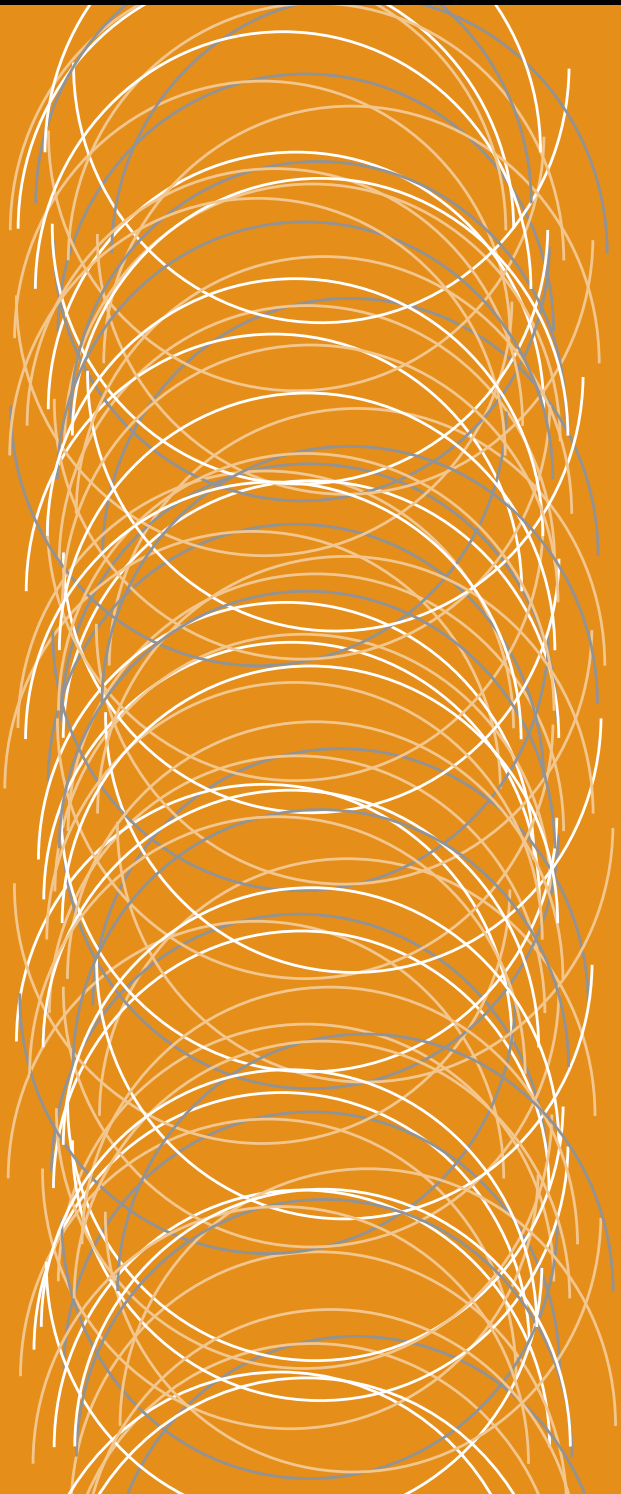


Australian Medical Council Limited

Accreditation of
Griffith University
School of Medicine

AMC



Medical School Accreditation Committee
February 2015

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Executive summary 2014

Accreditation process

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

Griffith University, School of Medicine is seeking reaccreditation of its medical program. The four-year graduate Bachelor of Medicine/ Bachelor of Surgery (MBBS) program was first accredited in 2004, and granted accreditation until July 2010. Accreditation was subject to conditions, including a follow-up visit, which was conducted in 2006, and the submission of satisfactory progress reports in 2007 and 2008. The School submitted a comprehensive report for extension of accreditation in 2009 and on the basis of this report, accreditation was extended to 31 December 2014, subject to satisfactory progress reports. In 2012, the School notified the AMC of plans to change its medical program from a four-year graduate-entry MBBS program, to a Doctor of Medicine (MD) from 2014. The AMC determined that the proposal was not a major change and that the medical program continued to meet the approved accreditation standards. In February 2014, the AMC extended accreditation by three months to 31 March 2015 in line with changes to other accreditation end-dates.

An AMC team reviewed the School's 2014 reaccreditation submission and the Griffith medical student society's submission and visited the School and associated clinical teaching sites in the week of 11 August 2014. This report presents the AMC's findings against the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012*.

Decision on accreditation

Under the *Health Practitioner Regulation National Law*, the AMC may grant accreditation if it is reasonably satisfied that a program of study and the education provider that provides it, meet 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.

Reaccreditation of established education providers and programs of study

The accreditation options are:

- (i) Accreditation for a period of six years subject to satisfactory progress reports. In the year the accreditation ends, the education provider will submit a comprehensive report for extension of accreditation. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to a maximum of four years, before a new accreditation review.
- (ii) Accreditation for six years subject to certain conditions being addressed within a specified period and to satisfactory progress reports. In the year the accreditation ends, the education provider will submit a comprehensive report for extension of accreditation. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to a maximum of four years, before a new accreditation review.
- (iii) Accreditation for shorter periods of time. If significant deficiencies are identified or there is insufficient information to determine the program satisfies the accreditation standards, the AMC may award accreditation with conditions and for a period of less than six years.
- (iv) Accreditation may be withdrawn where the education provider has not satisfied the AMC that the complete program is or can be implemented and delivered at a level consistent with the accreditation standards.

At their 11 March 2015 meeting, the AMC Directors agreed that they were reasonably satisfied that the medical programs of Griffith University, School of Medicine meet the approved accreditation standards.

The AMC Directors agreed:

- (i) That accreditation of the following medical programs of the Griffith University, School of Medicine **be granted for a period of six years; that is until 31 March 2021**, subject to satisfactory progress reports:
 - o Doctor of Medicine (MD).
 - o Bachelor of Medicine / Bachelor of Surgery (MBBS) (N.B. accreditation of the MBBS will cease 31 December 2017 as the School will withdraw the MBBS by the end of 2016).
- (ii) That accreditation is subject to the following conditions:
 - By February 2016** evidence that the School has addressed the following conditions from the accreditation report:
 - o Finalise and implement strategies to ensure Indigenous health educational expertise in the program (Standard 1.4).
 - o Demonstrate progress toward the development of an overarching First Peoples health (Indigenous health) curriculum (Standard 3.5).
 - By February 2017** evidence that the School has addressed the following conditions from the accreditation report:
 - o Demonstrate that the program has an overarching First Peoples health (Indigenous health) curriculum (Standard 3.5).

Key findings of Griffith University, School of Medicine

1. The context of the medical program	Met
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Standard 1.4 is substantially met.

2016 condition

By February 2016, finalise and implement strategies to ensure Indigenous health educational expertise in the program (Standard 1.4).

2016 recommendation for improvement

Increase the academic staff time available for the support and development of General Practice learning and research (Standard 1.4).

2016 area for reporting

Provide an update on how the School has managed the effects of any external changes (i.e., funding cuts to Queensland Rural Medical Education) to its rural program, as related to the training of medical students (Standard 1.6).

2. The outcomes of the medical program	Met
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This standard is met.

Conditions

Nil

Commendation

The equivalence of student learning and outcomes across all sites (Standard 2.2).

3. The medical curriculum	Met
----------------------------------	------------

Standard 3.5 is substantially met.

2016 condition

By February 2016, demonstrate progress toward the development of an overarching First Peoples health (Indigenous health) curriculum (Standard 3.5).

2017 condition

By February 2017, demonstrate that the program has an overarching First Peoples health (Indigenous health) curriculum (Standard 3.5).

Commendations

The curriculum is comprehensive and well-integrated (Standard 3.2) and the learning outcomes are well-developed, clearly communicated to students and accessible to students and staff (Standard 3.4).

The School's positive level of engagement and mutual respect with the University Council of Elders, and the GUMURRII Student Support Unit, to assist in the delivery of aspects of First Peoples health in the curriculum (Standards 3.5 and Standard 1.4).

2016 recommendation for improvement

Consider how students requiring re-assessment or remediation can have access to the learning opportunities available to other students (Standard 3.1).

2016 reporting item

Report on the curriculum content changes proposed with the implementation of integrated research training across the program in 2016 or 2017 (Standard 3.2).

4. Teaching and learning	Met
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This standard is met.

Conditions

Nil

Commendations

The use of highly trained and supported simulated patients in the Years 1 and 2 communication skills and clinical skills training (Standard 4.1).

The embedding of patient centredness and collaborative engagement as key elements in the simulated environment and the communication skills program (Standard 4.6).

The Health Group's interprofessional learning implementation framework, and the 'Clinical Learning through Extended Immersion in Medical Simulation' (CLEIMS) initiative, an intensive interprofessional simulation week for all students in both Years 3 and 4 (Standards 4.4 and 4.7).

5. The curriculum – assessment of student learning	Met
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This standard is met.

Conditions

Nil

Commendations

The extensive and thorough work undertaken in blueprinting, examination composition, and standard setting by both School academic staff and clinicians (Standard 5.2).

The comprehensive processes in place to review assessment quality and the continual quality improvement (Standard 5.4).

2016 reporting item

Report on the potential development of formative and summative progress testing and any resulting changes in assessment processes (Standard 5.2).

6. The curriculum – monitoring	Met
---------------------------------------	------------

This standard is met.

Conditions

Nil

Commendation

The evaluation capabilities built into the School of Medicine Resource Management System, which allows for students' ratings and written feedback on a variety of learning activities (Standard 6.1).

2016 recommendation for improvement

The School is encouraged to explore development of tools to more systematically evaluate the outcomes of the program (Standard 6.2)

7. Implementing the curriculum – students	Met
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All standards are met.

Conditions

Nil

Commendation

The recruitment pathway initiative established to improve the access of Aboriginal and Torres Strait Islander students to the School, which provides alternate-entry pathways and specific quotas that are reviewed annually (Standard 7.1).

2016 recommendations for improvement

Introduce an alternative access scheme into the program for students from a low socioeconomic status background (Standard 7.1).

Review the risk of conflict between the academic managers' student support role and their roles in assessment processes (Standard 7.3.4).

Review the function of the Professional Practice Development Panel to ensure a clear separation between disciplinary and support processes at this level, and consider the student representative on the panel being optional. This review should be followed by an evaluation of any changes made (Standard 7.4).

8. Implementing the curriculum- learning environment	Met
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This standard is met.

Conditions

Nil

Commendations

The outstanding co-located academic and clinical facilities at the Gold Coast campus, incorporating the new Griffith Health Centre with its impressive student teaching facilities; and the student opportunities available at the leading-edge Gold Coast University Hospital and Pathology and Education building (Standard 8.1).

The impressive functionality of the School of Medicine Resource Management System - its many uses include access to curriculum resources; delivery of curriculum content; scheduling and personalised calendars; management of student preferences and clinical placements; access to staff and student data and reporting (Standard 8.2).

The collaborative arrangements in all locations with the Bond University medical program are impressive and a credit to all involved (Standard 8.3).

The commitment and enthusiasm of clinical supervisors at all sites, and the well-organised liaison and support provided to them by the School (Standard 8.4).

2016 recommendations for improvement

At Tweed Hospital, improve the student internet access to School systems (Standard 8.2).

Review the program's General Practice rotation requirements, to ensure the student experience is comparable with other disciplines (Standard 8.3).

Consider strengthening procedures to guarantee that every longitudinally placed student has equivalent exposure to varied clinical settings and experiences, to those of students undertaking varied rotations (Standard 8.3).

Consider opportunities for increased student experiences in Aboriginal and Torres Strait Islander health (Standard 8.3).

Actively engage in a dialogue with the University of Queensland that fosters improved communication and potential collaborations between the two rural schools (Standard 8.3).

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.

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.

The University, the Faculty and the School

Griffith University was established in 1971, and commenced teaching in 1975 at its Nathan campus. In 2014, it has five campuses based at the Gold Coast, Logan, Mt Gravatt, Nathan and South Bank. Griffith University offers more than 300 degrees and has more than 43,000 students from 131 countries, making it Australia's ninth largest higher education provider.

The University organisational structure consists of four clusters: Arts, Education and Law; Business; Health; and Sciences. Griffith Health, led by the Pro Vice Chancellor, Health, has over 6,500 students in eight schools across five campuses, being the Schools of Medicine, Allied Health Sciences, Applied Psychology, Dentistry and Oral Health, Human Services and Social Work, Medical Science, Nursing and Midwifery, and Pharmacy.

The School of Medicine is located at the University's Parklands campus on the Gold Coast, Queensland in the Griffith Health Centre building, which opened in June 2013. The Gold Coast University Hospital, opened in September 2013, is located opposite. Geographically, the School is organised as five clinical schools at Gold Coast University Hospital, Logan Hospital, Tweed Hospital, the Wesley Hospital, and the Rural Clinical School at sites including Toowoomba and Warwick.

The School of Medicine, offers a four-year graduate entry medical program that was first accredited by the AMC in 2004. The first cohort of 86 students commenced in 2005, and in 2014 the cohort size is 150.

In 2004, the AMC granted accreditation of the medical program until July 2010. Accreditation was subject to conditions, including a follow-up visit, which was conducted in 2006, and the submission of satisfactory progress reports in 2007 and 2008. The School submitted a comprehensive report for extension of accreditation in 2009 and on the basis of this report, accreditation was extended to 31 December 2014, subject to satisfactory progress reports. A short accreditation extension was approved to 31 March 2015 in line with changes to AMC accreditation end-dates.

Qualification awarded

Completion of the program has resulted in the award of a Bachelor of Medicine / Bachelor of Surgery (MBBS). In 2013 the University approved the reclassification of the medical program from an Australian Qualifications Framework (AQF) Level 7 Bachelors program to an AQF Level 9 Masters (Extended). The level of qualification awarded to graduates of the medical program changed in 2014 from a Bachelor of Medicine/ Bachelor of Surgery (MBBS) to the award of a Doctor of Medicine (MD) with no change to program content or duration. All Year 1 students in 2014 were enrolled in the MD. Existing MBBS students from 2014 will choose to graduate with the MD or the MBBS. The School advised that the MBBS will be totally withdrawn by the end of 2016 when the 2014 Year 2 MBBS students graduate in December 2016 and that repeating students or leave of absence students will be automatically enrolled in the MD.

The MBBS and the MD are both referred to as 'the program' in this report as both medical programs are operating using the same curriculum.

This report

This report details the findings of the 2014 reaccreditation assessment. Each section of the accreditation report begins with the relevant AMC accreditation standards.

The members of the 2014 AMC team are given at **Appendix One**.

The groups met by the AMC in 2014 are given at **Appendix Two**.

Appreciation

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.

The University organisational structure consists of four clusters: Arts, Education and Law; Business; Health; and Sciences. Griffith Health, led by the Pro Vice Chancellor, Health, has over 6,500 students in eight schools across five campuses, being the Schools of Medicine, Allied Health Sciences, Applied Psychology, Dentistry and Oral Health, Human Services and Social Work, Medical Science, Nursing and Midwifery, and Pharmacy.

The Group's research centres include the Griffith Health Institute with six program areas (Behavioural Basis of Health; Heart Foundation Research Centre; Molecular Basis of Disease Research Program; Centre for Musculoskeletal Research; Population Health Research Program; Centre for Health Practice Innovation), and the Australian Institute for Suicide Research and Prevention.

The School of Medicine, offers a four-year graduate entry medical program that was first accredited by the AMC in 2004. The first cohort of 86 students commenced in 2005, and in 2014 the cohort size is 150. Completion of the program resulted in the award of a Bachelor of Medicine / Bachelor of Surgery (MBBS). In 2013 the University approved the award of a Doctor of Medicine (MD) with no change to program content or duration, and permitted existing MBBS students from 2014 to graduate with the MD. The MBBS and the MD are both referred to as 'the program' in this report. The School also offers an MD / PhD, and following the University's late-2013 restructure of the School of Public Health, it now offers programs and courses in environmental health, health services management, and public health and health promotion.

The School is located at the University's Parklands campus on the Gold Coast, Queensland in the Griffith Health Centre building, which opened in June 2013. The Gold Coast University Hospital, opened in September 2013, is located opposite. Geographically, the School is organised as five clinical schools at Gold Coast University Hospital, Logan Hospital, Tweed Hospital, the Wesley Hospital, and the Rural Clinical School; each led by a clinical subdean.

The governance structures of Griffith University are clearly outlined and provide for leadership, policy development, management and collegial decision-making. The roles of senior officers are well defined. The relationship between the School, which is responsible for the program, and Griffith Health, is strong and enables cross-disciplinary strategic development and organisation in learning and teaching; as evidenced for example by rational and effective cross-disciplinary clinical skills training.

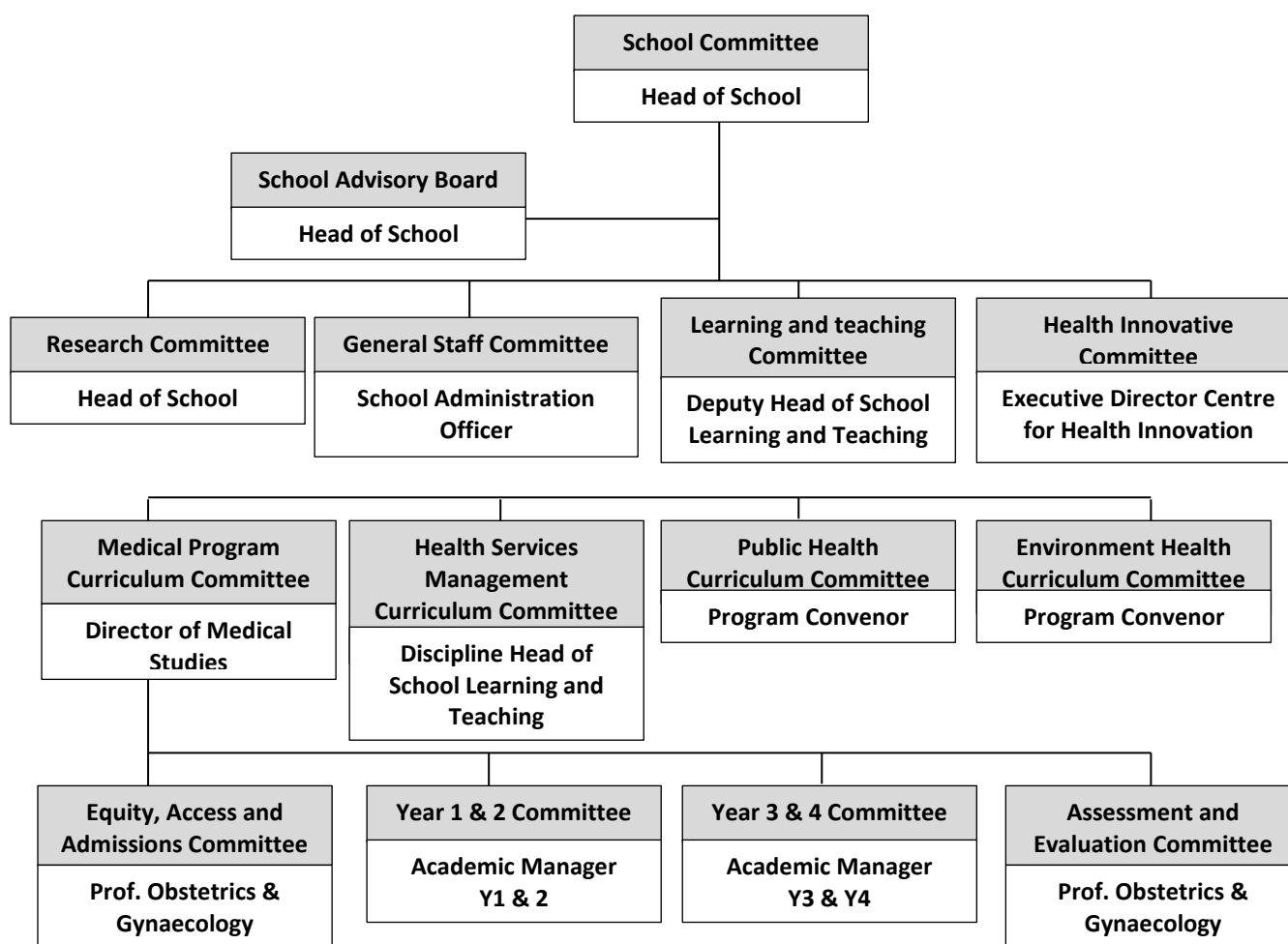
The program receives strong support from the Vice Chancellor and Pro Vice Chancellor, Health. It is seen as central to the overall mission of the University and has been supported by significant investment in staff and infrastructure over the last ten years.

The Head of School reports to the Pro Vice Chancellor, Health through the Dean Academic. There is a clear understanding of the respective roles of the Head of School (who also carries the title Dean of Medicine), Dean Academic, and Dean Research. This management group functions well but its success is in part personality dependent and more formal delineation of responsibilities may need to be considered.

Within the School, the Head of School is supported by the School Executive, which consists of the Deputy Head of School, Director of Medical Studies, Chair of the Professional Practice and Development Panel, the lead in admissions and assessment (held by one person), and the senior administrative officer. The Executive was formed three years ago and meets on a weekly basis regarding operational matters. It reaches consensus decisions through application of School policies and feeds issues into the relevant committee.

The School organisational structure is overseen by the School Committee, the primary School decision-making entity. Chaired by the Head of School, its members include the deputy Head of School; the chairs of the curriculum, research, professional behaviour and assessment committees; and representatives from academic and clinical staff, general staff, students, staff from the Health Group; Queensland Health, Indigenous and consumer representatives. This Committee meets as required and considers matters that have come through the committee process, and may feed directions back into the School. The School Advisory Board reports to the School Committee (discussed below). The organisational structure is shown in Figure 1.

Figure 1: School organisational structure



The Learning and Teaching Committee, chaired by the Deputy Head of School, was established in 2014 to oversee the School programs of medicine, health services management, public health and environmental health. It ensures that School programs and courses comply with University policy.

The Medical Program Curriculum Committee (previously known as the Education Committee) is chaired by the Director of Medical Studies and is the decision making committee for the medical program's curriculum. Following the recent incorporation of public health into the School of Medicine, the School's Learning and Teaching Committee was established, and the Education Committee was re-named in 2013. The relationship of the Learning and Teaching Committee with the Medical Program Curriculum Committee is currently being refined and this should be monitored to ensure that the structures continue to deliver appropriate support for the program.

The Year 1 and 2, and the Year 3 and 4 Committees are responsible for the organisation and coordination of the two halves of the program. These committees make recommendations to the Medical Program Curriculum Committee and implement its policies.

There is not a formal admissions committee, rather a group of people with School roles in admission, currently led by the Lead in Assessment.

The Assessment and Evaluation Committee, established in 2014, is chaired by the Lead in Assessment. It recommends strategic directions in the program's assessment and evaluation to the Medical Program Curriculum Committee. This committee is not involved with the operational aspects of assessment. The School Assessment Board, chaired by the Head of School, meets at the end of the year to make progression decisions. The Year 1, 2, 3 and 4 School Assessment Panels are chaired by the respective Year 1 and 2 academic manager or Year 3 and 4 academic manager, and report to the Assessment Board. The panels meet throughout the year to progressively consider assessment results and feedback. Matters requiring changes to processes or policy (guidelines) are conveyed to the Medical Program Curriculum Committee.

The team found the School's governance structures complex, but they were well understood by academics and professional staff and appeared to be working effectively. There are a large number of committees within the School and many academic staff are members of multiple committees and working groups. The team recognised that the School has achieved some rationalisation of the structures as it has matured, but believed that there are opportunities for further efficiencies.

The School's relationships with all clinical schools and sites, and with Queensland Health are functioning well, with good communication, clear evidence of collaboration, and well-understood pathways for the escalation of issues where necessary.

Formal engagement with the community is via the School Advisory Board, discussed at Standard 1.6.

1.2 Leadership and autonomy

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

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

The School Committee is responsible for the overall management of the program. This committee reports through the teaching and learning governance structure of the University to the University's Academic Committee chaired by the Deputy Vice Chancellor, Teaching and Learning. The Medical Program Curriculum Committee provides leadership and management in the teaching and learning activities of the program. The team was satisfied that this committee has oversight of curriculum change in consultation with relevant sub-committees.

The process for ratification of changes in the program is clear. Major program or course changes (such as the recognition of a Level 9 Masters (Extended) qualification) are considered by the Health Group Board before being submitted to the University Programs Committee and then the University Academic Committee.

Where academics from other Griffith schools teach into the two program themes of 'Doctor and Knowledge of Health and Illness', and 'Doctor and Patient' in Years 1 and 2, these staff are under the supervision of the Year 1 and 2 Academic Manager.

The responsibilities of the Head of School and Dean of Medicine are clearly outlined and are consistent with those in place for other heads of school in the University. These include academic planning, teaching, research, accountability for School budget, staffing matters and representation to external organisations (locally and nationally).

1.3 Medical program management

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

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

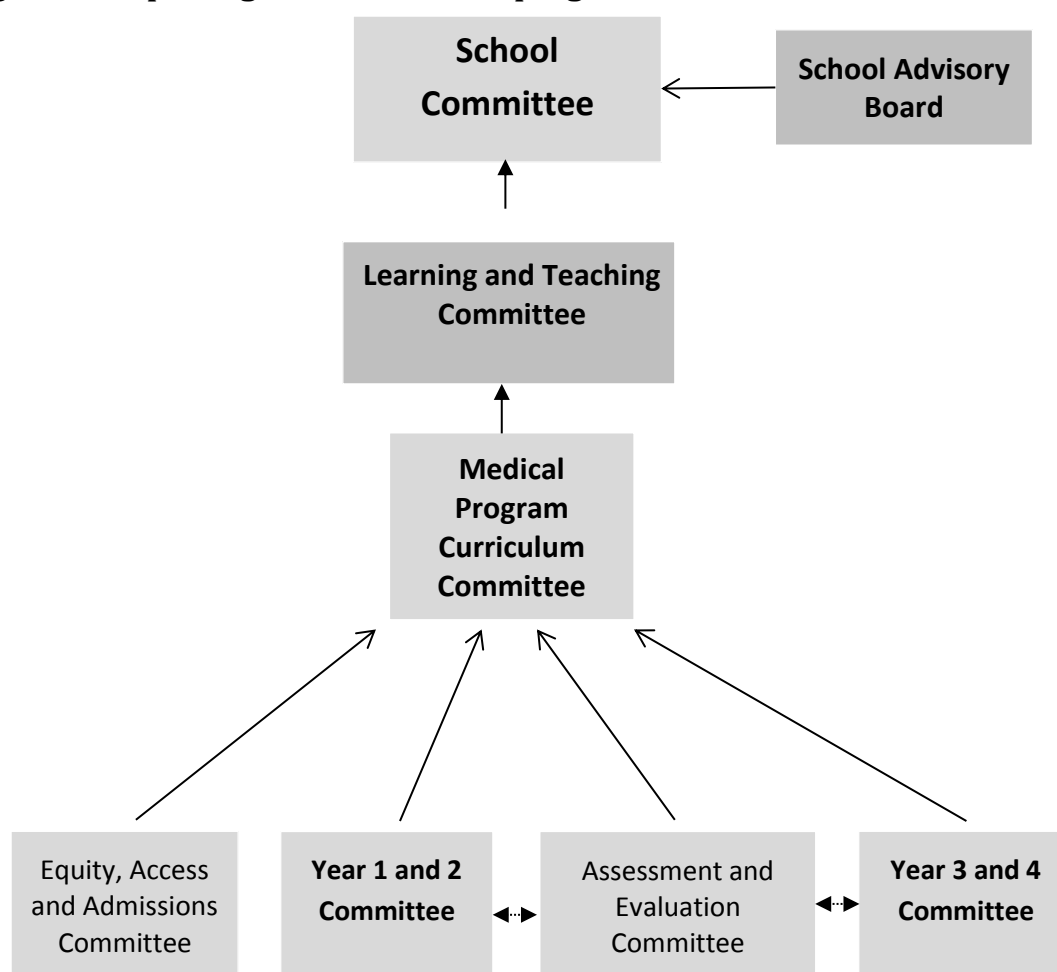
The Medical Program Curriculum Committee is responsible for the oversight, development, decision-making and policy for the medical program's curriculum. The members of the committee include the Director of Medical Studies, academic managers, theme leads, clinical subdeans and five student representatives. This works effectively and its members are clear as to their respective roles. This committee provides a policy framework for its sub-committees that include the Year Committees and the Assessment and Evaluation Committee.

The Year Committees organise and coordinate the two halves of the program. They implement the policies of the Medical Program Curriculum Committee and develop policies for its approval. Chaired by the Academic Manager, membership of the Year 1 and 2 Committee reflects teaching areas and includes representatives from anatomy, pathology, problem-based learning, clinician instructors, the various teaching blocks in Years 1 and 2, and students. The Year 3 and 4 Committee chaired by the Year 3 and 4 Academic Manager is larger and includes theme leads, clinical subdeans, clinical leads, clinical placement coordinators, and student representatives.

Figure 2 displays the reporting structure for the program committees.

The team was impressed by the effectiveness of the Medical Program Curriculum Committee in its development and implementation of several key initiatives since its inception and recognised the commitment of its members to achieving excellent outcomes.

Figure 2 - Reporting structure for the program committees



The University has appropriate internal mechanisms for making decisions about major changes to programs. The University's Academic Committee confirmed in May 2013 that the program allows for students to attain learning outcomes equivalent to that of an Australian Qualifications Framework Level 9 Masters (Extended) program.

1.4 Educational expertise

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

The School has developed and nurtured a team of academics and clinical titleholders that underpin the spectrum of learning and teaching of a medical program. The School has a broad cross-section of staff with responsibilities for learning and teaching within the program. The team noted the progressive development of the School over the ten years since the program was introduced. During this time there has been significant expansion of both hospital and community based placements and considerable increases in the number of academic staff. A strong relationship with the Gold Coast Hospital and Health Service has recently led to the establishment of three new professorial positions, one of which is a post of professor of medicine.

The School has made progress in developing a First Peoples health curriculum and has developed excellent links with the University's Council of Elders. Part of the strategy for further development has been the creation of a senior academic position in First Peoples Health. The team noted that the School had not yet recruited to this Level E position due partly to a shortage of suitable applicants, but was actively exploring other strategies to provide educational expertise of Indigenous peoples to the program. The School had broadened its criteria and will encourage applications from a wide range of health practitioners with the credentials to provide leadership in this area of the program. The School's endeavours in this regard have the strong support of the Council of Elders. The team supports the School's exploration of other strategies to ensure the Indigenous health educational expertise in the program, and recommends that the School provide evidence of success of its reviewed strategy.

Academic staff of the School exhibit a high level of commitment and passion for the program. However, the academic staff time available for the support and development of general practice learning and research is limited and the team recommended this issue be addressed in order to strengthen the program in this area.

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.

Financial resources in Griffith University are managed primarily by the academic groups, each of which is headed by a Pro Vice Chancellor. A Budget Advisory Group, that includes the Pro Vice Chancellor, Deans (Academic, Research, and Learning and Teaching), Heads of School and the Group Resource Manager, oversees the Health Group budget. The current budget model assigns income from all sources to the academic groups, and the majority of recurrent income is on the basis of student load. Allocation of financial resources related to large budget items, such as capital development, occurs at a University level. Funding for staff salaries is managed at the academic group level and is determined through a consultative process that seems to work well. The School is allocated a discretionary budget which includes provision for academic and general staff salaries, clinical teaching, and general activities including consumables, staff travel, staff development and equipment maintenance.

Overall, the program has been well-supported financially since its inception with cross-subsidy from revenue other than that generated by the program itself, and the School's budget has been neutral over the last five years. The team was aware that the funding model was under review and the details of support for 2015 were not yet known.

Nonetheless, the team was reassured by the Vice Chancellor's commitment to resourcing the program.

The School projects an increase in revenue from international student fees. The team considered that the School's target of 20 international fee-paying students per annum (refer to Standard 7.2) may be ambitious in a time of some uncertainty regarding the buoyancy of international student recruitment.

1.6 Interaction with health sector and society

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

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

The School has excellent relationships with Queensland Health. The Head of School attends Queensland Health's quarterly meetings as do the medical deans of Bond University and the University of Queensland and the James Cook University. The Head of School is in regular, less formal contact, with Queensland Health as required. Issues of mutual relevance or concern are regularly raised at the quarterly meetings where there is evidence of a collaborative and constructive relationship with the other medical education providers.

The University has flagged to Queensland Health its interest in potentially collaborating with the Sunshine Coast Public University Hospital project. Any future developments in this potential collaboration should be included in the School's AMC progress reports.

There is a joint consultative committee between the University and the Gold Coast University Hospital with senior leaders of each organisation represented. The Pro Vice Chancellor, Health also serves on the Gold Coast University Hospital Board.

The School has established a School of Medicine Advisory Board, the purpose of which is to ensure that the School's vision and strategic direction is shared with, and informed by, the Gold Coast community. Its 25 person membership includes a range of senior clinical, education and research expert stakeholders from the University and from the health sector; student representatives; Aboriginal and Torres Strait Islander leaders; and a former Gold Coast councillor. The terms of reference suggest potential for significant positive influence on the program however meetings are infrequent and evidence of the Advisory Board's influence over the School's direction is limited. The team noted that awareness of the Advisory Board amongst School staff and clinical teaching staff is variable and, in some areas, lacking.

The School has appropriate formal agreements with all the health care providers visited by the team. Placement agreements with Bond University School of Medicine at the Gold Coast Hospital and Health Service, and at Tweed Hospital, are excellent examples of a cooperative approach to student teaching that benefits all parties (refer also to Standard 8.3).

The School has strong and productive links with Queensland Rural Medical Education, a general practice regional training provider, which manages the University's facilities at several rural sites and also leads the successful 'Longlook' rural placement scheme. The absence of a formal arrangement with the University of Queensland regarding overlapping rural placements (coordinated by Queensland Rural Medical Education), was considered by the team to constitute a potential risk to some rural placements. Queensland Rural Medical Education is facing funding cuts and potential re-structure that are beyond the School's influence. The team noted the vulnerability of the School's rural program in the event of changes and recommends that the School's management of the effects of any change be an area for reporting.

The School has positive relationships with the GUMURRII Student Support Unit (the GUMURRII acronym is derived from 'Griffith University Murri - Queensland Aboriginal people, and Torres Strait Islander people') and discussions have addressed the School's strategy to facilitate the enrolment and nurturing of Aboriginal and Torres Strait Islander students. The School regularly meets with the University Council of Elders and the team was impressed with the positive nature of this relationship and with the mutual respect that is a hallmark of this partnership.

1.7 Research and scholarship

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

The University, Health Group and School show evidence of a strong and strategic commitment to research and scholarship. The School's research productivity and the number of publications continue on a steady upward trend, despite the focus on establishing the program during its first decade. The team acknowledged this promising research growth achieved during the period of program implementation.

The School's Research Committee provides advice to the School Committee on matters relating to research in the School, and it tracks grant and publication outputs. Chaired by the Head of School, its membership reflects the research activity within the School and includes representatives for research higher degree students, early career researchers and senior researchers. There is a goal to now increase the focus on research in the program's second decade.

The Medical Program Curriculum Committee oversees the applications for research projects that involve the program, ensuring compliance with ethical and professional practice standards.

There is an emphasis on medical education research but both clinical and basic scientific research is growing. Medical education research is closely linked to developments in curriculum and evaluation in the School and is likely to assist the School's decision-making in relation to selection and assessment in the future. The move of public health into the School has broadened the School's research base.

The Griffith Health Centre has wet-lab facilities to support basic science research, and clinical and translational research is facilitated by the colocation of the Gold Coast University Hospital.

Research income has increased from approximately \$1M in 2010 to \$2.8M in 2013. There has been a commensurate increase in research income per full-time equivalent staff member during the same period.

Students can engage directly in research by undertaking electives, by taking leave of absence to enable PhD studies, and by extracurricular research activity. There are postgraduate research programs leading to higher degrees in public health and health services management.

The team considered that the research culture at the School is in development and that, while it is not yet a fully established characteristic of the program, there is evidence of clear progression towards this.

1.8 Staff resources

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

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

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

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

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

The level of staffing, both administrative and academic, is sufficient to deliver the medical program. The University funds approximately 38 administrative and academic positions, and there are 15 jointly-funded clinical positions, with each clinical school having at least one appointee. Figure 3 shows the funded positions for staff in the program.

Figure 3: Funded positions for staff associated with the medical program

Positions	University Funded FTE	Jointly Funded
School Academic	2.4	
Clinical – Gold Coast		5.8
Clinical – Logan		3.1
Clinical – Tweed		1.6
Clinical – Wesley		0.9
Clinical – Rural		2.5
QE II Health Service District		0.65
Administration	17.25	
INS – IT	3.0	
INS – Technical	1.0	
TOTAL	37.65	14.55

An academic manager is appointed to each of the Year 1 and 2 and Year 3 and 4 streams, to ensure coordination and integration of the teaching and learning across all themes and across the respective two years. The academic managers chair their respective year committees, assessment panels and working parties, are involved in evaluation activities, and liaise with staff and students. The current appointees are highly regarded. There are also assistant academic managers to support this important role for the program.

The theme academic leads are responsible for curriculum content, assessment and integration, ensuring consistency for each theme, and the vertical integration of the theme in the program. There are clinical subdeans at each of the five clinical school sites (Gold Coast, Logan, Tweed, Wesley and Rural) to who clinical leads in a range of disciplines report in each instance. The clinical subdeans liaise with the Academic Manager Year 3 and 4, and with clinical leads, to oversee the learning and teaching activities in the clinical setting. The clinical leads provide academic leadership in their discipline, contribute to and coordinate the teaching and assessment of discipline-specific curriculum.

Decisions regarding staffing are made by the Head of School in consultation with the Executive team. The School's administrative staff provide assistance to over 1,500

people, including academic staff, lecturers and tutors, department heads, academic title holders and simulated patients. Of the 21.25 full-time equivalent administrative staff positions, ten staff are responsible for clinical placements, two for academic support, two for assessment and four in information technology and technical support. The staff informed the team that, while the workload is manageable, there is limited overlap of tasks between staff. The team considered that the level of administrative staffing is adequate, particularly given the projected increase in student numbers (refer Standard 7.1) and the importance of liaison with the clinical sites.

The School has 1 Indigenous person on staff. Indigenous educational expertise is discussed at Standard 1.4.

There is a pool of problem-based learning (PBL) facilitators, with 35 to 40 facilitators used across the 17 PBL groups in each of Years 1 and 2. The PBL facilitators are largely non-expert volunteers, with the pool made up of well-educated community members, university academics and some clinicians. The School trains and evaluates its PBL facilitators and conducts weekly briefings. While some students report variable experiences with facilitators, the team found that facilitator training was good, and the student evaluation, by block, of PBL facilitators showed students agreed that overall, the facilitator was effective (scores averaged 4.12 – 4.99, on a 1-5 Likert scale where 5 is 'strongly agree').

The team was impressed with the recruitment, induction, orientation and communication with simulated and volunteer patients who play an active role in Years 1 and 2 of the program. Students appreciate the important role of simulated and volunteer patients in the establishment of good clinical skills, and empathetic and effective patient communication.

All curriculum-related activities are covered through appropriate insurance and indemnity policies.

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.

School appointments include a standard period of probation consistent with University policies. Annual performance reviews are required of academic staff which ensure adherence to University standards and objectives, and which are intended to assist in career development.

All permanent staff are eligible to apply for promotion after two years of service and applications are reviewed by a Promotions Committee. There is the capacity to recognise non-traditional achievement as well as achievement in teaching and research.

The University offers a range of awards and citations for excellence in teaching and for service to staff and students.

An academic studies program, run under the auspices of the Vice Chancellor, offers staff the opportunity to work away from their normal duties for up to six months, though this is not available to research-only academic appointments or to clinical title holders. The School has the additional capacity to offer its staff up to \$2,000 per year for professional development activities.

There is a range of University-wide staff development programs and there is a teaching-specific enhancement scheme (known as PACES) which has been taken-up by many staff across the Health Group.

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.

The School has developed a clear global vision that aligns with the 2013-17 Academic Plan of the University. The vision statement was developed in consultation with staff, the School Advisory Board, Dean Academic, Health Group Executive and the University Academic Committee. The School's Advisory Board includes representation from a range of stakeholders including local and regional healthcare providers, Gold Coast City Council and patient advocacy groups.

The School's vision statement is:

Innovation for a healthier world.

Our School will be renowned for innovation and excellence in medical research and education. Through leadership and collaboration, we will engage and enrich our local and global communities to optimise health.

The University's academic plan recognises that the Griffith catchment area is extremely diverse in terms of ethnic and socio-economic composition. The School states that its vision succinctly includes the School's purpose in relation to Aboriginal and Torres Strait Islander people in mentioning its local communities. Both the program and Griffith University as a whole has a strong commitment to furthering opportunities for and the interests of Aboriginal and Torres Strait Islander peoples. This is borne out by the high enrolment and graduations. The GUMURRII Student Support Unit is effective and there is an excellent relationship with the Council of Elders.

The University has a tradition of providing access to students that did not previously have an open path to higher education including those from low socio-economic status. The School however recognises that there are no specific pathways for students from low socioeconomic status into the program (refer to Standard 7.2).

2.2 Medical program outcomes

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

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

- 2 *Clinical Practice: the medical graduate as practitioner*
 - 3 *Health and Society: the medical graduate as a health advocate*
 - 4 *Professionalism and Leadership: the medical graduate as a professional and leader*
- 2.2.1 *The medical education provider has defined graduate outcomes consistent with the AMC Graduate Outcome Statements and has related them to its purpose.*
 - 2.2.2 *The medical program outcomes are consistent with the AMC's goal for medical education, to develop junior doctors who are competent to practise safely and effectively under supervision as interns in Australia or New Zealand, and who have an appropriate foundation for lifelong learning and for further training in any branch of medicine.*
 - 2.2.3 *The medical program achieves comparable outcomes through comparable educational experiences and equivalent methods of assessment across all instructional sites within a given discipline.*

The underlying curriculum framework for the program is sound and demonstrates effective horizontal and vertical integration upon which the graduate outcomes are developed.

The team acknowledged the work to map the program's learning outcomes to those of the AMC Graduate Outcome Statements and in Years 3 and 4 to the *Australian Curriculum Framework for Junior Doctors* and the codes of *International Statistical Classification of Diseases and Related Health Problems, Tenth Revision*. There is also close alignment with the stated generic outcomes for Griffith University programs which are summarised in the following five statements: knowledgeable and skilled in their discipline; effective communicators and team members; innovative and creative, with critical judgement; socially responsible and engaged in their communities; competent in culturally diverse and international environments. The mapping and linkages are highlighted to staff and students in the School of Medicine's Resource Management System.

Equivalence of student learning across the sites has been satisfactorily addressed. The team recognised the effectiveness of the academic managers and clinical subdeans in achieving this. The governance structures for assessment ensure consistent use of appropriate tools across different sites. The performance of students in Years 3 and 4 across the five clinical teaching sites showed no discernible differences in outcomes. The program has highly effective evaluation mechanisms that link to program improvement processes; these include the School of Medicine's Resource Management System that provides an excellent platform for the integration and monitoring of feedback.

3 The medical curriculum

3.1 Duration of the medical program

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

The four-year program engages students in learning, teaching and assessment for 43 to 44 weeks per year. The team was satisfied that current program outcomes can be achieved within the duration of the program. The program is divided into four fully integrated year-long courses, each worth 80 credit points, within which four themes are vertically integrated. Students must pass each of the four themes in all years to pass the course and progress, so that although each year is an integrated program, each student who passes the year has achieved an appropriate standard in each theme.

Since 2006, the School has made changes to the program structure moving from the Flinders University 'off the shelf' curriculum to a more localised curriculum that continues to evolve. In 2015, the School's plans include changes in Year 3 and 4 rotation times and duration, with provision of a four-week 'Preparation for internship' block following the end of Year 4 exams. An additional research component of the program may also be introduced in 2016 (further details on both proposals at Standard 3.2). Students did not voice concern about the impact of the increased learning time on their holidays, however they were clear that adequate study time prior to examinations is a priority. The team had concern that students requiring reassessment or remediation may miss out on research or pre-internship rotations and recommends that consideration be given to ensuring these students have access to all learning opportunities available to other students.

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 and Society: The medical graduate as a health advocate.

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

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

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

Graduate Learning Outcomes for the program have been clearly mapped against the AMC Graduate Outcome Statements. The curriculum content is regularly revisited during an annual blueprinting exercise involving a week by week review of the four year curriculum.

In each year-long course, there are four themes integrated vertically across all years: Doctor and Patient (D&P), Doctor and Knowledge of Health and Illness (DKHI), Doctor and Health in the Community (DHC) and Doctor, Law, Ethics and Professional Practice (DLEPP).

Figure 4: Curriculum map by year, course and theme (2014)

MD				
Year 1		Year 2		Year 3
8001MED		8002MED		8003MED
				Year 4
				8004MED
Proportion of Course (42-43 weeks)	DKHI		DKHI	
	Doctor and Knowledge of Health and Illness (50%)		Doctor and Knowledge of Health and Illness (40%)	
	D&P		D&P	
	Doctor and Patient (25%)		Doctor and Patient (40%)	
	DHC		DHC	
	Doctor and Health in the Community (15%)		Doctor and Health in the Community	
	DLEPP		DLEPP	
	Doctor, Law, Ethics and Professional Practice (10%)		Doctor, Law, Ethics and Professional Practice (10%)	

The scientific foundations for medicine, evidence-based practice and scholarly development of medical knowledge are important learning outcomes for all themes but are especially important in the DKHI and DHC themes within the program. The

communication, clinical, diagnostic, management and procedural skills to enable graduates to assume responsibility for safe patient care at entry to the profession are likewise core graduate outcomes for the program and addressed in all themes, particularly in the D&P and DLEPP themes. Also addressed across all themes are the protection and advancement of the health and wellbeing of individuals, communities and populations. These graduate outcomes are especially important in the DHC and D&P themes of the program, as are the AMC Graduate Outcome Statements related to professionalism and leadership.

The curriculum content is comprehensive, well-integrated and a strength of the program. In Years 1 and 2, the content is structured in two half-year blocks, as listed in Figure 5. The Year 1 course examines the structure, function and development of the normal human body at all levels and the changes that occur as a result of disease, injury and abnormal development. The DKHI (50% of content) is presented as two blocks of teaching: Introduction to the Science of Medicine; and Systems Medicine covering the cardiovascular, respiratory, gastrointestinal and renal systems. D&P includes students learning professional communication skills; clinical, examination and procedural skills.

The Year 2 course is presented as Brain, Mind and Body, covering brain and behaviour and the musculoskeletal system; and Preparation for Practice covers the endocrine and reproductive systems and integration cases. In Year 2, the School is gradually modifying the content to ensure less boundaries between blocks of teaching.

In Year 3, students undertake six rotations of seven weeks in medicine, surgery, aged care and cancer care, mental health, women's health and child health. In the first half of Year 4 students complete three further seven week clinical rotations in general practice, critical care and emergency medicine. The latter half of Year 4 includes four by four week selective / elective rotations.

Figure 5: Curriculum map by year and course

Year	Course	Sub-Topics	CP	% Time in the medical school	% Time in clinical placements
1	Medicine 1	Introduction to the science of Medicine Systems Medicine	80	80	20
2	Medicine 2	Brain, Mind and Body Preparations for Practice	80	80	20
3	Medicine 3	Medicine; Mental Health; Surgery; Aged Care and Cancer Care; Women's health; Child Care	80	5	95
4	Medicine 4	Critical care and Orthopaedics; Emergency Medicine; General Practice; Electives; Selectives	80	5	95

The team was initially concerned about where learning regarding AMC Domain 2.12 (recognise and assess deteriorating and critically unwell patients who require immediate care...) was included, especially regarding management of patient deterioration. From discussion during the site visit it was evident that this domain was addressed during the program and in particular in the Clinical Learning through Extended Immersion in Medical Simulation (CLEIMS) experience in Years 3 and 4 of the program as well as in a Year 4 critical care module. Students participate in one week of CLEIMS in both Year 3 and Year 4.

The School's review of its graduate learning outcomes has led it to review its research training outcomes. The team found that research competencies are yet to be embedded longitudinally in the program and students assert that student engagement in research projects is minimal.

The School aims to better integrate research training in the program and improve outcomes related to research projects and outputs. It plans to incorporate a seven week research block at the end of Year 3 after the completion of clinical rotations, by way of moving the first Year 3 seven week clinical rotation to the end of Year 2, thus permitting a study week prior to the Year 3 mid-year exams. An optional pilot research training program is underway for students to collect data or write up research. Staff will work to create a bank of supervisors and projects, and following stakeholder discussion and review of the pilot, a whole cohort implementation in 2016 or 2017 is expected.

The students expressed confidence that research opportunities would be promoted, particularly through the Gold Coast University Hospital, and were supportive of this development as long as it did not impact on their study time. The team noted that updates on the development of integrated research training in the program should be included in progress reports to the AMC.

3.3 Curriculum design

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

The integrated design of the curriculum has been achieved through regular consultation with general practitioners, hospital-based clinicians, private consultants, clinical coordinators, as well as School-based clinical staff. In addition to committee meetings, curriculum retreats provide opportunities for participation in planning. The Academic Manager for Years 3 and 4 and theme leads visit teaching hospitals to talk with clinical subdeans and other hospital staff and seek their input in regard to learning and teaching within the program.

This consultation has resulted in an integrated curriculum design based on four, year-long courses with learning and teaching within each year developed, delivered, assessed and evaluated through four themes extending through each of the four courses. This integrated design is supported and overseen by a program director (convenor) with overall responsibility for the program, while academic managers for Years 1 and 2 and

Years 3 and 4, oversee the horizontal and vertical integration within their years of responsibility. Additionally theme leads for each of the four themes are responsible for the vertical integration of the theme across all four years.

Learning is planned in consultation with clinicians and in particular general practitioners and emergency physicians. Conditions are coded according to frequency of occurrence, for example asthma is a frequent condition so is scored as Level 1, while aortic dissection may be a Level 3 or 4 subject. Learning and assessment are weighted accordingly. Most lectures in Years 1 and 2 are presented by clinical staff covering all disciplines and a focus on professionalism is included from the earliest lectures in Year 1.

The School has responded proactively to students' areas of concern and the consequent strengthening of areas of learning such as pharmacology. Similarly in response to feedback, integration has been enhanced at transitional stages of the program such as at the end of Year 2. This includes a capstone, student-led problem-based learning experience introduced into the second half of Year 2 with a strong emphasis on clinical reasoning. This experience is planned to lead students into case-based learning in the clinical years of the program. Preparatory clinical placements in Years 1 and 2 and hospital orientation at the start of Years 3 and 4 also assist with articulation into the clinical years. The pre-internship block planned to be introduced at the end of Year 4 from 2015 will further enhance integration at this important transitional stage of the program, and articulate with the intern year.

Learning across core disciplines is well-attended in the program. However, the team considered that the relatively low number of general practice sessions required may underplay the importance of primary care in the Australian health care system. Additionally learning in general practice, beyond that described in the 'Doctor and Health in the Community' theme, may strengthen the integration of clinical teaching across themes. The team recommends that the teaching of general practice across the program be strengthened to enhance the learning opportunities provided in this setting and to improve student understanding of a discipline that will provide a career for a substantial proportion of graduands (refer to Standard 8 also).

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.

The learning outcomes are well-developed and clearly communicated to students. This is confirmed in the student report and was demonstrated during the site visit.

The School of Medicine Resource Management System is used to create cohort specific websites that remain accessible to each cohort for the duration of the program. This means that all learning and teaching related information can be accessed throughout the four years of study for each cohort. The School of Medicine Resource Management

System provides a searchable online database of learning objectives, learning items, conditions and disciplines.

Clear learning outcomes for each theme are listed in the course booklets for each year of the program and made available through the School of Medicine Resource Management System. Detailed learning objectives guide the weekly learning and teaching activities during Years 1 and 2. These objectives are delivered in conjunction with the problem-based learning cases, cover all four themes and are available to students at the completion of each case.

Course booklets describe learning outcomes (Years 1 and 2) and graduate learning outcomes (Years 3 and 4). The program information folder on each year's Learning@Griffith website includes documents that demonstrate how the program's learning outcomes map against the *Australian Qualifications Framework* and the AMC Graduate Outcome Statements. Additional information about the curriculum is provided in theme booklets (Years 1 and 2) and the block booklets (Years 3 and 4).

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).

First Peoples health is an area of the program still in development and this is reflected in the Leaders in Indigenous Medical Education (LIME) mapping tool provided by the School of Medicine. This confirms that the specific First Peoples content is delivered by:

- a lecture in Year 1: introduction to Indigenous health
- an Indigenous health symposium in Year 1 facilitated and presented by Aboriginal and Torres Strait Islander staff
- a lecture on communicating with Aboriginal and Torres Strait Islander patients
- some problem-based learning cases addressing Aboriginal and Torres Strait Islander health learning outcomes
- a requirement to complete the Royal Australasian College of General Practitioners' on-line cultural awareness module in Year 4
- access to on-line resources; and also
- optional community, general practice and student-led placements and activities in Aboriginal and Torres Strait Islander health settings.

In addition, related learning objectives are included in the problem-based learning curriculum, a Doctor and Patient workshop, two Year 3 online learning modules and a variety of lectures.

The absence of a specific overarching First Peoples health curriculum highlights the need for First Peoples oversight of ongoing program development through appointment

of an Indigenous academic lead. This will ensure cultural and academic integrity in learning about Aboriginal and Torres Strait Islander health issues.

The team was impressed by the level of engagement with the Griffith University Council of Elders and with the GUMURRII Student Support Unit to assist with the delivery of aspects of the First People's health and inform the curriculum. Also acknowledged are the wider University's significant achievements in contributing to the spiritual, social, emotional, economic and educational wellbeing of Aboriginal and Torres Strait Islander Australians.

3.6 Opportunities for choice to promote breadth and diversity

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

The program offers a broad and diverse range of experiences to students. In Year 1, students engage in four compulsory community placements of three to six hours duration with a wide variety of organisations. Students choose one placement from each of the four following categories: health promotion/ public health facilities; Aboriginal and Torres Strait Islander services/ cross cultural experience; allied health services; and community care/ social support. These placements provide early community experience for students, however at only three to six hours each, the team was uncertain of the benefits accrued.

During Year 2, medical students are offered optional dissection sessions in addition to the scheduled weekly prosection-based anatomy practical classes. Approximately 80% of the Year 2 cohort participates in the dissection sessions, though only 50% complete all sessions.

In the clinical years, the rural Longlook program is offered in Year 3 and sometimes extended to an additional year in Year 4. This optional stream provides students who are interested in rural medicine with an extended immersion clinical placement in a rural community. The experience is based in rural primary care hospitals and general practices where students are supervised by full-time clinicians with advanced skills and associated rural registrars. Rural placements may also be undertaken as electives and selective experiences.

Currently, in Year 4, each student undertakes two four-week blocks of electives. Students may seek placements in hospitals or general practices anywhere in the world, provided that the term is appropriate to the student's professional development. Electives may be completed in either a clinical or a non-clinical discipline including for research purposes. Selectives (also two four-week blocks) are selected from a list of clinically orientated placements in core teaching hospitals or their affiliated facilities. An anatomy dissection selective is also available.

The team noted a reduction in the Year 4 electives from eight weeks to seven weeks in 2015 in order to accommodate Bond University clinical placements at the Gold Coast Hospital and was not concerned about this slight reduction in elective experience.

There are numerous opportunities for students to gain knowledge and skills related to teaching during all four years of the program. These teaching opportunities include: as paid demonstrators for Years 1 and 2 anatomy practical classes; as facilitators of problem-based learning sessions at the end of Year 2 or of case-based learning presentations in the clinical years; participation as actors in interview stations for applicants to the program; and participation in peer and near-peer assessment activities.

The program provides opportunities for research training including electives (described above), as well as a two-year PhD program. The MD/PhD program is commenced during a leave of absence following second year and completed in the final two years of the program. The team noted that uptake in the MD/PhD program is unlikely to be substantial given the two years leave of absence required from this postgraduate training program. A recent opportunity for additional research experience has been introduced through a pilot research program offered to twenty students (refer Standard 3.2). If successful this is planned to be extended in the future.

Students pursue particular interests and gain valuable clinical and leadership skills through engagement with a wide variety of student societies including the Griffith University Medical Students Society, Hope 4 Health, Surgia and the General Practice Student Network. The initial student report indicated some issues with communication and support, however the team understood from interviews with students and academic staff that these concerns had been largely addressed.

Students indicated a desire for additional leadership training, however the team's discussions with students confirmed that the program provides a range of well-supported opportunities for student leadership including representation on School committees and leadership roles in student societies. The calibre and confidence of the students with whom the team met during the site visit further confirmed the adequacy of training in this respect.

4 Learning and teaching

4.1 Learning and teaching methods

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

The School employs a variety of teaching and learning modalities designed to engage students in active learning, and there is a strong pedagogical underpinning evident in many teaching activities.

In the first two years of the program small group work occurs in problem-based learning sessions, clinical skills sessions and in bedside tutorials. Large group resource sessions and workshops are designed to be interactive; and anatomy and pathology practicals give hands-on opportunities for learning.

The inclusion of regular hospital-based clinical teaching and a variety of community placements in Years 1 and 2 provides context for the program and are important in helping students ground their learning firmly in clinical practice. The involvement of junior medical officers in the Years 1 and 2 clinical skills teaching is popular with students and offers near-peer support.

The student submission initially highlighted a perceived over-emphasis on communication skills training in Years 1 and 2. This was carefully explored with students during the site visits, confirming strong recognition of the value of this training and satisfaction with the emphasis on this aspect of the curriculum. The use of highly trained and supported simulated patients in both communication skills and clinical skills training is clearly a strength of the program.

In Years 3 and 4, students rotate through a range of clinical placements in seven-week blocks. Engagement of students as part of a clinical team is encouraged and appears in the most part to work successfully. At this stage students are expected to learn, not only from the doctors and other health care professionals they work with, but also from patients. Students are expected to take an active part in the assessment and management of patients thus developing their diagnostic, clinical reasoning, communication and management skills. Students reported that they found their clinical placements enjoyable and the staff supportive.

The Core Learning and Integrated Clinical Knowledge System (CLICKS) supports clinical learning in Years 3 and 4 by providing on-line seminars that cover important topics. There is a system in place to ensure that materials are updated appropriately. The system is well-regarded by students.

Clinical skills facilities are available at Gold Coast University Hospital, Wesley Hospital, Rural Clinical School and at Tweed Hospital. The team found that keen clinical staff use the facilities to expose students to complex clinical situations in the safe environment of simulation. The clinical staff, in particular at Tweed Hospital, are motivated to develop

further simulation at clinical sites if funding for technical/ support staff became available.

The team was impressed by the care and effort put in to the planning of the program. The entire education team works collaboratively and achieves a cohesive, graduated learning experience for students across the four years of the program. The School's staff maintain good relationships with the clinical school staff including subdeans and clinical leads, contributing substantially to the success of the program.

Students reported great satisfaction with their learning and the opportunities available to them. Some variation in clinical experience exists but there was acknowledgement from students that often the clinical experience achieved depends on the application and attendance of the student. The School offers training in clinical teaching for clinicians but uptake is low. The School is encouraged to consider offering such training locally at its various clinical sites.

4.2 Self-directed and lifelong learning

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

The School expects students to be self-directed in their learning as a core element of the program and this is articulated in orientation and in year handbooks. There are several modes of self-directed learning in the course and students are guided as to how to find, appraise and share knowledge by written materials and through academic support. Problem-based learning sessions include mandatory group feedback requiring students to evaluate their performances individually and as a group.

In Year 3 students are expected to prepare and present one case-based learning case each week. This activity is designed to develop clinical reasoning skills and to practise sound decision-making. Students must submit an Online Student Care Report (OSCAR) through the School of Medicine Resource Management System every week.

The School of Medicine Resource Management System enables students to track progress and evaluate their learning across the program. The team was impressed by the comprehensive nature of the resource management system and the functions in place to ensure that students are both monitored and supported in their learning activities, both online and in clinical settings. Reports from the School of Medicine Resource Management System are made available to year coordinators in order to screen for students in academic difficulty. The educational designer responsible for it reported a close working relationship and open communication with the year coordinators.

4.3 Clinical skill development

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

The team met with the clinical skills team which has responsibility for the learning and teaching of core clinical skills and the Doctor and Patient theme. This team involves several standardised patients and members from the disciplines. This allows the School to share resources and expertise for communication, physical examination and procedural skills teaching with other disciplines within the Health Group, an important element of optimising cost-effectiveness.

An intensive and comprehensive clinical skills program using simulated patients is run throughout Year 1 and 2. The sessions are conducted in purpose-built facilities that allow for observation, video-recording of performance, and interactive review. The sessions involve an introduction and demonstration of the skill to the whole cohort followed by small group work with a clinician facilitator and a trained simulated patient. Students who met the team rated these sessions highly although some voiced concern that the facilitator did not demonstrate the relevant skill at the start of the small group session. Further discussion with academic staff revealed that a large group demonstration is done prior to the small group sessions so that students can benefit from clinician facilitation and feedback for the entire small group session, but that not all students choose to attend. The team recommends that the large group demonstration session held before the facilitated practice sessions be made an integral part of the program so that all students attend.

The clinical skills program allows students to develop communication, physical examination and procedural skills in a safe learning environment as a foundation to applying them in the clinical setting with real patients later in the program. Attending placements in hospital and in the community gives Year 1 and 2 students the opportunity to observe application of clinical skills by experienced doctors contemporaneously to their own learning. The team noted the enthusiasm and positivity of the clinical skills team regarding the delivery of this training, although the AMC team noted that future implementation is reliant on securing a sustainable budget.

4.4 Increasing degree of independence

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

There is timetabling of a range of stage-appropriate involvement with patients in a variety of settings for every student in the program. During Year 1 and 2 these include hospital-based clinical teaching and community-based sessions with a general practitioner, attending community organisations or being involved in community events. Students reported these experiences as valuable contextualisation for their simulated patient clinical skills sessions.

The Year 3 and 4 clinical placements are organised so that students have experience in core areas of medicine, aged care and cancer care, surgery, women's health, child health, and mental health prior to Year 4 placements when they need to integrate their knowledge and skills in the more demanding areas of general practice, critical care and emergency medicine. During these clinical immersion blocks students are expected to spend 50 hours a week on their studies through a combination of participation in the clinical settings and self-directed study.

The Clinical Learning through Extended Immersion in Medical Simulation (CLEIMS) initiative provides a one-week simulation experience for students in Year 3 and again in Year 4. During this week, in small interprofessional groups, students manage simulated patients through episodes of care, being responsible for all clinical encounters and decisions. It is a further way in which students have more advanced simulation experience to support the development of their team, interprofessional and leadership skills in the clinical setting (refer also to Standard 4.7).

In the latter half of Year 4, students become increasingly independent in preparation for internship by taking part in electives and selectives. The team noted that in 2015 there will be change to include elective and selective placements in the general practice / critical care / emergency medicine rotations, so as to end the year with a four-week 'Preparation for internship' block following the end of year-exam period, preferably in the hospital where the student is to be an intern.

The team spoke with supervisors and clinical teachers at all sites and found them to be well-informed about the School's program and supported by the School in managing students. Students were similarly very satisfied with their supervision and support.

4.5 Role modelling

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

Role modelling is integrated through the program and students are exposed to a variety of clinicians and academics in all years. In clinical settings senior students, interns, junior medical officers and registrars may all act as role models as well the consultant and senior staff.

The team noted that the entire senior staff of the School including the Head of School offered exemplary role modelling to students in the way they work together effectively and create a positive learning and working environment.

The team noted that students have more opportunity currently for exposure to clinician role models than researcher role models. With the development of research experience being piloted with 20 students (refer Standard 3.2) and the expansion of the research capacity in the new Griffith - Gold Coast Health Precinct this situation should improve.

4.6 Patient centred care and collaborative engagement

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

The team commends the School's efforts to embed patient centredness and collaborative engagement as key elements in the simulated environment early in the program. The communication skills program, which highly values warmth, respect and empathy, is a key step in embedding patient centredness into students' subsequent clinical practice. There is also theoretical teaching of the concepts in large group sessions during Years 1 and 2.

In the later years of the program, students are required to consider relevant learning items to holistic, patient centred care in the weekly preparation of their Online Student Care Report, and testing of the patient centred care approach is included in the setting of Objective Structured Clinical Examination criteria.

The team observed that there was limited understanding of the concept of patient centred care among hospital clinicians and recommends that patient centredness be made more explicit in the clinical setting. This would be an appropriate topic for tutor/supervisor training.

4.7 Interprofessional learning

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

The team commends the progress made by the School in enabling students to work with and learn from and about other health professionals.

The Griffith Health Institute for the Development of Education and Scholarship (Health IDEAS) has developed an implementation framework for interprofessional learning at Griffith Health. Now in its third year, much has been achieved. Phase 1 'Introduction to the health professions' has been completed by production of videos by each of the health specialties which can be shared among students across the various disciplines; Phase 2 is implemented through the Clinical Learning through Extended Immersion in Medical Simulation (CLEIMS) and through selective opportunities in interprofessional education at the Robina Health Precinct.

The CLEIMS program involves an intensive school week where students are taken through a series of simulations involving patient journeys. The students assess and manage patients and the initiative allows students from several health-related disciplines to work together. Members of other professions are skilfully incorporated into the scenarios adding authenticity and enhancing learning. This is an innovative and effective way to learn how to be an effective member of an interprofessional team to improve patient care and continued research is encouraged.

5 The curriculum – assessment of student learning

5.1 Assessment approach

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

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

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

The School has clearly defined assessment procedures (i.e. *Graduate Entry Medical Program Assessment and Progression Guidelines*) that link to the Griffith University policies regarding assessment, student misconduct and progression. The principles and philosophies of the School's assessment are clearly articulated in this document. The School's Assessment Board, chaired by the Head of School, has responsibility for determining progression and eligibility to graduate. Assessment and feedback to students is overseen by assessment panels that have been established for each year level. The terms of reference for the Assessment Board and assessment panels, as well as the program's Assessment and Progression Guidelines and associated policies are accessible to all staff and students.

The School has developed an integrated assessment strategy with formative and summative assessments across all year levels. In Years 1 and 2, formative assessment is provided by way of multiple choice questionnaires (MCQ), short answer questions (SAQ), objective structured clinical examinations (OSCE), case reports and anatomy practicals. Year 2 students also complete a peer-assisted learning exercise running the Year 1 formative OSCE with clinical skills staff. In Years 3 and 4, formative assessment is by way of feedback on frequent online student case reports (OSCARs), MCQ and short essay questions. The distribution of assessment in the program is documented in Figure 6.

The School's previous Assessment Review Committee in 2012/13 examined assessment processes in the program. Regarding formative and summative assessment, it recommended that there be increased opportunities for formative assessment, that there be benchmarking activities with summative written and practical clinical exams (OSCEs) and progressive summative assessment in Years 3 and 4, with the option for formative progressive testing in Years 1 and 2. The School has worked to increase formative assessment and provide improved student feedback in the last two years. The Assessment and Evaluation Committee continues to address the issues around compulsory formative assessment, and is considering the implementation of progressive assessment in 2016 (refer to Standard 5.2).

The team found that the balance of formative and summative assessment was satisfactory. The student body were appreciative of the formative assessment provided however expressed some concerns with regard to the balance between formative and summative assessment. The team encourages the School to liaise with students regarding the balance of assessment tasks.

5.2 Assessment methods

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

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

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

The School uses a range of assessment methods including written, clinical and practical examinations and assignments, which are integrated across the disciplines, to assess student learning throughout the program. The School has a number of key principles guiding its assessment. These include that assessment is an integral part of teaching and learning, it is integrated across scientific and clinical disciplines using multidisciplinary input, and it is criterion-referenced. The School selects assessment methods according to their educational impact, reliability, validity, generalisability and feasibility. The assessment items used in the program are displayed in Figure 6.

Figure 6: Distribution of assessment items across the four themes and four years of the program (2014)

	Medicine 1					Medicine 2					Medicine 3					Medicine 4									
Jan	P & E Scores	P & E Scores				P & E Scores	P & E Scores				OSCARs	ITAs	mini-CEXs					OSCARs	ITAs	mini-CEXs					
					WS					CR					CLEIMS Group 1						P PC ^a				
								CP & ITAs		CR				GP ^a		CLEIMS Group 2	CR				ME	P PC ^b			
			MCQ; SAQ; PA; PP		SAQ				MCQ; SAQ; PA					SAQ		Form MCQ SAQ	CLEIMS Group 3				Form SAQ	P PC ^c			
														GP ^b			CLEIMS Group 4						MCQ SAQ	OSCE	SAQ; PR
					EBM					PQA				EBM			CLEIMS Group 5				EBM		Selective/Elective Group A		
					RJ									GP ^c			CLEIMS Group 6						Selective/Elective Group B		
			MCQ; SAQ; PA; PP		OSCE			SAQ		MCQ; SAQ; PA					OSCE SAQ		MCQ SAQ				OSCE	SAQ	Selective/Elective Group C		
Dec	Medicine 1 Grades: NGP/F					Medicine 2 Grades: NGP/F					Medicine 3 Grades: 1 – 7					Medicine 4 Grades: 1 – 7									

Key

CLEIMS: Clinical Learning through extended immersion in medical Simulation

CP: Community Placement presentations and ITAs

CR: Case Report

D: Debate

EBM: Evidence Based Medical Assignment

GP: GP case report Groups a, b and c

ITAs: In Training assessment

MCQ: Multiple Choice Questions: Exam papers

ME: Medical Education assignment for DLEP

Mini-CEX: Mini-Clinical Evaluation Exercise

OSCARs: On-line Student Case Reports

OSCE: Objective, Structured, Clinical Examination

P: POEMs – Patient Oriented Evidence that Matters: Groups a, b and c rotations

PA: Practical Exam – Anatomy

P&E: Preparation and engagement

PC: Presentation on Preventative Care: Groups a, b and c rotations

PP: Practical exam – pathology

PQA: Phlebotomy and Qld Ambulance placements

PR: Professional Regulation Written Task (QCAT Task)

RJ: Reflective Journals

SAQ: Short Answers Questions: Exam papers

WR Website review

The School ensures the quality of assessment items by having theme and discipline experts, in consultation with the academic managers, draft and edit items. It commented that much of the assessment material is new, for example in the Year 1 and 2 MCQ, 66-75% of the items are new; in the Year 3 and 4 OSCEs, half are new items, and half are recycled and reviewed; and in the Year 3 and 4 SAQs, all items are new, are written by the clinical leads and developed by the assessment panel. Recycled items are not re-used the following year.

The draft exams are standard set by content experts and items are coded as: 'expected knowledge' for the course, 'higher level knowledge', or 'graduate knowledge', with the minimum standard being set as the sum total of the 'expected knowledge' items.

The School's Assessment and Evaluation Committee is considering the introduction of formative and summative progress testing from 2016. This would include summative progress testing in Years 3 and 4, formative progress testing in Years 1 and 2, and a weekly formative SAQ in clinical rotations. The School may replace the end of Year 3 and 4 SAQ and MCQ exams with summative MCQ exams mid-year and end year, and offer an additional SAQ exam for students who have not reached the required standard. Given these proposed changes, this is an area to include in future AMC progress reports.

The Year 1 and 2 and Year 3 and 4 assessment tasks are blueprinted by separate working groups with representation as required from years, themes and disciplines. There are well-documented processes for the blueprinting of examinations in both Years 1 and 2, and Years 3 and 4. The School ensures that each topic assessed corresponds to a learning objective. In Years 1 and 2, the exam blueprinting working group meets twelve times a year to maintain progress in setting MCQs and SAQs. The working group plans the balance of examinations, discusses clinical scenarios, seeks written items, refines these and seeks review of the draft examination.

In Years 3 and 4, once the assessments are blueprinted, academics and clinicians collaborate to produce the assessment items, the Clinical Learning through Extended Immersion in Medical Simulation (CLEIMS) scenario questions, and the assignments in the themes of Doctor, Health and Community; and Doctor and Law, Ethics and Professional Practice. Items are prepared, reviewed and entered in the OSCE database or the written paper database, and a blueprint summary is generated from the database and cross-checked against the proposed template.

The team commends the School staff on the extensive and thorough work of the School in blueprinting and examination composition.

The examinations are reviewed by the standard setting committees. The School uses validated standard setting processes which are overseen by a standard setting committee. The Angoff method for criterion-referenced standard setting is used for clinical scenario-based, SAQ, assignments and OSCE stations. Answer keys are generated for each component of a question which is submitted to the standard setting committee, which uses the Angoff method to reach consensus on a passing mark. The School uses the Ebel method for MCQ papers taking into account level of difficulty and level of importance, based on academic and clinician consensus. Again, the team were impressed with the standard setting processes in place, and the regular academic and clinician input into standard setting.

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.

In recent years the School has focused on improving its processes to identify and remediate underperforming students. This has included implementation of the *Graduate Entry Medical Program Assessment and Progression Guidelines*, which provide details regarding remediation and reassessment of students, as well as supplementary examinations. This information is disseminated to students via a number of different avenues including the Learning@Griffith portal, student representatives and information sessions.

Underperforming students may be identified in a number of ways including by the academic manager, problem-based learning and small group facilitators, through formative assessments, or through summative assessment by the academic manager and assessment panel. Students are identified who have not passed summative assessments or who have progressed with borderline results. A register of 'at risk' students is retained by the School on a common drive and can be accessed and annotated by staff for subsequent review at the Assessment Board and assessment panels. Additionally, the Year 3 and 4 academic manager receives information regarding underperforming students in Year 2 to ensure transition of information and support into the clinical years. Students can also self-report for additional help. The School has found that since it advertised the self-reporting option, there has been a significant increase in students doing so.

Once identified, underperforming students are offered support from staff, including advice on learning strategies, assessment techniques and problem-solving. The School found in 2013 that this program had a positive impact on the performance of students in this group.

Feedback is provided to the student cohort throughout the program following both summative and formative assessment tasks. Comparative data, broken down into themes or disciplines, is available through the Learning@Griffith portal so that students can gauge their level of performance against the wider cohort. Large group feedback sessions, as well as individual sessions for 'at risk' students, are provided throughout the program. The team found that there was ample and valuable feedback provided by committed staff.

Feedback on the student cohort performance is provided to academic staff via academic and clinical members of the Assessment Board and Assessment Panels as well as the year committees. In addition, all teaching staff have access to information on the performance of individual students upon request.

5.4 Assessment quality

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

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

The School's five-yearly external review conducted in 2010 included the recommendation to review the program's assessment. The Assessment Review Committee was formed and conducted an extensive review of the program's assessment in 2012-13. The School transitioned from the Assessment Review Committee to the Assessment and Evaluation Committee in 2014, which will play a key role in the ongoing oversight of assessment and evaluation in the program.

The School evaluates its exam questions to assure consistency within and across assessments, and to determine the reliability and validity of materials for re-use. It makes changes to its assessment processes as a result of its evaluation, for example in blueprinting and standard setting, in assessment item marking, in improved collection of exam data, and in benchmarking and feedback. The team was impressed with the comprehensive review processes in place and the continual quality improvement.

The objective structured clinical examinations (OSCEs) are run centrally and examiners from the clinical sites attend the School. Training and calibration of assessors includes provision of information in advance of the assessment, a detailed briefing before the assessment, followed by a breakdown of each station.

To promote consistency of assessors across the five clinical teaching sites in Year 3 and 4, relevant staff meet with clinicians regularly, clinical leads at sites are provided with information regarding expectations; a mini-clinical evaluation exercise (mini-CEX) training DVD is provided to sites to standardise marking of this assessment, and the clinical skills senior lecturer observes some assessments.

The School analysed student results across the five sites in Years 3 and 4 from 2007 – 2012, and found no discernible differences in the outcomes of students, including those students located at one site for the full year. This indicates that the varied locations do not impact on students meeting program outcomes, and that the clinical supervisors are teaching and assessing to similar standards.

6 The curriculum – monitoring

6.1 Monitoring

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

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

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

The School has clearly defined policies and procedures for monitoring the program, which are articulated in the *Graduate Entry Medical Program Guidelines for Program Monitoring*, and available to all staff. The program is subject to the evaluation processes of the University and the corresponding policies and procedures. This evaluation process, which works on a five-year cycle, includes the collection and analysis of data from teachers, students and external stakeholders, and reports on quality, efficiency, viability and sustainability. An Annual Program Review and Improvement Report is also required by the University. The year committees play a key role in the monitoring of the program as does the Medical Program Curriculum Committee.

A range of data is available to the School regarding the ‘student experience’ including the Griffith University Student Evaluation of Teaching (SET), Griffith University Student Evaluation of Course (SEC), and the Australian Graduate Survey (AGS). These data are available to staff via the planning and statistics portal on the School website. Staff can run reports on student profiles, student load and student retention. It is a University requirement that course convenors complete a Course Improvement Plan annually if the SEC rating is below 3.5 out of 5. The team notes that the SET evaluation tool may not be the most appropriate tool for evaluation of the program given the integrated nature of the curriculum.

The team were impressed by the evaluation capabilities (i.e. rating and written feedback) built into the School of Medicine Resource Management System which allows students to provide feedback on a variety of learning activities including individual lectures, learning resources and problem-based learning (PBL). For example, the PBL case evaluation includes a Likert scale and general questions to be completed by the group by consensus. PBL groups are motivated to complete each evaluation, as after they submit it, the group receives the link for the PBL learning objectives which are linked to assessment content.

While more formal evaluation of PBL tutor performance is conducted at the end of each teaching block, the School of Medicine Resource Management System makes the evaluation data available immediately for review. This allows the academic convenor to monitor all groups and facilitators and respond promptly; and enables staff to address learning issues. The School's analysis has shown the PBL evaluation tool to be a reliable and valid tool for curriculum development, student engagement, student risk assessment and staff development. The team commends the School on the capability and application of the School of Medicine Resource Management System.

A considerable quantity of informal feedback is obtained by the School through PBL tutor briefings and clinical skills staff briefings, which help inform the relevant theme and discipline leads. The team were impressed by the manner in which the School responds to issues raised by the students and/or staff with regard to the curriculum, teaching methods and assessment tasks. The key role of the academic managers in this process was noted. Staff feedback is also received and considered through the various committees.

The School has established a number of collaborative links with other medical programs to assist with monitoring of the Griffith program in key areas including admissions, assessment and clinical placements. In medical program outcomes, the School participates in the Australian Collaboration for Clinical Assessment in Medicine (ACCLAiM) group, and in the Australian Medical Schools Assessment Collaboration (AMAC). In 2013, the School embedded 25 AMAC items in a formative Year 3 exam, and 26 items in a summative Year 4 exam. When compared with four other AMAC education providers, the results placed Griffith ahead in both. The School is also collaborating on a longitudinal Graduate Medical School Admissions Test (GAMSAT) project with the University of Queensland.

6.2 Outcome evaluation

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

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

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

The School regularly monitors the performance of the student cohort and analyses its performance across themes, course and year level. The School's monitoring of the exam performance data reveals a low failure rate overall and consistency in the performance of students in each course across multiple years.

The School compares the performance of each student cohort and monitors student progression. These data are provided to key committees. Demographic data is closely scrutinised and the performance of students from different entry pathways is also monitored and analysed to inform admissions processes. The performance of the

program's direct entry Bachelor of Medical Science (BMedSci) students (60 per year) has been monitored since the first cohort entered the medical program in 2009, and the mean course score is close to the mean for all students.

The School's 2013 review of assessment included consideration of whether assessment in Years 3 and 4 addressed key features. It found overall that it was fit for purpose and was defensible, though it could better drive student learning, improve formative feedback, and promote good practise. It recommended that the program needed a clear shift in emphasis from barrier assessment preparation, marking and feedback towards a more student-focused promotion of learning and formative feedback; and that progress testing be considered (refer also Standard 5.4). Future evaluation of any changes agreed will be of interest.

There has not been a formal or comprehensive evaluation of the School's graduates. The School has used the Medical Schools Outcomes Database to evaluate the outcomes of the program. These data indicate that the Griffith graduates are overwhelmingly positive regarding their preparation for work as an intern. This outcome was supported by anecdotal evidence collected by the team during the visit and speaking to staff and Griffith graduates in clinical settings. The School is encouraged to explore development of tools to more systematically evaluate the outcomes of the program.

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.

The School has established a process for the dissemination of outcome evaluation through a number of committees with widespread representation including external stakeholders. Student representatives and the Learning@Griffith learning management system are also used to disseminate evaluation data.

Various stakeholders are represented on school committees, such as the School Advisory Board and School Committee, and have the opportunity to discuss the evaluation results at these meetings. Committee feedback is then fed through the School's organisational structure (as outlined at Standard 1.1).

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.*

The School has 600 Commonwealth supported places over the four years of the program with an additional six international fee paying students in the total cohort. Figure 7 shows the student intake data from 2009 onwards. Since 2009, there has been a significant increase in the number of students entering through the BMedSci feeder pathway with up to 60 in each year cohort.

Figure 7: Student numbers by offer type*, 2009 - 2014

Year	Total students enrolled (A+B+C+D)	A Government supported	B Government funded bonded (Rural/Medical); Qld Health Bonded	C Fee paying domestic	D Fee paying International	Numbers of B Med Sci students
2014	602	428	168; 0	0	6	176
2013	610	411	144; 51	0	4	123
2012	613	371	140; 102	0	0	81
2011	589	314	126; 149	0	0	59
2010	599	283	115; 201	0	0	37
2009	565	280	94; 182	9	0	17

*: data from the [Griffith University Planning and Statistics](#) Portal plus School Admission reports

The School plans to increase the number of international fee paying students to 20 in each year cohort bringing the total maximum to 680 students by 2020. Student numbers projected to 2023 are shown in Figure 8. The team found that there is adequate space and physical resources for the projected student complement. The School advised that its new Griffith Health building can cater for 220 medical students per year and its Gold Coast campus has adequate infrastructure to resource student needs. While the team considered the staffing structure was adequate for the current numbers, the School will be required to consider the staffing and clinical placement implications for the extra student load. To this end, the Health Group's negotiations with

Queensland Health and the Sunshine Coast Hospital and Health Service could expand the number of clinical placements to accommodate increased student numbers.

Figure 8: Projected student numbers by offer type

Year	Total students enrolled (A+B+C+D)	A Government supported	B Government funded bonded (Rural/Medical); Qld Health Bonded	C Fee paying domestic	D Fee paying International	Numbers of B Med Sci students
2015	616	428	172	0	16	214
2016	631	428	172	0	31	240
2017	650	428	172	0	50	240
2018	665	428	172	0	65	240
2019	675	428	172	0	75	240
2020	680	428	172	0	80	240
2021	680	428	172	0	80	240
2022	680	428	172	0	80	240
2023	680	428	172	0	80	240

*: Assumes that commencing international fee-paying student numbers increase by 5 from 4 in 2014 to 20 in 2017 and then remains static so that the total number of international fee paying places across the 4 years is anticipated to be 80 by 2020.

Program leave is approved by the Head of School and one year is permitted. The team noted the significant number of student requests for leave of absence during 2014 (17 at the time of the AMC visit) and recommends the School establishes processes for monitoring the number and reasons for deferrals.

The School acknowledged that attracting Aboriginal and Torres Strait Islander students has been challenging. After a review in 2011/12, in 2013 a new recruitment pathway was established to improve the access of Aboriginal and Torres Strait Islander students to the School, which provides for alternate-entry pathways and specific quotas that are reviewed annually. The team commends the School on this initiative, which has resulted in four of the five places being filled by Aboriginal and Torres Strait Islander students for the 2014 cohort. The School was interviewing a further six students for the 2015 student cohort.

The School's dedicated First Peoples staff member, with the assistance of the GUMURRII Student Support Unit, engages actively with local communities and schools to promote the program, mentor potential students, and conduct community outreach activities. GUMURRII and the dedicated School staff member also help prepare students for entry into the School.

The University promotes equity and diversity and encourages students from diverse backgrounds. The School does not have alternate entry pathways or quotas for rural students as it does not receive Rural Incentive Program funding. The School acknowledged that there were no specific pathways for students from a low

socioeconomic status (SES) into the program, and currently only 6% of students enter the School with a low SES. The team recommends that the School introduce an alternative access scheme for these students. Although the School, through the University, provides access to free, weekly individual tuition and access to the GUMURRII Student Support Unit, to enhance retention of First Peoples and low SES students, the School could consider additional financial support.

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.

The School has clear selection policies and processes. Students are admitted through one of two admission pathways: the BMedSci feeder program or the Graduate Entry Medical Program (GEMP).

Since 2011, sixty students per year enter the medical program via a two-year BMedSci feeder program. Selection for admission into the program is based on their school leaver's overall position score, subsequent attainment of a 'Human Skills in Medicine' course and maintaining a grade point average (GPA) of at least 5.0 throughout their BMedSci degree. To date, although BMedSci students have deferred their entry into the medical program, no student has failed to enter the medical program.

The GEMP selection process is hosted by the Graduate Entry Medical School Admissions System (GEMSAS). Since the 2014 cohort, a minimum GPA of 5.0 is required with a GAMSAT overall score (with 50 and above in each section). The team noted students with a research only masters or PhD are automatically awarded a GPA of 7.0. A combined GPA and GAMSAT score (1:1) is used to rank applicants for invitation to the Griffith University Multi Station Admission Assessment (GUMSAA). One and a half the number of available GEMP places are interviewed. The offer for admission is based on a combination of GAMSAT and GPA (50%) and GUMSAA scores (50%).

The types and number of domestic places offered is performed within these two cohorts proportional to the number of BMedSci feeder places and GEMP places. Conditional offers are made to those still completing their bachelor's degree.

Aboriginal and Torres Strait Islander students with a health degree are not required to complete GAMSAT or GUMSAA but should have a GPA of 5.0 or above. Aboriginal and Torres Strait Islander students with a non-health degree also require a GPA of 5.0 or

above, a GAMSAT score of at least 50, but not GUMSAA. All Aboriginal and Torres Strait Islander students are required to participate in an assessment of cultural and social support, and academic needs with representatives from the School of Medicine and the GUMURRII Student Support Unit. Students maintain a close relationship as needed with GUMURRII during the program. With increasing numbers of Aboriginal and Torres Strait Islander students entering the program, consideration could be given to increasing the support available through the School. This would need to be in close collaboration with the GUMURRII Student Support Unit.

The School has no profession-specific guidelines for the selection of and support for students with disabilities, although there is a wide range of University support services. The School has the appropriate policies on students with infectious diseases, including those with blood-borne viruses.

Information about the mechanisms for appeals regarding selection process are available publicly via web links to GEMSAS found on the 'Admission' link. Appeals for admission are dealt with by GEMSAS and if there are any ongoing issues, these are dealt with by the Griffith University Admissions Office.

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*
- o 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.

There is a full range of student support services provided by the University, including personal, academic and finance/ welfare. There are no specific School supports for those with disabilities, under-represented groups or admitted through schemes to increase diversity, other than First Peoples students. The team was satisfied that the students were adequately covered by the University-wide support.

The School has a comprehensive process to detect and support students at-risk of not completing the program (refer also Standard 5.3). The chair of the assessment panel

(Academic Manager) or the lead in assessment and evaluation identifies students at-risk of failing to complete each year. The remedial process incorporates group instruction and feedback, and as needed, individualised feedback, coaching and follow-up. The School also works with and supports the Griffith University Medical Society (GUMS) in its peer mentoring and peer-assisted learning sessions for struggling students. The School is encouraged by the improved student performances in assessments.

Student support is built into the conceptual model that underpins the curriculum, and academic managers, theme leads and the Director of Medical Studies have important roles in overseeing student welfare. The academic managers also perform a valuable student support role, which is much appreciated by students and staff. The academic managers can learn of students' concerns either directly from the student or via other sources including the theme leads, problem-based learning tutors and the clinical placement officers. The School advised that the academic managers spend a considerable amount of time with students addressing their needs.

The academic managers also have a number of other key roles including, but not limited to, being responsible for organising the summative OSCEs, chairing the assessment panels, reviewing and altering the curriculum content as required. The academic managers certify results before they are presented to the assessment panels and School Assessment Board, and may discuss results with the School Assessment Board. All decisions on student progression, either to the next year or to graduation, are made by the School Assessment Board, which is chaired by the Head of School.

The School considers that its policies do ensure that progression decisions are separated from the support services available to students. While students raised no concerns about the current process, and spoke highly of the academic managers, the team was concerned that the functions of support and academic decision making in general are not adequately separated. It recommends that the School review its documented processes to ensure that it is clear when a staff member should refer a student to student support services. This could minimise any future risk or perceived conflict, for example if a student considered that a staff member had influenced a decision based on knowledge of their personal issues.

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.

Griffith University has over-arching policies pertinent to the issues of fitness to practise medicine. There is a *Professional behaviour for medical students* policy (which is under review) where if the student is in breach of the accepted professional standards, they are referred to the Professional Behaviour Committee. The Professional Behaviour

Committee can make recommendations to the Dean, Learning and Teaching (Health) who may take action in accordance with the *Student Misconduct Policy* (or other relevant policy).

In 2009, the School established a Professional Practice Development Panel that sits below the Professional Behaviour Committee. The aim of the panel was to facilitate targeted support to students needing assistance and the development of appropriate standards of behaviour. Those students likely to be referred are for a mixture of academic, health and professional issues. On average, 33 students are referred a year to the panel (28 in 2013) and the reason for referral is 70% professionalism issues, 31% health / personal issues, and 19% academic issues (some students present with a number of issues).

While the team understood the philosophy behind the development of such a panel, it was aware that the presence of senior academic staff was perceived as confronting to students. Additionally, the presence of a student representative on the panel presented confidentiality concerns for the students. The School is attempting to improve the student understanding of the panel, though the team considered that review is required to ensure a clear separation between disciplinary and support processes at this level. Implementation of a less-confronting behavioural pathway for students is encouraged, with inclusion of the student representative on the panel being optional at the discretion of the student appearing before the panel, and students should always be aware that they may take a support person with them to the Professional Practice Development Panel. The team recommends that this review should be followed by an evaluation of the change to the professional support process.

The team noted that the curriculum provides excellent learning opportunities for self-care and self-identification of at-risk behaviours with its Doctor and Law, Ethics and Professional Practice theme integrated through the program.

7.5 Student representation

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

The Griffith University Medical Students Society (GUMS) is the student society that provides advocacy and support through academic, social and community activities. The students also have two other societies: Surgia for students with an interest in surgery, and Hope4Health a charity that aims to improve health outcomes for local, rural, First Peoples and international communities.

Through GUMS, students are strongly represented on committees and in the decision making processes of the School. Students feel valued and the students appreciate the opportunities given by the School for this level of participation. Students are not on the Assessment and Evaluation Committee but this was not seen as an issue by the students or staff.

7.6 Student Indemnification and insurance

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

The University holds medical malpractice, professional indemnity, student accident and public liability insurance to cover the activities of all students within the medical program. The School indemnifies students while at Australian healthcare facilities.

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.

The School has outstanding purpose-built facilities on campus, housed in the Griffith Health Centre building that opened in 2013. This ten-floor building houses the School of Medicine and a number of other health schools, including Dentistry and Oral Health, and the School of Rehabilitation. Its design lends itself to interprofessional learning. There are shared lecture facilities, supporting seminar rooms and multidisciplinary health clinics. The School has sole access to 22 problem-based learning rooms each of which accommodates up to 10 students in spacious, well-illuminated and well-connected surroundings. There is capacity for increased student numbers. These facilities are ideal for problem-based learning, for the teaching and learning of advanced communication skills, for clinical skills, and provide multiple OSCE stations when the rooms are partitioned.

The team was very impressed with the extensive and modern, well-appointed anatomy facilities which have appropriate security and safety design features. The dissecting laboratories are enhanced by an extensive and extremely well-maintained museum of gross anatomical and pathological specimens. There are also three specialist pathology laboratories, a histology/pathology laboratory, a surgical skills laboratory and a plastination lab.

Clinical facilities are of a good standard at all clinical school sites (Logan, Tweed, Wesley and Rural) and are outstanding at the recently-opened Gold Coast University Hospital. The School can be rightly proud of its co-located academic and clinical facilities at the Gold Coast campus.

The Gold Coast University Hospital opened in 2013 and includes a separate Pathology and Education building that houses state-of-the-art auditorium facilities. There are simulation facilities which also facilitate interprofessional learning. Though the Gold Coast University Hospital has not yet opened all its beds, its capacity of 750 overnight beds enables room for student expansion. Staff and students of the hospital have reciprocal access to the School's facilities on campus. Within the hospital, there are also study spaces, teaching and meeting rooms. The hospital site has a new light-rail terminus for travel south to the Gold Coast. Future development at the site includes a private hospital, and the 2018 Commonwealth Games village being built nearby is slated in future to become part of the health knowledge precinct. The Health Group and School are commended for the vision and planning of the Health Centre building, and for their involvement in the development of the Gold Coast University Hospital.

The Gold Coast University Hospital and Health Service encompasses Robina Hospital, and while Griffith students may rotate here, Bond University students predominantly

undertake rotations at Robina, and Griffith students tend to major at Gold Coast University Hospital.

The team visited a number of clinical sites. Logan Hospital is a 330 bed hospital serving a population of 300,000, and is a 40-minute drive north of the Gold Coast campus, and 5-minutes from the Griffith Logan campus which students can access. Logan Hospital has satisfactory student facilities in demountable buildings adjacent to the hospital, and has a new student common room in the hospital building, though there is little room for further expansion of student facilities. The hospital is expanding its patient-load in rehabilitation and paediatrics. Many students commute long distances to attend the clinical school and parking may be at some distance from the hospital, presenting safety concerns after hours. The School has proactively worked with the hospital to implement a bus service to the parking site.

At the Wesley Hospital, a large private hospital in metropolitan Brisbane, a clinical school has been established which is shared with University of Queensland and Bond University students. The hospital accommodates 12 Griffith students at a time. Students have access to the education centre for study and online access to Griffith IT. Students from all three schools are taught a common tutorial program that was developed following a cross-analysis of the three curriculums.

Student facilities at Tweed Hospital in northern New South Wales, are housed in a purpose-built building which includes meeting rooms, clinical staff offices, simulation facilities, a library and recreational facilities. Clinical placements are shared equally with Bond University and a process is underway to better align curriculum delivery with student timetables.

The Queensland Rural Medical Longlook program is an innovative student placement that enables up to 24 students to experience clinical placement for a year at a time in either Year 3 or Year 4 in rural towns on the Darling Downs and in the South Burnett region. The team visited the Queensland Rural Medical Education centre in Toowoomba, which is modern and has tutorial and problem-based learning rooms, clinical skills and simulation training space; and the Warwick Hospital, also with student facilities including modern problem-based learning and tutorial rooms. The main infrastructure developments have been the construction of accommodation and teaching facilities at Kingaroy, Warwick and Stanthorpe funded by Health Workforce Australia in collaboration with Queensland Rural Medical Education and Queensland Health. The rural school provides free student accommodation close to its sites.

The team noted detailed information, including relevant University policies, concerning security, safety, health and well-being of students and staff in the School's submission.

8.2 Information resources and library services

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

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

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

The School has developed its own web-based learning management system, the School of Medicine Resource Management System. The team commends the School on this system which is well-integrated with the program curriculum. Its many uses include the maintenance of problem-based learning cases (including resources, tools, evaluation); a resource database and access to online resources; online student case report delivery; lecture and workshop listings; and the Year 3 and 4 curriculum framework. It manages scheduling of tutorial groups, student preferences and clinical placements, and provides a calendar function for each student which is updated automatically. It also manages school-specific staff and student data and reports (refer also to Standards 3, 4 and 6).

The School of Medicine Resource Management System is linked with and is dependent upon the University-wide Blackboard IT system. The resource management system has enabled the School to adapt its curriculum and evaluation systems to the IT platform with great flexibility and adaptability. This initiative has been managed by a small and stable team of committed IT staff. It is critically dependent on the knowledge and skills of the support staff and the system is therefore at risk in the event of any unplanned changes in the support staff.

Student internet access is variable across the School's sites and is reportedly poor at Tweed Hospital. Students at Tweed frequently resort to using their smart phone 'hotspot' capability to connect to the School's systems and to use the internet. At Tweed Hospital, this is the result of limited bandwidth for the hospital generally and is not confined to students. While the School may have limited influence on hospital IT decision-making, this remains a significant issue for students at Tweed Hospital.

Library facilities on the Gold Coast campus are excellent, with a modern and spacious main library housing print, online and recreational resources. The School has access to over 58,000 medical books both print and electronic. It has access to more than 13,000 journals in both print and electronic format. There is a biomedical section of the library housed in a quiet area. The library subscribes to a wide range of major medical databases and other health databases.

All clinical schools with the exception of Wesley Hospital have on-site libraries which vary in size and range of services. Students at Wesley have texts available and appeared

satisfied with online library and resource access. Students on rural placement are able to borrow books from their remote location and to access library services including IT assistance. The library also offers workshops and training services to students. There is also a range of self-help resources.

8.3 Clinical learning environment

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

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

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

8.3.4 The medical education provider actively engages with other health professional education providers whose activities may impact on the delivery of the curriculum to ensure its medical program has adequate clinical facilities and teaching capacity.

Patient contact is embedded in all years of the program and is graded in a way that ensures students are ready for clinical practice and that graduates are prepared for internship.

In Years 1 and 2, students are exposed to simulated patients on campus and to 20 hospital-based teaching sessions per year. Students in Years 1 and 2 are placed in two general practice placements and students attend four short-term placements in community organisations, including Aboriginal and Torres Strait Islander services.

In Years 3 and 4, there is more extensive patient contact with six by seven-week rotations in Year 3 at one of four teaching hospitals (Gold Coast, Logan, Tweed and Wesley). In Year 4, students undertake three by seven-week rotations including a seven-week term in general practice.

The Longlook program enables 14 Year 3 students to spend an entire year at a rural placement in rural hospitals and general practice clinics located across southern Queensland. The rural placement is also available in Year 4. Students are exposed to a wide range of patients from all 'blocks' on a weekly basis. The students and medical education staff monitor students' exposure to the required case-mix determined by the learning objectives of each block. Rural students are also required to complete three additional one-week blocks in surgery, cancer care (radiation / oncology) and acute mental health.

The School has over 300 general practice placements in rural and metropolitan practices. Students are expected to attend for a minimum of 20 sessions of general practice during the seven week rotation, and the general practice rotation includes

additional sessions of specialist teaching in ophthalmology and dermatology. Both the School and students confirmed that the general practice term is considered to be lighter in work-load than other terms, so was often used as revision time for examinations. The three half-day general practice sessions per week compare unfavourably with the 35 hours of clinical work expected in the hospital-based blocks.

The team considered that the requirement of 20 sessions of general practice is at the lower end of expectation compared with most medical schools and that this disparity, combined with the term being seen as light in load, may send an unintended signal to students about the value of general practice to the Australian health care system. It recommends that the School review its general practice rotation requirements.

There is a wide range of clinical teaching facilities from rural and metropolitan general practice settings through to hospital-based settings which facilitate group learning and bedside experience. The students affirmed the variety of teaching facilities as an asset of the program, and the team heard positive commentary regarding all sites.

Students can elect to take two years in the same clinical setting, for example a rural setting or at a private hospital, and gain valuable clinical experiences in these settings. While noting that rural students do undertake three one-week rotations away from rural, and that the Wesley Year 4 placement includes a rotation to a public emergency department, the team recommends that the School ensure there are mechanisms in place that indicate that such students have an equivalent experience to those students undertaking varied rotations. This may include supervision from junior doctors, exposure to a wider range of clinical contexts, including specialist units in public hospitals.

The Aboriginal and Torres Strait Islander curriculum is in development and includes problem-based learning cases, symposia and planned teaching in cultural awareness and sensitivity (refer to Standard 3.5). Opportunities for clinical placements in Aboriginal and Torres Strait Islander communities are limited. There are some GP placement opportunities at Kalwun Health Centre and Inala Indigenous Health Service. Alternatively, there are selective or electives options for placements in regional or remote Aboriginal communities. Students may also see Aboriginal and Torres Strait Islander patients in any clinical placement. The team recommends that experience in Aboriginal and Torres Strait Islander health could be strengthened and that increased opportunities could be provided.

The School shares clinical sites with Bond University at Gold Coast University Hospital and Health service sites, Tweed Hospital and Wesley Hospital and shares some rural sites with Bond University, through Queensland Rural Medical Education.

The Gold Coast University Hospital Student Placement Committee supports a synergistic relationship between the Health Service, Griffith, and Bond. The Committee advised it coordinated 150 Griffith students across the Gold Coast Hospital and Health Service sites including Gold Coast University Hospital, Robina Hospital, Carrara Rehabilitation and community centres. The maximum number of medical students on placement on

any day across all year levels and the two programs was 300 students. The Committee has facilitated alignment of placement schedules between Griffith and Bond, and requires its staff to teach the students as future colleagues, not as Griffith or Bond students.

The team found that the number of students placed at each site is appropriate to provide adequate clinical experience. The successful cooperative relationship between Griffith and Bond Universities with respect to clinical placements and combined teaching activities is strongly supported by clinicians at all co-located sites, and the team was impressed by the well-organised approach and the enthusiastic teaching culture. The collaborative arrangements in all locations with Bond were impressive and a credit to all involved.

In addition to Bond, the School shares Wesley Hospital with University of Queensland medical students, which also works well for both schools. The University of Queensland Rural Clinical School at some rural practices has an overlapping footprint with Griffith's Rural School through Queensland Rural Medical Education. The team noted the absence of a formal agreement with the University of Queensland in this regard (refer also Standard 1.6) and recommends that the two rural schools work to improve communication and potential collaborations.

Clinical teachers reported seeing generally little or no difference between cohorts from each School.

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.

Clinical placements are overseen by a placement officer who liaises closely with administration staff at each of the clinical schools. Hospital coordinators provide the School's placement officer with details of clinicians, ward rounds and other activities in each hospital. Similar coordination occurs in the case of rural placements.

There are clinical subdeans at each of the clinical schools who are responsible for the orientation of clinical supervisors and the publication of guides for supervisors. Clinical subdean appointments are shared between the University and Queensland Health (or NSW Health in the case of Tweed Hospital). The clinical subdeans provide teaching staff with a *Clinical Supervisor Guide* that covers expectations of teachers, resources available,

student responsibilities, student attendance requirements, and processes for staff to follow for students experiencing difficulties.

Expectations of students, of supervisors and of the University itself are clearly articulated and are prominent on the School's website, in printed form (*Clinical Supervisor Guide*) and in relevant university policies. Clinical subdeans run orientation programs for clinical supervisors on at least an annual basis. The Year 3 and 4 academic manager and theme and discipline leads also liaise with the clinical subdeans and clinician teachers.

Monitoring of student progress is ensured by communication between clinical supervisors and the School, through various School committees and by the involvement of clinical supervisors in training assessment and in the setting and marking of examination questions.

Training for clinical supervisors is provided through online resource and central School-based training workshops. The team noted that training opportunities were not widely utilised by clinical supervisors.

There are close links between the School and each of the clinical settings which ensures that clinical supervisors have sufficient time to teach. While the School pays fees to hospitals and directly to general practitioners, the team observed at all sites a generosity of spirit amongst clinical teachers where teaching is motivated by altruism.

The team was impressed with the commitment and enthusiasm of clinical supervisors at all sites they visited, and with the well-organised liaison and support provided to them by the School.

Appendix One Membership of the 2014 assessment team

Professor Wayne Hodgson (Chair) BSc, PhD, GradDipHighEd

Deputy Dean (Education) Faculty of Medicine, Nursing and Health Sciences, Monash University

Associate Professor Kirsty Foster (Deputy chair) BSc, MBChB, DRCOG, Med (ALGC), PhD

Associate Professor in Medical Education, Associate Dean International Sydney Medical School, and Subdean (Education) Sydney Medical School Northern, University of Sydney

Professor Alastair Burt MBChB, MD, FRCPATH, FRCP, FSB

Executive Dean, Faculty of Health Sciences, University of Adelaide

Dr Peter Dohrmann MBBS, FRACS, GradDipOccEnvH, FRACMA

Clinical Director, International medical graduate assessments, Royal Australasian College of Surgeons

Professor Imogen Mitchell BSc (Hons) MBBS, PhD, FRCP, FRACP, FCICM

Deputy Dean, ANU Medical School, Australian National University

Professor Jennifer Reath MBBS, Dip RACOG, FRACGP M Med

Foundation Peter Brennan Chair of General Practice, the University of Western Sydney

Ms Stephanie Tozer

Manager, Medical School Assessments, Australian Medical Council

Ms Fiona van der Weide

Accreditation Administrator, Australian Medical Council

Appendix Two Groups met by the 2014 assessment team

Senior leadership

Dean Academic

Dean of Medicine / Head of School

Dean Research

Deputy Head of School

Pro Vice Chancellor (Health)

Vice Chancellor

Academic Provost

School of Medicine staff

Academic Manager Year 1 and 2

Academic Manager Years 3 and 4

Administration staff

Associate Academic Manager Years 3 and 4

Chair of the Medical Program Curriculum Committee

Chair of the Professional Behaviour Committee

Chair of the Professional Practice and Development Panel

Chair of the Research Committee

Clinical co-ordinator Rural Clinical

Clinical Subdean Gold Coast Hospital

Clinical Subdean Logan Hospital

Clinical Subdean Rural Program

Clinical Subdean Tweed Hospital

Clinical Subdean Wesley Hospital

Convenor Human Skills of Medicine

Course Convenor, First Australians Social and Emotional Wellbeing

Course Convenor, Health Challenges for the 21st Century

Course Convenor, Human Skills of Medicine

Course Convenor, Pathology General (for the Dental Program)

Director of medical studies

GUMURRII Student Support Unit, Office Manager

Lead in Admissions and Assessment
Lead in Doctor and Health in the Community
Lead in Doctor and Knowledge of Health and Illness
Lead in Doctor and Law, Ethics and Professional Practice
Lead in Doctor and Patient
Lead of Equity, Access and Admissions
Lead of Program Assessment and Evaluation
Medical Librarian
Professor in Population Health
Program Convenor, Bachelor of Environmental Health
Program Convenor, Bachelor of Public Health
Program Convenor, Honours Programs
Program Convenor, Master of Health Services Management
Program Convenor, Master of Public Health
School Administration Officer
School of Medicine Year 1 Coordinator
Senior Administration Officer
Senior Lecturer, Clinical Skills

School of Medicine Committees

Assessment and Evaluation Committee
E-Learning IT group
Health Group – Interprofessional Learning Steering Group
Medical Program Curriculum Committee (Education Committee)
Professional Practice and Development Panel
School of Medicine Committee
School of Medicine Research Committee
Selection and Admissions Committee
Years 1 and 2 Committee
Years 3 and 4 Committee

Stakeholders

Dean of Medicine, Faculty of Health Sciences and Medicine, Bond University

Deputy Executive Director, Medical Services, Queensland Health

Griffith University Council of Elders

Head, School of Medicine, University of Queensland

Medical Students

Griffith University Medical Society representatives

Students representing different subgroups – Domestic, Rural, International and Indigenous

Students from clinical sites

Clinical sites

Gold Coast University Hospital

Clinical school staff

Clinicians and adjuncts

Hospital executive

Student placement committee

Hope Island GP Clinic

Practice Manager

GP clinical teachers

Logan Hospital

Clinical school staff

Clinicians and adjuncts

Hospital executive

Rural Clinical School

Clinical school staff

Clinicians and adjuncts

Queensland Rural Medical Education staff

The Tweed Hospital

Clinical school staff

Clinicians and adjuncts

Hospital executive

Joint clinical placements committee

The Wesley Hospital

Clinical school staff

Clinicians and adjuncts

Director of Medical Services

