittee, a UN Millennium Development Goals Subcommittee, and a Research Subcommittee. There may be some value in engaging the 'pre-med' students, who are in the first two years of the dual degree program, to give them some connection to the School.

2014 team findings

Student representation remains a strength of the School. UQMS is a large and active student association, with elected UQMS officers representing all years and clinical teaching sites in the program, as well as special interest groups. The President and Vice-President of UQMS are members of key curriculum and governance committees (Teaching and Learning, Assessment, MBBS/MD Program Committees and School

Council) and also meet fortnightly with the Director, MBBS/MD Program and Deputy Heads, where they may raise student concerns.

UQMS reported their views had been sought regarding the MD program and they were satisfied with the level of consultation and communication.

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.

2010 team findings

(In 2010 these findings were presented under Standard 7.5.)

The indemnity arrangements appear to be adequate but the exact nature of indemnity cover for the UQ students while at Ochsner is unclear (i.e. if this is through a separate insurance policy or using existing UQ policies). Adequate indemnity arrangements are in place for both onshore and offshore student activities.

2014 team findings

The School reported adequate indemnity arrangements and insurance is in place for all School sanctioned activities, both offshore and onshore. The uncertainty regarding coverage for Ochsner students which was noted in the 2010 report has been resolved; the School confirms coverage for these students.

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.

2010 team findings

Team members visited the University's three campuses delivering the medical program, and all the School's major clinical teaching sites in Queensland, Brunei and New Orleans.

The major infrastructure developments across UQ and several of its ten clinical schools are impressive. Particularly commended are the outcomes achieved at the Rural Clinical School's major sites, and the Ipswich campus developments. The teaching facilities at Ipswich Hospital are limited but satisfactory. Given the planned increase in student numbers at the Ipswich Hospital, expanding teaching facilities should be included in the hospital redevelopment planning.

The rejuvenation of many existing teaching facilities and the new building programs are creating a medical school with the physical facilities to meet the challenges of training large numbers of medical students over the coming decades. Increased physical capacity is being developed to deal with the increase in the Year 1 and 2 medical student cohorts. This needs to continue to ensure consistent standards in the quality of physical facilities, and equity of access to teaching resources for students in Years 1 and 2 at the three main campuses (St Lucia, Herston and Ipswich).

The team was concerned about some disparity in the standard of some physical facilities training Years 3 and 4 students, including teaching spaces at the Mater Hospital and at the Ipswich Hospital. There is a need to ensure consistent standards and equity of access to resources for Years 3 and 4 students across all ten clinical schools, including Brunei.

The team was impressed by the recently announced plans to extend Caboolture Hospital, including more teaching space. However, teaching space at Redcliffe Hospital is limited and this is affecting the number of students who can be taught at the hospital. The clinical school administration at Prince Charles Hospital is housed in a demountable on the car park. This is unsatisfactory, but the team recognises the School's plans to redress this with a new building.

The team visited both the UQ Ipswich campus and the Ipswich Hospital, which will provide much of the clinical training experience for the Ipswich medical student cohort. The team was impressed with the quality of the physical facilities at the Ipswich campus and noted further plans for building and refurbishment, and the new super clinic facility. The team also heard about the long-term plans to rebuild the Ipswich Hospital on the showgrounds adjacent to the University campus, but noted that firm commitment is yet to be obtained for this development. However, a ninety bed expansion of the current hospital campus will be implemented over the next three years.

The Ipswich Clinical School has office space in a recently refurbished building within the Ipswich Hospital. A new Education Centre has also been built and is available for

student use. The Education Centre includes a simulated clinical training room and tutorial rooms. Overall, the students were very happy with the physical facilities at the Ipswich Clinical School, which includes a common room, a small tutorial room with smart board, access to computers and a library.

The School is encouraged to explore stronger links between the UQ Ipswich campus and Ipswich Clinical School. For example, use facilities such as videoconferencing to support Clinical School teaching, and involve Ipswich Hospital clinician teachers more in delivering lectures at the Ipswich campus.

Greenslopes Private Hospital provides excellent facilities for the students and staff at the Clinical School. The hospital is undergoing a major redevelopment, building new education facilities that will house the Clinical School. The new development will include office space, two lecture theatres, tutorial rooms, study areas and meeting rooms, as well as a common room shared with junior medical staff. The Hospital has also recently built a simulation facility for clinical staff and students, and intends to use this facility for interprofessional and team training.

Students at the Mater Clinical School appreciate many aspects of the physical and information technology facilities, and speak highly of the excellent clinical teaching and welcoming environment at the Mater Hospital. The main concerns raised by students about the facilities at the Mater are:

- lack of a dedicated student common room (the current common room is used for tutorials and classes)
- lack of 'wired' computer access for students without wireless devices
- lack of after-hours access to the library, PBL rooms and study facilities
- insufficient copies of current edition core texts and
- lack of access to the Mater's in-house pathology and radiology reporting systems, which means that they need to use treating clinicians' access codes to check results.

Comments on physical facilities at Brunei Clinical School

The Centre of Medical Education at Brunei has been moved to temporary accommodation in the basement of Raja Isteri Pengiran Anak Saleha (RIPAS) Hospital while a nearby building is refurbished. The Centre includes a large reception area and a meeting room (accommodating about 15 people) and adjoining room with desks for the Clinical School Head and two administrative staff.

Bruneian students stay with their families during their rotations. Australian students pay a nominal 'deposit' of B\$30, which acts as a bond. This will increase to B\$60. The Ministry of Health has recently paid for extensive refurbishment of four flats adjoining the main block of RIPAS.

There is a lack of student on-call rooms near the wards. Students are not able to stay after-hours, which means they miss out on being involved in the management of many interesting obstetric, and accident and emergency cases.

Comments on physical facilities at the Rural Clinical School

Team members visited each of the Rural Clinical School's major sites (Toowoomba, Bundaberg and Rockhampton). Capacity has grown in each of these locations since the

last review. The team was advised that new funding for infrastructure has been obtained from the federal government for teaching and learning centres in Bundaberg, Hervey Bay and Rockhampton. Free, high-quality accommodation in Bundaberg, Toowoomba and Rockhampton is seen as a major attraction by students.

Toowoomba has had considerable development and there are excellent teaching and clinical facilities for students. One very impressive feature at Toowoomba is the extensive use of the two private hospitals. This has been made possible by local 'champions' who have been highly effective in extending the teaching program to these sites.

Since 2005, a new Teaching and Learning Centre has been built next to the Toowoomba Base Hospital. The Centre houses the Rural Clinical School offices and meeting space, lecture space, a clinical skills laboratory, a computer lab and library which is accessible twenty-four hours a day).

Bundaberg Hospital is a busy regional hospital that has matured since the last visit with a significant increase in senior staff. Teaching is described as part of the hospital's culture and, from the beginning, there has been strong involvement with private clinicians. The new Teaching and Learning Centre, to be completed in 2012, will be a welcome addition.

Rockhampton Hospital has a \$4M Teaching and Learning Centre being built with an estimated completion date of June 2011. Students commented on the excellent administrative support, library facilities and staff. The University's Director of Undergraduate Medical Education has a dual role as the Director of Medical Services, and this ensures good communication and understanding about the role of hospital staff in undergraduate teaching.

Students at Bundaberg and Rockhampton sites were very positive about their experience on placements, describing it as more 'hands on' with a good student to consultant ratio and strong community support. In both locations, students were considered as crucial to solving the current workforce shortages. Clinicians and students expressed difficulty in accessing core sets of lectures on Blackboard. New technologies such as videoconferencing do not yet seem to be used optimally.

Comments on physical facilities at the Sunshine Coast Clinical School

The Sunshine Coast Clinical School (SCCS) is based adjacent to the Queensland Health Executive Suite at Nambour General Hospital. The physical facilities comprise a student resource room with four computers and a textbook collection, a combined common room and office space for academic and administrative staff. All facilities are 'multipurpose', and are also used for meetings, tutorials and examinations. The resource room is used for web-based examinations.

The physical facilities at the Sunshine Coast Clinical School are adequate for the current needs, but will be much improved when the new Sunshine Coast University Hospital is completed.

The Clinical School has access to Queensland Health facilities including library, meeting rooms (for tutorials and examinations), videoconferencing facilities (used for obstetrics and gynaecology, and paediatrics tutorials), and a residential property used in the General Practice rotations (PBLs and examinations).

Students have access to a new Scenario-Based Learning Centre for simulation-based learning. The team visited the Block 3 building site, which will house an Education Centre (lecture and tutorial space, a computer training room and library). While the Education Centre is primarily for Queensland Health staff, it will be available to the SCCS and students. The Education Centre will be completed by 2011.

In 2016, the SCCS will relocate to a new, purpose-built tertiary teaching hospital, the Sunshine Coast University Hospital, to be located at Kawana. This University Hospital is a collaborative enterprise with Queensland Health, the UQ School of Medicine, University of the Sunshine Coast, and Sunshine Coast TAFE. Teaching and research facilities will include tutorial rooms, computer workstations, skills training rooms, office/reception areas, 'wet labs', 'dry labs', academic and general offices, student common room, library, lecture theatres, and work spaces for clinical trials. The Nambour campus will be retained.

Comments on physical facilities at Ochsner

The team had the opportunity to visit the many training facilities at the Ochsner Medical Centre, which is the main facility on Jefferson Highway in New Orleans, and many of the other hospitals and clinics forming the Ochsner Health System in New Orleans, surrounding areas, and rural Louisiana. The team was very impressed with the infrastructure and the quality of the physical teaching facilities currently available.

A new education and research facility is planned. This will be located directly opposite the main hospital facility, and has funding support from the State of Louisiana. The major facility will add additional classrooms, a conference centre, simulation training space, a student activity centre, as well as faculty and administrative space. The Ochsner group has great potential for expanding its role as a provider of high-quality training of medical students.

2014 team findings

There are impressive physical facilities for students across all sites, with flexible teaching and learning spaces, and good student amenities. The School has invested significantly in the physical facilities at its major teaching sites over the past few years; in particular, at the Ipswich campus, the refurbished Health Sciences building at Herston and the new university teaching spaces at the Translational Research Institute, Greenslopes Clinical School and the Ochsner Clinical School. There is great potential for students to access clinical and biomedical research facilities and institutes within the School and the Faculty.

Ochsner has a new academic building that was opened in December 2013. It houses all educational activities with classrooms, a large room with capacity for 120, a testing facility room with approximately 60 workstations, and a floor dedicated to research. The team found that the facilities available to students at the Ochsner sites visited exceeded expectations.

At the Wesley Hospital (UnitingCare Health Clinical School), a Student Training Centre with skills training and tutorial rooms, computers and student amenities has recently opened. A new clinical school building adjacent to the Ipswich hospital opened with academic staff offices, tutorial rooms and student facilities. Facility upgrades are either under construction or scheduled for a number of teaching sites including the Northside

Clinical School, Princess Alexandra-Southside Clinical School, the Mater Clinical School, the Sunshine Coast Clinical School, and the Rural Clinical School (Hervey Bay and Rockhampton). These facility upgrades have enabled the School to accommodate its growth in student numbers.

The Ipswich campus has functioned well to provide a quality learning experience for students, notwithstanding persistent concerns about the lack of wet laboratory facilities. The benefits of Phase 1 learning at Ipswich, as described by staff and students, derives from the close-knit cohort, generous physical facilities and sense of connection with the community and staff. While beneficial for learning, these intangibles were in contrast to the tangible benefits of moving Phase 1 students to St Lucia, described by the academic staff faced with delivering the same curriculum across two campuses, often face to face.

With the confirmed withdrawal from the Ipswich campus by the end of 2016, staff are developing contingency plans to manage the potential loss of over eighty clinical skills places, twenty clinical coaching groups, and expected pressures with lecture, PBL, and anatomy and physiology lab timetabling for a cohort of 540. The School has undertaken an audit of teaching spaces and student facilities as part of planning for the MD program. It has commenced contingency planning for additional Phase 1 students to be accommodated at the St Lucia campus and the Princess Alexandra-Southside, Royal Brisbane and Mater Clinical Schools, with two critical areas being lecture delivery and clinical coaching. The Ipswich Clinical School located beside the hospital will continue to host Phase 2 students.

Regarding lecture delivery, there is no one venue capable of accommodating the entire cohort. The School is considering its options for splitting the cohort across three sites, which include using the Translational Research Institute (which was not designed as a teaching space), with or without synchronous delivery using videoconferencing. There is a new 500 seat Engineering lecture facility that could be accessed. The School should monitor and report on the success of the proposal to simultaneously deliver lectures at multiple sites in Phase 1.

The School has identified the need for refurbishment of PBL rooms at the St Lucia campus. St Lucia has the newly expanded Otto Hirshfield Building used by Phase 1 students for anatomy, with teaching space for 120 students. Access to wet laboratories for anatomy teaching is still an issue at the Ipswich campus.

Regarding Year 2 Clinical Coaching, an additional twenty groups will need to be accommodated. Due to constraints on clinical teaching capacity, clinical coaches are paid to teach at Ipswich. However, clinical coaches elsewhere are not. The Royal Brisbane Clinical School expressed confidence in its ability to recruit sufficient registrars and consultants to deliver extra sessions. Other contingency plans included private hospitals, nursing homes and extension of the Community Volunteer program.

The first cohort of the MD program will commence at Ipswich in 2015 and will complete Phase 1 there in 2016. No cohort will commence at Ipswich in 2016. At the Ipswich campus, the University of Southern Queensland (USQ) will manage teaching space allocation and the UQ staff and students will become tenants. Pending ongoing negotiations with USQ, it is anticipated that the staff will move to an alternative building and the students will continue to use the PBL and lecture facilities in the medical school

building for the teach-out time, with visiting student support and library services from St Lucia.

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.*

2010 team findings

The School continues to develop its information technology resources and staff expertise. The School is moving towards effectively meeting the distance education delivery challenges for both students based at each major Rural Clinical School hospital, and those based with the Ochsner Clinical School. However, information technology access is limited for students based at the Brunei Clinical School.

Students raised specific concerns about access to patient information, including investigation results, at the Mater Hospital. Electronic patient information should be available to all students at all clinical teaching sites.

Students were also concerned about the efficiency and reliability of the School's electronic communication systems. Examples included multiple emails with confusing information about timetables and schedule changes, and students being inadvertently left off an email distribution list for a message containing important information about an assessment. Student confidence in the School's communication systems is important to consider for the large and geographically dispersed student population. Students with the Rural Clinical School expressed their need to have access to a complete set of online core lectures. This was noted as being developed.

The University has some excellent library facilities. While there is some student concern in some clinical schools about a lack of twenty-four hour physical access to library facilities, the team noted anywhere students have computer access, they also have access to the University's computer-based reference systems.

The team noted the quality of information technology infrastructure available at UQ Ipswich, including using innovative technology to teach anatomy and the impressive main library.

Comments on the Brunei Clinical School

For students at the Brunei Clinical School, access to the hospital library, which is next to the student quarters, is available on Thursdays (office hours) and Saturday morning. There is a bookcase with new UQ textbooks earmarked for student loans. Wireless internet is available in the library, although students complained that downloading was

very slow across the hospital campus and that the journal holdings were very limited and inadequate.

There is no defined budget for Brunei Clinical School for purchasing updated textbooks or new references, video teaching material, or journals for medical education and training. To date, all such purchases have been one-off and ad hoc. Students comment on the disadvantage undertaking offshore rotations, especially preparing for examinations. There are no videoconferencing facilities available at the Brunei Clinical School.

Comments on the Rural Clinical School

Clinicians and students expressed difficulty in accessing some of the core set of lectures on Blackboard. Students did appreciate the Voice-over PowerPoint now available. New technology, such as videoconferencing, has been introduced but it does not yet seem to be used optimally in all sites. Students commented on the excellent library facilities at Rockhampton and Toowoomba.

Comments on Ochsner

The team was impressed with the availability of information technology resources, videoconference and audiovisual technology across the Ochsner main teaching hospital facility, and the level of staff support. The team witnessed effective linkage with the main campus at UQ. The team visited the main hospital library and noted the access and support provided to the medical student cohort.

The team was particularly impressed with the single electronic medical record, the Ochsner Clinical Workstation, which is used across all the clinical sites of the Ochsner group, and noted the plans to move to the Epic Electronic Management Record system. The team noted the capacity for student notes to be added to the record system is being developed. This focus on shared electronic patient information should prove to be a very useful asset for clinical training. The team witnessed the success and sophisticated use of videoconferencing between staff at Ochsner and staff at the main teaching campuses in Brisbane.

2014 team findings

The School has improved its information technology facilities to support the delivery of its medical program across its many teaching sites.

Students are able to access learning resources and other important information through the Blackboard system and this has improved since the last visit. The School has continued to develop its online resources including: lecture recordings, video files, discussion forums, Voice over PowerPoint, as well as self-paced online learning modules such as the excellent Paediatric Online Learning Interactive Environment (POLIE) resource and materials to support problem and case-based learning.

Videoconferencing facilities observed by the team worked effectively. Videoconferencing facilities in the Brunei Clinical School have improved enabling live lecture access via computer. Ready access to IT support for videoconferencing will be essential to ensure delivery of streamed lectures across multiple teaching sites.

Some centralised University systems for managing teaching and learning do not fit the structure and needs of the program. These include timetabling, venue booking and clinical placement allocation systems. Students reported some delays in timing and formatting of Blackboard resources and some last minute scheduling changes, which can create difficulties if the students have a family or work commitments in addition to their studies. The School is working with the University on improving these systems, but progress appears slow.

Students have excellent access to program information, on-line journals and other resources through the UQ site. Wireless access is available at most of the larger teaching facilities. Students have access to university computers and excellent library facilities at many of teaching sites. Ipswich wireless access is now good and students reported ample access to computers and study areas on campus. Internet access is available at all Ochsner sites. Staff and students have ready access to the UQ computer systems and report that they receive good IT support from the University. Students can use personal tablet devices to access the electronic patient records.

Queensland Health is implementing electronic patient records and student access is one of the issues on the agenda of the Medical Schools Liaison Committee.

8.3 Clinical learning environment

- 8.3.1 The medical education provider ensures that the clinical learning environment offers students sufficient patient contact, 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.*

2010 team findings

The School's network of clinical schools is meeting the challenge of organising clinical teaching for expanding student numbers. The School's progress towards ensuring sufficient clinical teaching and learning resources, including sufficient patient contact in each clinical rotation to achieve the outcomes of the medical program, is commended.

As noted earlier, the clinical school structure is new, and encompasses a mix of sites, including some where clinical teaching and a medical school presence are well established, such as the Royal Brisbane Clinical School and the PA-Southside Clinical School. These sites have extensive teaching and research infrastructure. The Rural Clinical School was established six years ago with Australian Government funding, and has grown to include major sites at Toowoomba, Rockhampton, Hervey Bay and Bundaberg, as well as many small rural towns. The Northside, Sunshine Coast and

Ipswich Clinical Schools have had a limited School presence until the last two or three years, although UQ medical students have had clinical placements there for many years.

While the team commends the development of the Clinical School Network, the degree of discipline control over teaching delivery at some sites varies, including a lack of student access to some specialist teachers in areas such as obstetrics and gynaecology, paediatrics and psychiatry at some sites. The team urges the School to take steps to ensure consistency of clinician and patient access at all clinical teaching sites.

The School does have sufficient clinical teaching facilities to provide a range of clinical experiences in all models of care, including primary care; general practice; private and public hospitals; rooms in rural, remote and metropolitan settings; and Indigenous health settings. The team was concerned about capacity for international students to access rural experience while balancing the needs and wishes of domestic students. In addition, the team was concerned about access to experiences providing health care to Indigenous people in a range of settings and locations. The team encourages the School to continue expanding the focus of Indigenous health curriculum beyond rural areas to give greater attention to the health care needs of Indigenous communities in metropolitan areas.

Comments on clinical teaching resources at Brunei

The Brunei Clinical School provides clinical education in surgery, obstetrics and gynaecology, and paediatrics. Of the students who have completed Core Clinical Rotations in Brunei, most have done a surgery rotation. In 2009, 29 students completed a rotation in Brunei. The UQ School of Medicine is keen to expand these numbers slightly, but intends Brunei to remain a small clinical school. From 2010, the UQ School of Medicine will take two graduates of the Universiti Brunei Darussalam Bachelor of Health Sciences into Years 3 and 4 of the MBBS Program.

The discipline heads/coordinators and clinical teachers in Brunei do not identify themselves as being teachers of the University of Queensland. They appear to have minimal interactions with the University and no input into curriculum design or development of teaching materials or assessment questions.

Clinical teachers are fully employed by the Ministry of Health on standard civil service contracts, which do not specify teaching responsibilities. However, clinicians earn continuing medical education points for teaching medical students and residents. During interviews for promotion, teaching activities are discussed and the degree of commitment to research, teaching and service is raised, although how this is handled varies from discipline to discipline.

There is no formal recognition of staff teaching contribution, or requirement to attend 'teach the teacher' training sessions with quarantined time away from service delivery. This was identified as a major barrier to engaging interested clinicians.

The team noted the lack of dedicated facilities for teaching procedural skills or clinical simulation laboratories. The paediatrics and obstetrics and gynaecology wards have a small number of meeting rooms, equipped with whiteboards, which can be used for teaching and are shared with other hospital staff for meetings and seminars.

The team remained concerned that very few clinicians have received any training in teaching medical students. While all expressed desire for such training, they widely

acknowledged the difficulties in fitting such training into their schedules. Many clinicians express willingness to teach, however recruiting teachers needs reinvigoration through recognition of teaching and ongoing faculty development.

Staff of the medicine discipline complained that they had not had any students for the medicine rotation in a number of years, and that they had received no feedback as to why this had occurred. The separation of renal medicine from the discipline of medicine has resulted in students being unable to access renal medicine teaching in their Brunei rotations, a disquieting disjunction. This is a great pity as RIPAS has one of the largest renal services in the region.

While the University has provided some books and computers, and some airfares for the Head of the Clinical School, Brunei has not received any money for students. This is in sharp contrast to Ochsner.

Comments on clinical teaching resources at the Rural Clinical School

The team noted the positive feedback from Year 3 and 4 students on the quality of their clinical placements in each Rural Clinical School location. The Team also received positive feedback from University staff, clinicians and stakeholders in rural locations about clinical teaching. The team noted that the Rural Clinical School's capacity for clinical training has grown considerably in each location since the last review.

New Australian Government funding for infrastructure has been obtained for teaching and learning centres in Hervey Bay and Bundaberg. The Rural Clinical School is commended for developing excellent training opportunities in regional private hospitals. At Toowoomba, students work with consultants at St Andrew's and St Vincent's hospitals in a range of medical and surgical disciplines. There is also opportunity for training in the private hospital facility at Bundaberg, with students reporting excellent opportunities, especially for surgery experience.

The Rural Clinical School has a partnership with many general practices across the region, many of which are well-established practices with a strong commitment to medical student education. The new GP super clinic in Bundaberg will also be used as a significant site for medical student teaching.

Comments on clinical teaching resources at Ipswich

The team noted the high-quality existing infrastructure for teaching at the Ipswich campus and that plans for further development are under way. The team was concerned about the limited current clinical experience opportunities for Year 2 students at Ipswich Hospital, but noted that this was being addressed.

Comments on clinical teaching resources at Ochsner

One major component of this review was the assessment of the clinical teaching resources of the Ochsner Health Service in Louisiana. The team confirms the Ochsner Health Service has the capacity to meet each of the AMC educational resource requirements for implementing the UQ curriculum.

The Ochsner Clinical School is located in New Orleans, within the Ochsner Health System. The Ochsner Health System is a non-profit, integrated, academic health system

that includes:

- seven acute and one sub-acute hospital
- 37 community clinics
- 1300 licensed inpatient hospital beds
- 750 employed physicians
- 11,000 employees and
- 1.3 million patient contacts annually.

The Ochsner Health System footprint comprises four regions that cover the southeast of Louisiana. The Team visited sites in three of these regions: East Bank, West Bank-Bayou and Northshore. It did not visit the Baton Rouge facilities. The team visited well-equipped primary care premises in a number of urban and rural locations, and noted the many and varied opportunities for student training. Students in the Ochsner cohort will be exposed to a range of clinical experiences including primary care, rural medical practice, small hospital practice, and tertiary hospital medicine. The team also noted the profile of clinical conditions being managed in primary care is similar to what is seen in Australia.

The Ochsner Health Service has long experience in training medical students, especially from Tulane University and the Louisiana State University, and residents, with 27 accredited graduate medical education programs. Plans are well developed to handle the full cohort of Ochsner students in Years 3 and 4. The Clinical School has mapped student numbers to staff numbers and clinical services, defined by number of beds and/or patient contacts. At full capacity in 2016, the Clinical School will have 290 UQ medical students on site: 120 students in each of Years 3 and 4 in the Ochsner cohort, and 50 students from the main UQ cohort completing one or two Core Clinical Rotations and the Year 4 elective. The clinical school took its first UQ medical students in 2009, with four non-US Year 4 students undertaking their elective and eighteen students finishing twenty-six Core Clinical Rotations (Specialties I and II, Paediatrics, and Obstetrics and Gynaecology) at the Ochsner Clinical School.

The Clinical School's plans will need review as student numbers increase. The team noted that teaching is being considered a core part clinical staff work, and involvement in student teaching will be rewarded under the financial remuneration model.

The University of Queensland is rolling out formal staff appointments of Ochsner staff as members of the UQ faculty, using the same standards used for academics based in Australia. Non-doctor staff members involved in clinical teaching are being appointed. The team noted plans for expanding clinical simulation skills training in the new clinical training building, which is being constructed across the road from the main teaching hospital.

The School's engagement with other medical schools

A major change since the 2005 AMC assessment of the University of Queensland MBBS Program has been the increased number of medical schools and medical students in Queensland. Two other medical schools, at Bond University and Griffith University, now occupy the South-East corner of Queensland, and James Cook University's medical school has continued to grow in North Queensland.

As noted earlier, Queensland Health has established processes with the four medical schools, through the Medical Schools Liaison Committee, to help manage training requirements and capacity across the state. Matters considered through this forum include clinical placement capacity, rural placements, internships for international fee-paying students, and vertical integration of medical education. This mechanism, combined with direct liaison between the schools, provides for good discussion on activities that may affect curricula delivery.

The large increase in the number of medical students in Queensland has placed significant pressure on rural places. The team remained concerned at the likely impending competition for rural training. To ensure the UQ School of Medicine can deliver its program and meet its objectives in relation to rural training in this environment, the School will need to engage actively with the other Queensland medical schools concerning clinical training requirements in general, and rural placements in particular.

The Ochsner Health System has historically provided clinical training for students for two local universities, Tulane and Louisiana State Universities. For the past five years, because of the damage to and/or destruction of a number of other health facilities in New Orleans, the Ochsner Health System has provided additional clinical teaching for both medical schools, largely at the main health facility on Jefferson Highway. The Ochsner Clinical School stated it had made a public commitment not to reduce the number of medical student places available in Ochsner Health System to both local medical schools. As noted earlier, a more formalised collaborative relationship with Tulane and Louisiana State Universities has the potential to offer significant benefits for staff and Ochsner UQ students.

UQ students will benefit from access to Ochsner Health System's newly acquired hospitals and health facilities, which have not traditionally been used for clinical teaching.

Comments on clinical teaching resources in general practice

The School has an extensive network of general practitioner teachers who represent a high-quality teaching resource, in both urban and rural settings. Appropriate parallel experiences have been organised for Ochsner students, as noted elsewhere. The planning for this rotation has been thorough. Adequate placements are currently available to meet the rotation requirements in the general practice discipline, and realistic plans are in place to deal with future expansion.

The team had the opportunity to meet GP teachers in Queensland and in Louisiana. There is a high level of enthusiasm for the UQ program. However, the level of knowledge of the School's curriculum and teaching methods was variable, and continued efforts to extend staff development to these more 'peripheral' teachers is recommended.

2014 team findings

The School continues to have access to excellent clinical teaching facilities, including a range of inpatient and community health care settings across metropolitan, rural and international centres.

The proposed clinical placements outlined in 2010 were implemented for the full student numbers. The 2013 clinical student allocations are shown:

2013 Clinical School Allocations:

Clinical Schools	Year 2 Numbers	Year 3 Numbers	Year 4 Numbers	TOTAL
Greenslopes		40	26	66
Ipswich	73 (Campus)	37	29	139
PA – Southside	163	73	81	317
Mater	40	30	40	110
Northside		53	82	135
RBWH	223	66	103	392
Sunshine Coast - Nambour		33	24	57
Wesley – St Andrews		17	18	35
Toowoomba		36	29	65
Harvey Bay		7	8	15
Bundaberg		13	6	19
Rockampton		26	13	39
Ochsner		30	31	61
TOTAL Students	499	461	490	1450

There were variable reports of the number of students allocated per clinical team in Phase 2; with general agreement up to two students were commonly allocated. The School is confronting clinical placement pressures in paediatrics, obstetrics and gynaecology, and mental health. It is working to address these, for example obstetrics and gynaecology students are now placed at Greenslopes Private Hospital. Further reporting to the AMC on these pressure areas will be required.

General practice placements are offered in a wide range of locations. All students spend eight weeks in general practice (urban/peri-urban), and all also experience eight weeks in a rural or remote setting. Three general practice super-clinics have opened at Annerley, Ipswich and Meadowbrook boosting capacity for student placements.

The loss of the Sunshine Coast Clinical School campus from 2015 will require approximately eighty Phase 2 students (forty each in Year 3 and 4) to be reallocated to other clinical schools. The opening of the UnitingCare Health Clinical School at the

Wesley / St Andrews Hospital in 2013 has contributed additional capacity for student places and additional places are planned for other sites within the UnitingCare group of health services.

The School considers there is potential for expansion of clinical placements in Brunei, which continues to place a modest number of students on core clinical rotations in surgery, obstetrics and gynaecology, and paediatrics. The School reported students gain considerable clinical exposure in Brunei and expansion of student numbers may be possible in the current specialties and potentially in medicine and general practice also. The AMC would require details regarding any Brunei expansion if this is planned.

The School has commenced contingency planning for clinical placements and is confident that there is sufficient capacity to accommodate students reallocated from Sunshine Coast Clinical School. This will need to be monitored carefully over the next several years. The School is asked to demonstrate its continued capacity to accommodate students in Phases 1 and 2 by reporting on current and projected student placement data for each course or rotation and every location (campus or clinical school).

The School reported its clinical placements are dependent on clinician good will, and it works hard to foster goodwill with its unpaid teachers.

The School reports students in all Clinical Schools have the opportunity to undertake clinical placements in public and private hospital settings, attachment to community health services or community outreach services, including health services for specific minority groups and attachment to general practices of various configurations.

Indigenous health settings include both urban general practice settings and rural settings. A substantial proportion of the cohort undertakes a placement in an Indigenous health setting, and those that do not gain some exposure to Indigenous health. The Year 3 Indigenous health placements will remain available to students in the General Practice rotation.

The Ochsner Clinical School is able to deliver all core clinical rotations, including General Practice and Medicine in Society. It has detailed plans to manage the full cohort of students and train its clinical teachers. The team observed the new Women's Pavilion at the Ochsner Baptist Hospital, which now manages all obstetrics and gynaecology. It toured the new Ochsner Primary Care Center located adjacent to the Clinical School, which provides primary care, family medicine and paediatrics and contains educational space for students and staff; and the Covington Care Center. The team commends the School on these impressive facilities and the potential for steady growth in clinical placement sites.

The team reviewed the Ochsner general practice rotations and found them to deliver a high-quality and comparable experience to Australia. Students attend two different sites each week during the eight-week rotation to ensure a broad experience, and are required to complete the School's self-directed material and attend tutorials. Students are supervised one-on-one, seeing patients, not just observing clinicians.

The management of clinical placements has changed with the introduction of a University-wide allocation system underpinned by algorithms to allow preferences. Year 3 MBBS students are allocated to a clinical school for the duration of the academic year and nominate their clinical school preferences. Students may be allocated to

another location if their clinical school doesn't offer all rotations. Year 4 MBBS students nominate their preferred geographic region for clinical rotations, being: South-eastern Queensland, Rural Clinical School (RCS) Bundaberg, RCS Hervey Bay, RCS Rockhampton and RCS Toowoomba.

The allocation system has caused considerable concern amongst the clinical schools and disciplines. The School is working with the University to adjust the algorithms to fit with medical program requirements for consistent and predictable student numbers across the year. General Practice placements are allocated differently, with students locating suitable practices from a database of over 200 practices. Some students have reported delays finding practices who will agree to take students. The timing of the release of practice information is being adjusted in response to these experiences. These processes need to be improved as much as possible before the impact of re-allocating Sunshine Coast and Ipswich campus students is felt.

Queensland Health provides subsidies to health services to support student clinical placements. For example, at the Royal Brisbane Hospital, these funds are used, according to agreement between the Head of School and the CEO, Metro Northside Health Service District, to employ a chief medical registrar who plays a major role in student teaching and organising Year 3 examinations in the medicine rotation.

The School is represented on Queensland Health's Medical School Liaison Committee which provides an opportunity to discuss issues of mutual interest and concern with representatives from other Medical School in Queensland, health care services and Queensland Health. The team was impressed by the UnitingCare Health Clinical School team's approach to managing medical students from three universities to create a collegial and cooperative environment among students and teachers.

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.*

2010 team findings

(In 2010 these findings were presented at Standard 1.8)

Clinicians employed in health services are essential to providing the MBBS program, but not all feel obligated to teach in the program. The conjoint appointment (by the School and respective health service) of the heads of clinical schools is a positive step to engage clinicians as teachers. However, an extension of such conjoint appointments, to include the leaders of the clinical disciplines within the health services and training clinicians as teachers, would further strengthen their engagement.

As noted earlier, work will be required to support professional development of hospital and community practitioners who contribute to the teaching program. At the Ochsner Clinical School, faculty development for introducing the UQ program has begun, but more will be required before Year 3 is offered for the first time 2011.

The School has been successful in engaging new clinical teachers, especially in hospitals previously underused for teaching. However, with a significant national shortage of all clinical staff, the demands of the significant student number expansion may stress the system.

2014 team findings

The University policies, procedures and guidelines for clinical placements have not changed since 2010.

Support of the clinical supervisors at teaching sites is overseen by the discipline heads who conduct training and provide feedback, both online and in person. Discipline leads at each site orient and monitor staff. Clinician handbooks are available that outline student learning expectations, and the Electronic Course Profiles list learning objectives and assessment modalities. Each year, all clinicians who have been rated highly by their students receive clinical teaching excellence certificates. Each clinical school also awards a 'Clinical Teacher of the Year' award.

In the Year 2 clinical coaching program, the School liaises with hospital staff to identify appropriate clinical coaches for small group clinical bedside coaching and rostered time for teaching where possible. In Years 3 and 4, students are generally allocated to clinical teams.

The School has developed strong relationships with health care facilities to support the delivery of clinical teaching and learning in a busy service environment. The School has negotiated clinical placement agreements with the clinical sites.

Focused efforts to maintain these relationships will be essential and this is a key role for the Cluster Heads and the Associate Dean (Clinical). The heads of disciplines play a major role in ensuring colleagues within their discipline remain committed to teaching, and the academic and administrative staff in each discipline engage locally to ensure students are appropriately placed and well supported.

All clinical supervisors are encouraged to apply for an academic title with the University. This provides access to University library services and facilities. Although there is a clear policy for academic titles for health professionals, there is some variation in the approach to conjoint clinical appointments. This has posed some challenges with respect to managing performance and accountabilities of these roles to the University and the Health Service. The team observed good will and a collaborative approach to addressing these challenges. The School and students greatly value the efforts of its clinical teachers.

Appendix One Executive Summary 2010

The AMC's *Assessment and Accreditation of Medical Schools: Standards and Procedures* provides for schools to make major changes which can be approved for introduction within the current accreditation period of a course. When it considers the initial advice from a school about planned changes, the Australian Medical Council (AMC) Medical School Accreditation Committee decides whether the change is major. If it is, the Committee decides whether the major change can be approved within the current accreditation or is of comprehensive impact and requires reaccreditation of the whole course.

The School of Medicine, Faculty of Health Sciences, the University of Queensland (UQ), is seeking approval for a major change to its four-year medical course, which has AMC accreditation until December 2011. The magnitude of the proposed changes led the Medical School Accreditation Committee to decide the whole program would need to be re-accredited. The School's planned changes include:

- A proposal to admit up to 120 fee-paying students per year from the United States of America (US citizens and US permanent residents) who would complete the first two years of the program at the University's Brisbane campuses, and then undertake the majority of their Years 3 and 4 clinical training through the School's Ochsner Clinical School, established through the Ochsner Health System in New Orleans
- Delivering the first two years of the University of Queensland's four-year medical program at the University's Ipswich campus
- With the addition of the proposed Ochsner student cohort, a 50 per cent increase in student intake since the last AMC program assessment in 2005
- A medical program review in 2009, which the School described as a wide-ranging analysis of every feature of its education and governance arrangements.

The AMC policy statement *Medical Courses Conducted Offshore by Australian and/or New Zealand Universities* sets out additional criteria that apply when the AMC considers a proposal to deliver an accredited course offshore. This policy also defines a limited number of offshore course proposals the AMC will assess and its rationale for limiting its assessment to these proposals. These are courses that:

- are offered by AMC-accredited medical schools located in an Australian or New Zealand university, where the Australian/New Zealand university has developed the program and has responsibility for overseeing the academic standards; and
- result in the award of a recognised higher education qualification of the Australian or New Zealand university; and
- are essentially the same as the course accredited by the AMC for delivery in Australia or New Zealand, in terms of educational objectives, curriculum framework, educational process and assessment outcomes; and
- include adequate experience within the Australian/New Zealand health care system.

A school proposing change to its accredited medical program must first satisfy the AMC that the proposed changes are likely to comply with AMC accreditation requirements and it has the capacity to implement the changed program. In 2008, the School

submitted a proposal outlining the planned Ochsner developments. The AMC determined this proposal did not meet AMC requirements. In July 2009, the School submitted a revised proposal, together with information on the other major changes in the medical program.

On advice from the Medical School Accreditation Committee, the AMC Directors agreed to accept the School's submission as a proposal for a major change to the University of Queensland's accredited medical course, and to invite the School to proceed to full assessment of the plans by an AMC team.

An AMC team assessed the program in August and September 2010, visiting three campuses and all 10 clinical schools, including Ochsner (New Orleans), Brunei, and the Rural Clinical School. The Team reported to the November 2010 meeting of AMC Medical School Accreditation Committee. The Committee considered the draft report of the 2010 assessment and made recommendations to the November 2010 meeting of AMC Directors on accreditation within the accreditation options described in the AMC accreditation procedures and the policy document *Medical Courses Conducted Offshore by Australian and/or New Zealand Universities*. This report presents the Committee's recommendation on accreditation, as endorsed by AMC Directors, and the detailed findings against AMC accreditation standards.

Decision on accreditation

Under the *Health Practitioner Regulation National Law Act 2009*, 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 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.

In recommending accreditation of a major change to a medical program that entails reaccreditation of the full course, the AMC Directors may grant:

- (i) Accreditation for a period up to two years after the full course has been implemented, subject to conditions being addressed within a specific period of time and depending on satisfactory annual reports. In the year before the accreditation ends, the medical school will be required to submit a comprehensive progress report. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to a maximum of four years, before a new accreditation assessment.
- (ii) Accreditation of the new course may be refused where the school has not satisfied the AMC that the complete medical course can be implemented and delivered at a level consistent with AMC Accreditation Standards. The AMC will advise the school on the deficiencies to be addressed before it will reconsider accreditation.

The AMC's finding is that overall, the MBBS Program of the School of Medicine, the University of Queensland, meets the AMC accreditation standards. The School has managed well the initial implementation of major changes necessary to support the

increasing student intake, the inclusion of the Ochsner Clinical School, and the expansion of MBBS Program Years 1 and 2 to the Ipswich campus. The School has revised its governance structures, and significantly enhanced infrastructure supporting these developments. It has implemented comprehensive quality assurance systems to monitor and evaluate the quality of the medical program. In addition to the usual assessment against the AMC's accreditation standards, the Team addressed three specific issues raised by the major program changes:

- 1 *The School's capacity as a whole to deal with its current and planned increase in student numbers.* More than half of the planned expansion in student numbers since the AMC's 2005 accreditation has already occurred (total students in years 1 to 4 2005 = 1100 est., 2010 = 1699, in 2015 = 2176). The teaching program is being maintained, with significant increases in staff and infrastructure having been put in place. Communication failures with the large and scattered student body have occurred. Plans are in place to deal with the further increases, but this will need careful management and monitoring, both by the School and by the AMC.
- 2 *The capacity of the Ipswich campus to deliver the first two years of the course such that students there experience an equivalent educational program to their colleagues in Brisbane.* The Ipswich campus has benefited from substantial University investment generally and from the Faculty of Health Science. It has adequate resources overall to deal with the current student numbers. Anatomy teaching available at Ipswich has limitations, as does student access to inpatients, supporting clinical coaching tutorials.
- 3 *The capacity of the Ochsner Clinical School to deliver the final two years of the program such that students there experience an equivalent educational program to their colleagues in other clinical schools.* In the Ochsner Health System, the University of Queensland has allied itself with a partner that has the clinical capacity to offer high quality clerkships to its planned cohort. Commitment from Ochsner staff and management is very strong, and appropriate management structures and links to Brisbane are in place. All clinical disciplines (including general practice) and the Medicine in Society rotation can potentially offer programs in New Orleans equivalent to those in Queensland.

The November 2010 meeting of AMC Directors endorsed the accreditation report and resolved:

- (i) The major changes proposed to the MBBS Program of the School of Medicine, Faculty of Health Sciences, the University of Queensland—including the proposals to offer the medical program offshore through the Ochsner Clinical School, to expand student numbers to incorporate this cohort, and to implementation of MBBS Program Years 1 and 2 of the MBBS Program at the University's Ipswich campus – be approved;
- (ii) The MBBS medical program of the School of Medicine, Faculty of Health Sciences, the University of Queensland, be granted accreditation until 31 December 2016, subject to the submission of satisfactory progress reports being submitted to the Medical School Accreditation Committee and evidence:

(a) by September 2012:

- o of clear and effective clinical school and academic discipline support structures to maintain a high quality teaching and learning experience for teaching staff and students across all University-affiliated clinical teaching sites (standard 1.1)
- o that, in relation to the biomedical sciences offered by the Faculty of Science, the School of Medicine has the autonomy to deliver the curriculum and to ensure course objectives are met (standard 1.2)
- o of development and implementation of plans to address curriculum gaps in patient safety, communication and professional behaviour (standard 3.2)
- o that elements of course are appropriately integrated (standard 3.3)
- o the School has appropriate control over assessment in Years 1 and 2 to ensure integration of assessment and alignment of the assessment with learning objectives (standard 5.1 and 5.2)
- o the School has appropriate control over assessment in Years 3 and 4 to address the wide variation in the content and standards of assessment and their alignment to learning objectives (standard 5.1 and 5.2)
- o of an appropriate mechanism to ensure students' competence in critical specific procedural/ clinical skills in years 3 and 4 (standard 5.2)
- o the School has addressed concerns about content validity by reviewing the match between the course objectives, the course delivered and experienced by students, and the course assessment (standard 5.4)
- o the School has reviewed its standard setting methods for Years 3 and 4 to address concerns about variability between Multi-Station Assessment Task stations; standard- setting for the multiple-choice question components in Years 3 and 4; quality assurance and training of examiners; and standardisation of the application of the seven-point Standards Reference Grading (standard 5.4)
- o of mechanisms to review comparability of assessments across the 10 clinical schools particularly to address inter-rater reliability of preceptor/consultant assessments (standard 5.4)
- o of continued planning to address the challenges to clinical teaching capacity particularly rural placements for the medical school's students, including the impact of the other Queensland medical schools' activities. (standard 8.3)

(b) by September 2014:

- o when the School has expanded to planned size and all clinical schools are operating at full capacity, the governance structure remains robust and appropriate (standard 1.1)
- o the School is monitoring the implications of the increased student load, and has measures to accommodate the resourcing of the various teaching

sites to meet the needs of such a large student cohort, including facilities and teaching resources for nearly 550 students in each of Years 1 and 2 (standard 7.1)

- (iii) That an AMC team conduct a follow up assessment in 2014 to review the School's progress in implementation of these major changes and, as required, the changes that may follow from the 2009 MBBS review.

Overview of findings 2010

The findings against the AMC accreditation standards are summarised below.

<p>1. Context (governance, autonomy, course management, educational expertise, budget, health sector, research context, staff)</p>	<p>Meets the standards</p>
<p><i>Areas of strength</i></p> <ul style="list-style-type: none"> • the improved relations between the School and health services, and health service managers' engagement with the School, have resulted from the establishment of the clinical schools • the support of the Ochsner Health System for the development of the clinical school in New Orleans <p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> • a role for the clinical school heads in the development of their local expenditure budget (standard 1.5) • build the School's relationship with Queensland Health at the executive level (standard 1.6) • professional development of hospital and community practitioners who contribute to the teaching programs (standard 1.8) • succession planning given the relative dominance of more senior levels of academic appointment (standard 1.9) 	<p>Standards 1.3, 1.4, 1.5, 1.6, 1.7, 1.8, 1.9 and 1.10 are met.</p>
<p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> • ongoing reports concerning governance and teaching models of the Faculty's three superclinics, including their relationship with the clinical schools (standard 1.1) • clinical school and academic discipline support structures which maintain high quality teaching and learning experiences across all University-affiliated clinical teaching sites (standard 1.1) 	<p>Standard 1.1 is substantially met. While the School's academic governance structure appears strong, the AMC requires evidence:</p> <ul style="list-style-type: none"> • by 2012 of clear and effective clinical school and academic discipline support structures to maintain a high quality teaching and learning experience for teaching staff and students across all University-affiliated clinical teaching sites • by 2014 when the School has expanded to planned size, and all clinical schools are operating at full capacity, that the governance structure remains robust and appropriate.

<p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> • clarity concerning the respective roles and responsibilities of the School of Medicine and the Faculty of Science for curriculum and assessment development, delivery and resourcing in the biomedical sciences (standard 1.2) 	<p>Standard 1.2 is substantially met. The AMC requires evidence by 2012 that, in relation to the biomedical sciences offered by the Faculty of Science, the School of Medicine has the autonomy to deliver the curriculum and to ensure course objectives are met.</p>
<p>2. Outcomes (mission, course outcomes)</p>	<p>Meets the standards</p>
<p><i>Area of strength</i></p> <ul style="list-style-type: none"> • the engagement of academic staff and clinicians in the 2009 MBBS Review • innovative approaches to explore the differences between the US and Australian health systems as a topic for learning. <p><i>Area for improvement</i></p> <ul style="list-style-type: none"> • connection between the School's core values and the curriculum. (standard 2.2) 	
<p>3. Curriculum (framework, structure, content, duration, integration, research, choices, continuum).</p>	<p>Meets the standards</p>
<p><i>Areas of strength</i></p> <ul style="list-style-type: none"> • the development of the program aims, goals and outcomes linked to individual learning objectives across the program by year and/or domain. <p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> • development of more consistent and clearer learning objectives to guide students and teachers (standard 3.1) • responding to the 2009 MBBS Review in terms of program organisation and curriculum content (standard 3.1) • continued effort to develop student research opportunities, taking advantage of the University's rich research environment. (standard 3.4) 	<p>Standard 3.1, 3.4, 3.5 and 3.6 are met.</p>
<p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> • attention to curriculum gaps in patient safety, communication and professional behaviour (standard 3.2) • mechanisms to ensure the curriculum framework of domains appropriately informs the curriculum offered by the academic clinical disciplines (standard 3.2) 	<p>Standard 3.2 is substantially met. The AMC requires evidence by 2012 of development and implementation of plans to address curriculum gaps in patient safety, communication and professional behaviour.</p>

<p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> improved vertical integration of a program that now operates effectively as two halves (standard 3.3) 	<p>Standard 3.3 is substantially met. The AMC requires evidence by 2012 that elements of course are appropriately integrated.</p>
<p>4. Teaching and learning methods</p>	<p>Meets the standards</p>
<p><i>Area of strength</i></p> <ul style="list-style-type: none"> the Year 1 clinical coaching program, which has had excellent evaluations the development of new interactive pathology teaching material and environment at Herston <p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> anatomy teaching, including the style of teaching, the extent of subject coverage, the choice of teachers, and all students' access to teaching (standard 4.1) access for all students in Years 3 and 4 to core lectures and tutorials provided at the large teaching hospitals (standard 4.1) the Year 2 clinical coaching model (standard 4.1) 	
<p>5. Assessment (approach, methods, rules and progression, quality)</p>	<p>Substantially meets the standards</p>
<p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> control of the implementation of the School's assessment policy in all years of the program (standard 5.1) report in annual reports on the implementation of plans to re-organise the Years 1 and 2 program into units and particularly measures to ensure integration of assessment (standard 5.1) review the alignment between assessment and learning objectives, and the balance between knowledge and clinical assessments in Years 3 and 4. (standard 5.1 and standard 5.2) 	<p>Standards 5.1 and 5.2 are substantially met. The AMC requires evidence by 2012:</p> <ul style="list-style-type: none"> that the School has appropriate control over assessment in Years 1 and 2 to ensure integration of assessment and alignment of the assessment with learning objectives (standard 5.1 and 5.2) that the School has appropriate control over assessment in Years 3 and 4 to address the wide variation in the content and standards of assessment and their alignment to learning objectives (standard 5.1 and 5.2) of an appropriate mechanism to ensure students' competence in critical

	specific procedural/ clinical skills in Years 3 and 4. (standard 5.2).
<p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> clarify the progression rules for Years 3 and 4. (standard 5.3) 	Standard 5.3 is met.
<p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> improve examiner training (standard 5.4) consider instituting blueprinting for all summative assessments (standard 5.4) consider carrying out a range of statistical analyses for all summative assessments (standard 5.4) improve the validity and reliability of the final MSAT stations, considering the number of stations, the testing of students procedural skills, and the introduction of a recognised standard-setting process. (standard 5.4) 	<p>Standard 5.4 is substantially met. The AMC requires evidence by 2012:</p> <ul style="list-style-type: none"> the School has addressed concerns about content validity by reviewing the match between the course objectives, the course delivered and experienced by students, and the course assessment the School has reviewed its standard setting methods for Years 3 and 4 to address concerns about variability between MSAT stations; standard setting for the MCQ components in Years 3 and 4; quality assurance and training of examiners; standardisation of the application of the seven-point Standards Reference Grading of mechanisms to review the comparability of assessments across the 10 clinical schools particularly to address inter-rater reliability of preceptor/ consultant assessments.
6. Monitoring and evaluation (ongoing monitoring, evaluation, feedback and reporting, educational exchanges)	Meets the standards
<p><i>Area of strength</i></p> <ul style="list-style-type: none"> the systems to monitor and evaluate the quality of the medical program and the culture of data-driven quality improvement the School's publication of a considerable body of research on student and graduate outcomes 	

<ul style="list-style-type: none"> the School's mechanism to analyse the performance of student cohorts in relation to student background, student selection policies and student demographics. <p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> mechanisms to facilitate a comprehensive overview of program quality and student satisfaction across all the disciplines and all years of the course (standard 6.1) a formal survey and evaluation system that seeks the views of teachers within the medical program. (standard 6.2) 	
<p>7. Students (intake, admission, support, representation)</p>	<p>Meets the standards</p>
<p><i>Areas of strength</i></p> <ul style="list-style-type: none"> the resourcing and structure of student support at the clinical schools student engagement and representation, particularly through the UQ Medical Society the substantive increase in the number of Indigenous students in the course and development of the Indigenous Health teaching program. <p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> methods of engagements with the students who enrol in a completed UQ undergraduate degree and the MBBS Program (standard 7.3) ensuring a core set of support services is available to students irrespective of their campus or clinical school location. (standard 7.3) 	<p>Standards 7.2, 7.3 and 7.4 are met.</p>
<p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> monitor the implications of the increased student intake for the capacity of the medical school to adequately resource the course at all stages (standard 7.1) 	<p>Standard 7.1 is substantially met. The AMC requires evidence by 2014 the School is monitoring the implications of the increased student load, and has measures to accommodate the resourcing of the various teaching sites to meet the needs of such a large cohort of students, including facilities and teaching resources for nearly 550 students in each of Years 1 and 2.</p>
<p>8. Resources (physical, IT, clinical teaching)</p>	<p>Meets the standards</p>
<p><i>Areas of strength</i></p> <ul style="list-style-type: none"> the impressive major capital and infrastructure developments across the University and several of its 	

<p>10 clinical schools, and outcomes achieved at the Rural Clinical School</p> <ul style="list-style-type: none"> the capacity of Ochsner Health System to meet each of the AMC educational resource requirements for implementing the UQ curriculum. <p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> equivalence of standards in the quality of physical facilities and equity of access to teaching resources for students in Years 1 and 2 at the three main campuses (St Lucia, Herston and Ipswich), and for students in Years 3 and 4 at all clinical schools (standard 8.1) the access to information technology for students based at the Brunei Clinical School. (standard 8.2) 	
<p><i>Areas for improvement</i></p> <ul style="list-style-type: none"> the variable degree of discipline control over delivery of teaching at some sites, and a lack of student access to some specialist teachers at some sites. (standard 8.3) 	<p>Standard 8.3 is substantially met. The AMC requires evidence by 2012 of continued planning to address the challenges to clinical teaching capacity and particularly rural placements for the Medical School's students, including the impact of the other Queensland medical schools' activities.</p>

Appendix Two Medical courses conducted offshore by Australian and/ or New Zealand universities

1 Role of the Australian Medical Council

- 1.1 The Australian Medical Council is a national standards and assessment body for medicine. Its purpose is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.
- 1.2 The AMC has been assigned the accreditation functions for medicine by the Ministerial Council on behalf of the Medical Board of Australia from 1 July 2010 until 30 June 2013. Under the *Health Practitioner Regulation National Law Act 2009*, the Medical Board of Australia is responsible for the registration of medical practitioners. The Medical Board may grant registration to practitioners who complete an approved program of study (a medical program). AMC assessment and accreditation of medical schools (called education providers in the legislation) results in advice to the Medical Board to enable it to make a decision to approve a program of study for registration purposes.
- 1.3 The purpose of AMC accreditation is the recognition of medical courses that produce graduates competent to practise safely and effectively under supervision as interns in Australia and New Zealand, and with an appropriate foundation for lifelong learning and for further training in any branch of medicine. To obtain AMC accreditation, a medical school is required to satisfy the AMC that the medical program meet this standard.
- 1.4 The AMC developed this policy statement in 2005 as a response to proposals to offer offshore medical courses that lead to the award of a degree by an Australian or New Zealand university. This statement takes account of the quality assurance framework already in place for higher education courses. The AMC has reviewed this statement in 2008 and 2010.

2 Higher education in Australia and New Zealand

- 2.1 Basic medical education in Australia and New Zealand is provided by university-based medical schools. Apart from the Australian National University, which is constituted under an Act of the Federal Parliament, all of Australia's universities are established or recognised under State or Territory legislation. In New Zealand, universities are also established under national legislation. The legal authority of universities in both countries to grant degrees and offer courses is specified in their enabling legislation.
- 2.2 In Australia, national governments have encouraged universities to seek fee paying students from overseas since the late 1980s. In line with this policy, all Australian medical schools enrol international fee paying students. These students occupy places offered over and above the number of places available for domestic students. Similar policy applies in New Zealand.
- 2.3 A number of Australian universities also offer courses in other countries. Arrangements include the establishment of campuses, companies, joint ventures or contracts with other organisations to assist in the delivery of programs. The

organisation delivering programs may be operating under the name of the delivery agency or the institution offering the award.

- 2.4 Both Australia and New Zealand have a national quality assurance framework for higher education. In Australia, this provides for audit of the operations of universities and other self-accrediting institutions by the Australian Universities Quality Agency (AUQA). In addition, it includes National Protocols for Higher Education Approval Processes approved by the Ministerial Council on Education, Employment, Training and Youth Affairs to ensure consistent criteria and standards across Australia in such matters as the recognition of new universities, the operation of overseas higher education institutions in Australia, and delivery arrangements involving other organisations, including campuses in other countries³. In New Zealand, the New Zealand Vice-Chancellors' Committee is responsible for the approval and quality assurance of university qualifications, with audits of quality assurance and quality enhancement processes carried out by the New Zealand Universities Academic Audit Unit.

3 *Implications of an AMC-accredited medical school offering a medical course offshore*

- 3.1 Increasingly medical schools have campuses and major sites of clinical teaching in distant locations. In Australia for example, 16 universities have established rural clinical schools. In the light of these developments, the AMC has strengthened its accreditation standards concerning:

- A How medical schools supervise and monitor educational experience in clinical attachments.
- B How medical schools test and verify students' experience by assessment and examination.
- C How medical schools ensure consistency in the scope of the assessment, and assessment standards and processes across teaching sites.
- D The physical facilities available for students on attachment to hospitals and other centres, including appropriate facilities for information exchange between sites.
- E How medical schools articulate the responsibilities of hospital and community practitioners who contribute to the delivery of the medical course and the responsibilities of the school to these practitioners.

- 3.2 Plans to offer an AMC-accredited medical course in a new setting may fit the AMC's definition of a major course change⁴. The AMC expects to be informed prospectively of such developments through the regular reports required of accredited medical schools.

³ http://www.mceetya.edu.au/verve/resources/NationalProtocolsOct2007_Complete.pdf Revised Guidelines were approved by MCEETA October 2007.

⁴ A major change in a medical course is a change in the length or format of the course, including the introduction of new distinct streams; a significant change in objectives; a substantial change in educational philosophy, emphasis or institutional setting; and/or a substantial change in student numbers relative to resources. Significant changes forced by a major reduction in resources leading to an inability to achieve the objectives of the existing course are also major changes."

3.3 Major changes to a medical course may affect the accreditation status of a medical school and require a series of procedures to be instituted. To assess such changes, the AMC institutes a two-stage assessment process, described in greater detail in *Assessment and Accreditation of Medical Schools: Standards and Procedures*.

3.4 The AMC would certainly regard the delivery of a medical course in other countries as a major course change. The development may have a significant effect on the resources available to the local (Australian or New Zealand based) course:

- by diverting staff time and/or resources from the existing medical course
- by making additional resources available
- by the effect on the Faculty's strategic planning and management.

Whilst syllabus content and structure may be identical to that of the local course, differences are likely in areas such as staffing and resources, governance and administration, and student admission and services generally. There will be important differences in the clinical training and experience, reflecting patient case mix and health care system issues in the local community, and in society and culture.

3.5 The AMC would also regard the dis-establishment of an offshore course offering as a major change to an AMC-accredited medical course, since it would constitute a major change in the institutional setting and may affect the available resources.

4 *Proposals that will be considered for assessment by the AMC*

4.1 The AMC recognises there are many possible options for offering Australian/New Zealand higher education courses overseas (see 2.3). It will assess only proposals for courses:

4.1.1 Offered by AMC-accredited medical schools located in an Australian or New Zealand higher education institution, where the Australian/New Zealand institution has developed the program and has a responsibility for overseeing the academic standards, and

4.1.2 That result in the award of a recognised higher education qualification of the Australian or New Zealand higher education institution, and

4.1.3 That are essentially the same as the course accredited by the AMC for delivery in Australia or New Zealand, in terms of educational objectives, curriculum framework, educational process and assessment outcomes, and

4.1.4 That include adequate experience within the Australian/New Zealand health care system⁵.

⁵ It will be the institution's responsibility to demonstrate that its course provides adequate experience. This might be demonstrated by requiring students to undertake some of their clinical placements in Australia or New Zealand.

The AMC has chosen to limit its assessment to proposals that satisfy these requirements because it considers that such proposals are most likely to meet the purpose of AMC accreditation, described in 1.1.

5 *Applying the AMC process for assessing major course changes to the assessment of a proposal to offer an AMC-accredited course in another or other countries*

5.1 General requirements

5.1.1 Course changes entailing delivery of the AMC-accredited course offshore will require separate accreditation. Assessment will require a site visit.

5.1.2 The AMC has prepared a separate questionnaire in relation to the documentation required of medical schools seeking assessment of a proposal for an offshore course offering⁶.

5.1.3 The AMC's process for assessing a major change brought about by the development of an offshore offering of an AMC-accredited medical course will require more time and will cost more than the process for assessing other course changes, in view of the additional procedural requirements and additional travel. In keeping with AMC policy, the institution being assessed will be charged the direct costs of the AMC assessment.

5.1.4 The Medical School Accreditation Committee sets a forward program for assessments two years in advance. Accredited medical schools seeking to implement a major change that involves offering their accredited medical course offshore need to provide adequate notice of their intentions. This would normally require the AMC to receive a notice of intention at least 30 months in advance of intended offering of the course in its new setting.

5.1.5 Where the AMC needs to establish a priority order for assessments, it will give priority to the assessment of local courses over the assessment of a major change that involves offering an accredited medical course offshore.

5.2 First stage of AMC's consideration of the proposal

5.2.1 The institution provides an initial submission to the Medical School Accreditation Committee outlining its plans at least **20 months** before the course is to be offered in its new setting, and provides evidence of support for the plans from the offshore medical school, and from all relevant government authorities in the overseas country. This should include information on the requirements for accreditation in the overseas country, if any.

5.2.2 The Medical School Accreditation Committee will consider the submission, and advise the Council on whether the AMC should assess the proposed development for accreditation purposes, taking account of:

- (a) The purpose of AMC accreditation, as stated in 1.3
- (b) The range of proposals that the AMC will assess, as stated in 4.1; and
- (c) The stage of development of the institution's plans.

⁶ Australian Medical Council, *Preparing a Submission for Assessment of an Offshore Offering of an AMC Accredited Medical Course: A Guide for Medical Schools*, June 2004.

- 5.2.3 Where all details have not yet been developed, the institution's initial submission should indicate how and when further development will be undertaken.
- 5.2.4 Guidance on those matters the AMC would consider in deciding on the outcome of this initial evaluation of the proposal is provided in ATTACHMENT 1.
- 5.2.5 The outcome of this evaluation will be one of the following decisions by the Council:
- (a) The AMC will assess the proposed development for accreditation purposes.
 - (b) The offshore course proposal does not satisfy AMC standards and/or fit within the range of proposals the AMC has agreed to assess (see 4.1), the AMC will not assess the proposed development for accreditation purposes. In this event, the AMC would not proceed to stage two. This implies rejection by the AMC of the major course change proposed. In such an event, should the Australian or New Zealand university plan to offer the same award title (that is badge the course in the same way) as the home country program, it would put at risk the institution's accreditation by the AMC (see also 1.3 and 5.4.2).
- 5.3 Second stage of AMC's consideration of the proposal
- 5.3.1 The magnitude of the changes entailed in offering an accredited medical course in another country would warrant a site visit by an AMC team to the offshore campus, as well as meetings with senior staff of the parent university and medical school. The AMC may assess the proposal in one or more visits. Issues relating to the conduct of the visit are outlined in ATTACHMENT 2.
- 5.3.2 The accreditation submission should be submitted sufficiently in advance of student selection and of the course commencement (**at least 10 months**) to allow the school to respond to any further requirements of the AMC. The school is required to present details of the full course, of the financial, physical and staff resources available to design and implement all years of the course and to support the course when fully established, and the measures in place to ensure that quality and standards are at least equivalent to those provided locally (in Australia/New Zealand). A copy of the questionnaire developed by the AMC for this purpose is at ATTACHMENT 3.
- 5.3.3 The comparability of clinical experience and clinical training of graduates trained elsewhere with that of local (Australian and New Zealand) graduates and the preparation of graduates for practise as interns in Australia and New Zealand will be significant issues in the AMC's assessment of any proposal to offer a medical course offshore. Should the AMC be unable to reach a decision about these matters before the offshore course has produced graduates, it may choose to defer a decision on accreditation of the course until at least two cohorts of graduates have been produced. *Depending on the award title proposed for the offshore course, this may have implications for the accreditation status of the school (see 5.4).*

5.4 Decisions on accreditation

5.4.1 The options open to the AMC in accrediting a major course change are described in the Accreditation Standards and Procedures. In summary, these are:

- (a) Accreditation of the new course until two years after the full course has been implemented, depending on satisfactory annual reports. This may be subject to certain conditions being addressed within a specified period and to follow-up reviews by the AMC.
- (c) Accreditation of the new course is not granted.

5.4.2 The AMC accredits medical schools and medical courses. Council accreditation decisions relate to the accreditation of a particular medical school and a specific award. To obtain AMC accreditation, the school must demonstrate that it delivers medical education and training that satisfies AMC accreditation standards. AMC accreditation standards relate to the delivery of the course as a whole, and therefore weaknesses in the medical course at a particular location or locations result in accreditation conditions on the course as a whole. If the institution intends to grant the same award title to its offshore course offering as granted to the course accredited by the AMC in Australia or New Zealand, then the AMC accreditation decision will relate to the course as a single entity. If the offshore course offering does not satisfy AMC standards, then the entire AMC-accredited course does not satisfy the accreditation standards. A decision to remove the accreditation of a medical course offered in Australia or New Zealand would be taken only if discussion between the AMC and the institution did not lead to resolution of the AMC's concerns. This might, for example, entail granting a different award to the offshore course offering than granted to the local AMC-accredited course.

Appendix Three Membership of the 2014 and 2010 assessment teams

Membership of the 2014 assessment team

Professor Peter Stanton (Chair) BMedSci, MBBS, PhD, FRCS, FRACS, FCSHK
Emeritus Professor of Surgery, University of Tasmania; Consultant Surgeon, Hobart, Tasmania

Dr Marie-Louise Stokes (Deputy chair) BA, MBBS, MPH, Grad Dip Applied Epidemiology, FAFPHM
Director of Education, Royal Australasian College of Physicians

Associate Professor Wendy Brown MBBS (Hons), PhD, FRACS, FACS
Director, Centre for Obesity Research and Education; Associate Professor, Monash University Department of Surgery, Alfred Hospital

Professor Ben Canny BMedSc (Hons), MBBS, PhD
Chair, Academic Board, and Associate Dean (MBBS International), Faculty of Medicine, Nursing and Health Sciences, Monash University

Professor David Cook BSc(Med), MBBS (Hons), MSc Phys, MD, FRACP, FAAS
Associate Dean (Finance), Faculty of Medicine; and Professor of Cellular Physiology, School of Medical Sciences, Bosch Institute, University of Sydney

Professor Jennene Greenhill RN, RPN, DipAppSc(Adv Nurs), BA, MSPD, PhD
Associate Dean, School of Medicine and Director, Rural Clinical School, Flinders University

Professor Wendy Hu MBBS, DipPaed, MHA, PhD, FRACGP
Professor of Medical Education, Director of Academic Program, and Head, Medical Education Unit, School of Medicine, University of Western Sydney

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

Ms Fiona van der Weide
Accreditation Administrator, Australian Medical Council

Membership of the 2010 AMC assessment team

Professor Peter Stanton (Chair) BMedSci, MBBS, PhD, FRCS, FRACS, FCSHK

Former Professor of Surgery, University of Tasmania

Practicing Endocrinology and Breast Surgeon

Professor David Ellwood MA, DPhil, MBBChir, FRANZCOG, CMFM, DDU

Deputy Dean and Professor of Obstetrics and Gynaecology, School of Clinical Medicine,

Australian National University Medical School, The Canberra Hospital, Australian

National University

Associate Professor Tessa Ho MBBS, MPH, MD

Acting Director, Perinatal and Reproductive Epidemiology Research Unit AIHW,

National Perinatal Statistics Unit School of Women's and Children's Health, Faculty of

Medicine, The University New South Wales

Professor Michael Kidd AM MBBS, MD, DCCH, Dip RACOG, FRACGP, FACHI, FAFPM

Hon, FHKCFP Hon

Executive Dean, Faculty of Health Sciences, Flinders University

Professor Peter McCrorie BSc (Hons) PhD

Professor of Medical Education, Associate Dean for International Affairs

Head of Centre for Medical and Healthcare Education, St. George's, University of London

Dr Marie Louise Stokes BA, MBBS, MPH, Grad Dip Applied Epidemiology, FAFPHM

Assistant General Manager and Senior Medical Officer, New South Wales Institute of

Medical Education and Training

Professor Napier Thomson AM MBBS, MD, FRACP, FRCP, FACP, FRCPI

Professor and Head, Department of Medicine and Head Central Clinical School

Faculty of Medicine Nursing and Health Sciences, Monash University

Director, Department of Renal Medicine, Alfred Hospital

Ms Karin Oldfield

Manager Medical School Assessments, Australian Medical Council

Ms Theanne Walters

Deputy Chief Executive Officer, Australian Medical Council

Appendix Four Groups met by the 2014 and 2010 assessment teams

Groups met by the 2014 assessment team

Senior Leadership

Vice Chancellor and President

Pro Vice Chancellor (Indigenous Education)

Deputy Vice Chancellor (Academic)

Executive Dean

Head of School

Associate Dean (Clinical)

School of Medicine Leadership Staff

Deputy Head and Head, Northern Cluster

Deputy Head and Head, Academic Programs

Deputy Head and Head, South-Western Cluster

Director, MBBS/MD Program

Head, Ipswich Campus

Head, Oschner Clinical School

Head, Rural Clinical School

Manager, Strategy and Organisational Development

School Manager

School of Medicine, Faculty of Medicine & Biomedical Sciences Staff

AOLIE Development Officer

Clinical Coaching Head

Coordinator, MBBS/MD Research & Medical Education Research

eLearning Officer

Head, Brunei Clinical School

Head, Discipline of Anaesthesiology & Critical Care (representative)

Head, Discipline of General Practice

Head, Discipline of Medical Ethics, Law and Professional Practice

Head, Discipline of Medicine (representative)

Head, Discipline of Molecular & Cellular Pathology

Head, Discipline of Obstetrics & Gynaecology (representative)

Head, Discipline of Paediatrics & Child Health

Head, Discipline of Psychiatry

Head, Discipline of Rural and Remote Medicine
Head, Discipline of Surgery
Head, Mater Clinical School (representative)
Head, Northside Clinical School
Head, Ochsner Clinical School
Head, PA-Southside Clinical School
Head, Royal Brisbane Clinical School
Head, School of Biomedical Sciences
Head, School of Chemistry and Molecular Biosciences
Head, School of Population Health
Head, Sunshine Coast Clinical School
Head, UnitingCare Clinical School
Manager, Faculty student administration

School of Medicine, Faculty of Medicine & Biomedical Sciences Committees and Groups

Assessment Subcommittee
Clinical Lead Educators
Health Sciences Heads
MD / MBBS Program Committee
Medical education staff
School administration staff
Teaching and Learning Committee
UQMD Working Party

Medical students

President UQMS
Academic Vice President UQMS
Student representatives
Students from clinical schools
Students from all phases of the program

Queensland Health

Acting Principal Medical Officer
Manager, Queensland Medical Education & Training

Clinical Sites

Annerley GP Super Clinic

Annerley GP Super Clinic Management

Clinical teachers and supervisors

School GP Discipline representatives, Academic staff

Ipswich Campus & Clinical School

Academic staff

Campus Operations Manager

Clinical teachers and supervisors

Hospital Executive staff

Senior School staff

Ochsner Clinical School

Center for Academic Excellence

Clerkship Directors

Covington Clinic, Family Practice teaching staff

Evaluation and Assessment staff

Interprofessional Learning staff

OMC Baptist Executive Administration

Ochsner Academic leads

Ochsner Clinical School Administration team

Ochsner Research staff

Ochsner Senior Executive Group

Senior School staff

Princess Alexandra-Southside Clinical School

Clinical teachers and supervisors

Hospital Executive staff

Senior School staff

Royal Brisbane Clinical School

Clinical teachers

Clinical teachers and supervisors

Hospital Executive staff

Rural Clinical School

Academic staff

Clinical teachers and supervisors

Director, Indigenous Health

Hospital Executive staff

Senior School staff

UnitingCare Health (Wesley/St Andrew's) Clinical School

Clinical teachers and supervisors

Hospital Executive staff

Senior School staff

Groups met by the 2010 AMC assessment team

Senior Executive Staff

Deputy Executive Dean, Faculty of Health Sciences

Deputy Vice-Chancellor (Academic)

Deputy Vice-Chancellor (International and Development)

Executive Dean, Faculty of Health Sciences

Head, School of Medicine, Dean of Medicine

Pro-Vice-Chancellor, UQ Ipswich

Senior Deputy Vice Chancellor

Vice Chancellor

Medical School Staff

Acting Executive Manager, Engineering & Sciences Library Service

Acting Head, Royal Brisbane Clinical School

Acting Head, School of Chemistry and Molecular Biosciences

Administrative Officer, Ochsner Clinical School

Business Analyst and Finance Manager, Faculty of Health Sciences

Chief Financial Officer

Clinical Coordinator, Years 1 and 2

Clinical School Senior Officer, Sunshine

Clinical School Senior Officer, Team Leader Mater Clinical School

Deputy Director, MBBS Program

Deputy Head of School (Clinical Schools)

Deputy Head of School (Research)

Deputy Head of School (Teaching and Learning)

Deputy Head of the Royal Brisbane Clinical School

Deputy Head, Greenslopes Clinical School

Deputy Head, Ipswich Clinical School

Deputy Head, MBBS Program at Ipswich

Deputy Head, Ochsner Clinical School (Curriculum) and Program Director, Medicine/MIS

Deputy Head, Ochsner Clinical School (Research)

Deputy Head, Ochsner Clinical School (Students) and Program Director, General Practice

Deputy Head, Years 1 and 2 (Ipswich)

Director of Operations, Faculty of Health Sciences
Director, Centre for Indigenous Health
Director, Ochsner Program and Partnership
Director, Rural Clinical School Research Centre
Director, UQ International
Discipline Heads
Evaluation Officer
Executive Director (Operations)
Faculty Information Technology Manager
Head of Brunei Clinical School
Head, Evaluation Service Unit, TEDI
Head, Greenslopes Clinical School and Head, Medicine
Head, Ipswich Clinical School
Head, Mater Clinical School
Head, MBBS Program (Ipswich)
Head, Medical Education and Head, MBBS Program
Head, Northside Clinical School
Head, Ochsner Clinical School
Head, PA-Southside Clinical School
Head, Rural Clinical School
Head, School of Biomedical Sciences
Head, Sunshine Coast Clinical School
Head, Years 1 and 2
Head, Years 3 and 4
Indigenous Health Coordinator
Indigenous primary care physician, Inala Health Centre
Indigenous Student Recruitment Manager
Indigenous Student Support Officer
International Manager, Partnerships
International Manager, Recruitment and Support
Liaison Librarian
Manager, School of Medicine
Manager, Strategy and Organisational Development
Manager, Student and Academic Support

MBBS Education Program Manager
Northside Clinical School Senior Officer
PA-Southside Clinical School Senior Officer
PBL Tutors
Program Director Physician Assistant Program (phone)
Senior Administrator, Ipswich Clinical School
Senior Lecturers
UQ Rural Clinical School Librarian

Medical School Committees

Biomedical Sciences Domain Committee
Health at UQ leadership committee representatives
MBBS Curriculum Committee
School of Medicine Executive Committee
Teaching and Learning Committee
Undergraduate Medical Education Executive Committee - Ochsner

Medical students

Students Years 1-4
Graduates

Teaching health services

Ipswich Clinical School

Chief Executive Officer, St Andrew's Ipswich Private Hospital
Coordinator, Staff Development/Undergraduate and Postgraduate, St Andrew's Ipswich Private Hospital
Directors of Disciplines
Clinical Teachers
Executive Director/Director Medical Services, Darling Downs - West Moreton, Chief Executive Officer, Ipswich Hospital (tentative teleconference)
General Practitioners, tutors and community teachers
Student Supervisors

The Northside Clinical School (Prince Charles, Redcliffe and Caboolture Hospitals)

Academic Head, Redcliffe Hospital
Deputy Director of Medical Services, Redcliffe Hospital
Executive Director of Medical Services, Redcliffe Hospital

Manager, Redcliffe Hospital Clinical Skills Centre
Simulation Coordinator, Redcliffe Hospital Clinical Skills Centre
Academic Head, Caboolture Hospital
Executive Director of Medical Services, Caboolture Hospital
Head, Caboolture Hospital (Paediatrics)
Head, Discipline of Paediatrics, Local Discipline
Director of Medical Services, Holy Spirit Northside Private Hospital
Executive Director, Holy Spirit Northside Private Hospital
Executives, Northside Holy Spirit Private Hospital
Academic Head, The Prince Charles Hospital
Clinical Teachers
Hospital Executives, The Prince Charles Hospital
Executive Director of Facilities and Management, The Prince Charles Hospital
Executive Director of Medical Services, The Prince Charles Hospital

Princess Alexandra-Southside Clinical School (Princess Alexandra, Queen Elizabeth II and Redlands Hospitals)

Acting Director of Medical Services, Redland Hospital
Executive Director, Redland Hospital
Medical Superintendent, Queen Elizabeth II
Executive Director, Queen Elizabeth II
School of Medicine Academics
Directors of Disciplines, Queen Elizabeth II
Chief Executive Officer, Metro South Health District
Deputy Director of Medical Services, PA Hospital
Clinical Teachers

Mater Clinical School

Chief Executive Officer, Mater Health Services
Clinical teachers
Directors of Disciplines, Mater Health Services
Head, Department of Medicine, Director Infectious Diseases
Senior Lecturer

Greenslopes Clinical School

Clinical Teachers
Consultant and Deputy Chair, Medical Advisory Committee

Consultant and Director of Physician Training
Deputy Chief Executive Officer, Greenslopes Private Hospital
Director of Medical Services, Greenslopes Private Hospital
Director of Nursing, Greenslopes Private Hospital
Heads of Disciplines
Medical Services Manager, Greenslopes Private Hospital
Senior Librarian, Greenslopes Private Hospital

Royal Brisbane Clinical School

Clinical Teachers
Executive Director Royal Brisbane and Women's Hospital
Heads of Disciplines
Library Manager
Museum Attendant, Pathology Museum
Year 3, Medical Course Coordinator

Rural Clinical School (Toowoomba, Rockhampton, Bundaberg and Hervey Bay Hospitals)

Board Chair, Capricornia Division of General Practice
CEO Division of GP, GP Connections
Chief Executive Officer, Central Queensland Health Service District
Chief Executive Officer, St Andrew's Hospital
Clinical Academic Coordinator
Clinical Director
Clinical Skills Centre Coordinator
Clinical Teachers
Director Medical Services Toowoomba Hospital
Director of Operations, Mercy Health & Aged Care
Director Undergraduate Medical Education & Executive Director Medical Services, Rockhampton Hospital
Directors of Disciplines
Discipline Academic Coordinators
Discipline Academic Supervisors
Education Director, Rural Clinical School
Executive Director Medical Services, Central Queensland Health Service District

Executive Director Medical Services, Sunshine Coast and Widebay District Health Service

Executive Director of Nursing & Midwifery Nurses

Executive Director Toowoomba/ Exec Director Medical Services

Executive Director, Rural & Remote Medical Services QH

General Manager, St Vincent's Hospital

Medical Education Officer

Northern Cluster Manager, Sunshine Coast and Widebay District Health Service

Nursing Director, Education & Research Unit, Rockhampton Hospital

Physician, Rural Clinical School Clinical Academic Coordinator

Senior Medical Education Officer

Sunshine Coast Clinical School

Clinical Directors

Clinical Teachers

Deputy Executive Director, Medical Services (Southern Cluster)

Director Nursing Services (Nambour Hospital)

Director, Medical Services Group (Nambour Hospital)

Discipline Academic Supervisors

District Chief Executive Officer – Nambour Hospital

District Management Committee

Education Level and Clinical Skills Centre staff

Executive Director, Medical Services (Southern Cluster)

Kilcoy Medical Centre

Southern Cluster Manager (Q Health)

Ochsner Clinical School

Academics, Ochsner Health System

Administrative Officer

CEO, Ochsner Health System

Chair, Ochsner Health System Institutional Review Board

Chairman of various Disciplines

Chairperson, PPD Committee

Chief Academic Officer

Chief Executive Officer, Ochsner Medical Center New Orleans

Chief Nursing Officer, Ochsner Medical Center New Orleans

Clinical Teachers

CMO, Ochsner Health System

CNO, Ochsner Health System

COO, Ochsner Health System

Director, Center for Health Research

Director, Clinical Research Support

Director, Recruiting, MedEdPath

Executive Vice President

Faculties of various Disciplines

Head, Academic Discipline of General Practice

Manager, Ochsner Library

Ochsner Clinical School Vice President,

President, CEO International Pathways

President, Ochsner Health System Board

Program Director, Ochsner Clinical School

Program Directors

Regional Medical Director, New Orleans Region

Scientific Officer, Ochsner Health System

Student Coordinator

Vice President Academics

Brunei Clinical School

Acting Chief Executive Officer, RIPAS Hospital

Clinical Teachers

Director General of Medical Services, Ministry of Health

Director of Policy and Planning, Ministry of Health

General Practice, Health Services, Ministry of Health

General Practice, Penaga Health Centre, Shell, Seria

External bodies

Director, Queensland Medical Education and Training

MBBS Senior Vice President and Dean, Tulane School of Medicine

Dean, Louisiana State University Health Science Center

Executive Director, Louisiana State Board of Medical Examiners

Deputy Secretary, Louisiana Department of Health and Human Services

President and CEO, Association of American Medical Colleges

Brunei Minister of Health

