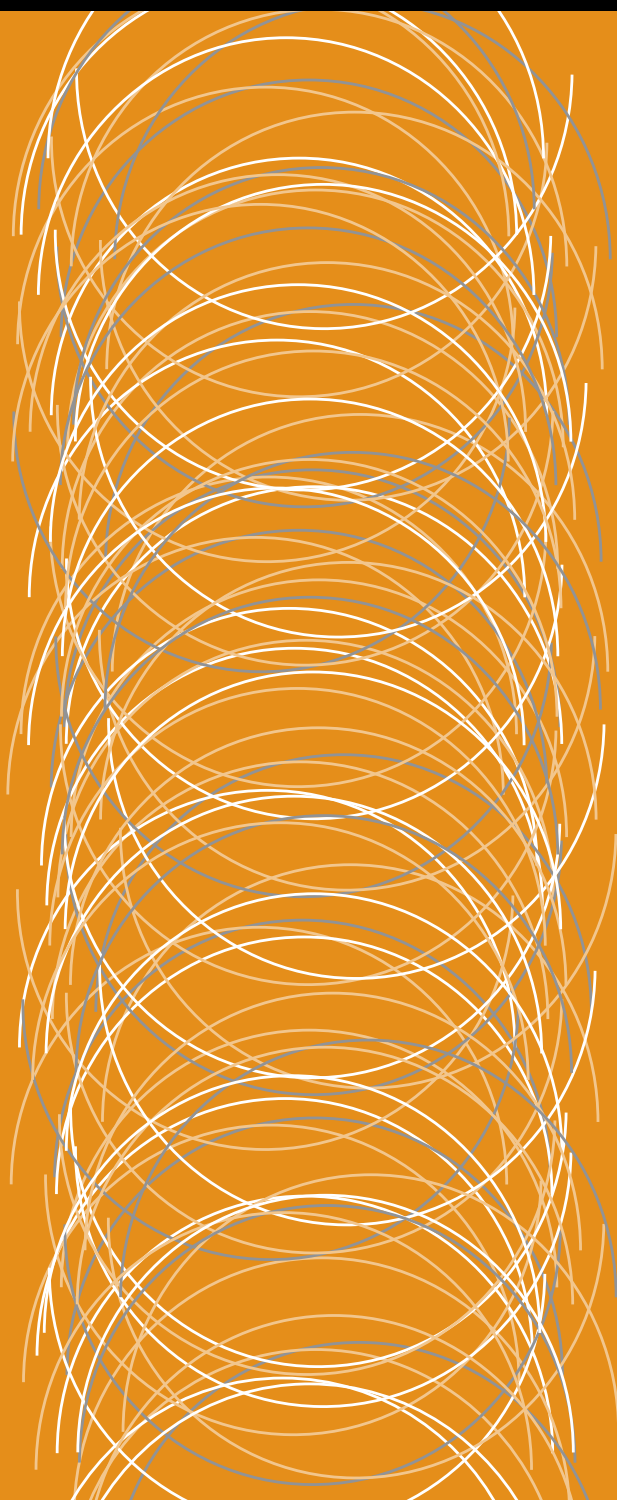


Australian Medical Council Limited

Accreditation of  
University of Auckland  
Faculty of Medical and  
Health Sciences

AMC



Medical School Accreditation Committee  
June 2015

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Australian Medical Council Limited

Australian Medical Council Limited  
PO Box 4810  
KINGSTON ACT 2604

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

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## Executive summary 2015

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### Accreditation process

The University of Auckland, Faculty of Medical and Health Sciences is seeking reaccreditation of its Bachelor of Medicine / Bachelor of Surgery (MBChB) medical programme.

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<sup>1</sup> 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.

Under a Memorandum of Understanding, the AMC and the Medical Council of New Zealand (MCNZ) agree to assess programs of study based mainly in Australia and New Zealand, leading to general or specialist registration of the graduates of those programs to practise medicine in Australia and New Zealand, to determine whether the programs meet approved accreditation standards, and to make recommendations for improvement of those programs.

The agreement assures the Medical Board of Australia and the Medical Council of New Zealand that a medical school's program of study satisfies agreed standards for primary medical education, and for admission to practise medicine in Australia and New Zealand. The MOU outlines processes for joint assessment of medical programs between the AMC and MCNZ.

The AMC first assessed the Faculty's Bachelor of Medicine / Bachelor of Surgery (MBChB) medical programme in 1995, and granted accreditation for the maximum period. It conducted a reaccreditation assessment in 2005 and reaccredited the program for the maximum possible period. In 2010, the Faculty submitted a comprehensive report and the AMC Directors found that the programme met the standards, and extended accreditation for four years until 31 December 2015, subject to satisfactory progress reports. The Faculty submitted a satisfactory progress report to the AMC in 2012, as part of the AMC's ongoing monitoring process.

For the 2015 reaccreditation assessment, an AMC team reviewed the Faculty's submission and the Auckland Medical Students Association's submission, and visited the Faculty and associated clinical teaching sites in the week of 2 March 2015.

This report presents the team's findings against the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012*.

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<sup>1</sup> N.B. 'Program' is used in the report when referring to medical programs in the context of the National Law, and AMC accreditation standards and procedures. The Faculty's MBChB is spelled 'programme', and this spelling is used in the report when referring to the Faculty's MBChB.

## **Decision on accreditation**

Under the Australian 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 in Australia.

The AMC also reports its decision to the Medical Council of New Zealand, and the Council makes a final decision on accreditation of the medical education provider and its medical program for registration purposes in New Zealand, in the independent exercise of its own discretion.

## **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. At the conclusion of this period, or sooner if the education provider requests, the AMC will conduct a review. The provider may request either:
  - o full accreditation assessment, with a view to granting accreditation for a further period of six years; or
  - o more limited review, concentrating on the areas where deficiencies were identified, with a view to extending the current accreditation to the maximum period (six years since the original accreditation assessment).
- (iv) Accreditation may be withdrawn where the education provider has not satisfied the AMC that the complete program is or can be implemented and delivered at a level consistent with the accreditation standards. The AMC would take such action after detailed consideration of the impact on the health care system and



on individuals of withdrawal of accreditation and of other avenue for correcting deficiencies.

**At their 28 July 2015 meeting, the AMC Directors agreed that they were reasonably satisfied that the Bachelor of Medicine / Bachelor of Surgery (MBChB) medical programme of the University of Auckland, Faculty of Medical and Health Sciences meets the approved accreditation standards.**

The AMC Directors agreed:

- (i) That accreditation of the University of Auckland, Faculty of Medical and Health Sciences MBChB programme **be granted for a period of six years; that is until 31 March 2022**, subject to satisfactory progress reports; and
- (ii) That accreditation is subject to the following conditions:  
*2016 conditions*
  - o Establish a mechanism to ensure that community and health service consumers are consulted on key issues relating to the curriculum, graduate outcomes and governance (Standard 1.1.3).
  - o Demonstrate consistency of the programme's Graduate Learning Outcomes with all AMC Graduate Outcome Statements (Standard 2.2).
  - o Demonstrate that the assessment methods and formats in use to assess the Personal and Professional Skills domain learning outcomes are fit for purpose (Standard 5.2.1).
  - o Complete an overarching assessment blueprint structured by phase and year (Standard 5.2.2).
  - o Demonstrate that the mechanism for appeals regarding selection is publicly available (Standard 7.2.4).

## Key findings of the AMC's 2015 reaccreditation assessment of the University of Auckland, Faculty of Medical and Health Sciences' medical programme

<b>1. The context of the medical program</b>	<b>Met</b>
--	------------

Standard 1.1.3 is substantially met.

### *2016 condition*

Establish a mechanism to ensure that community and health service consumers are consulted on key issues relating to the curriculum, graduate outcomes and governance (Standard 1.1.3).

### *Commendations*

The degree of coherence in and functionality of the programme governance structure, which is a reflection of the outstanding leadership at University, Faculty, School, Head of Medical Programme and departmental levels, and a collaborative approach from all staff within the Faculty and externally (Standard 1.1).

The effective change management process and broad Faculty engagement related to the introduction of the reinvigorated curriculum (Standard 1.3).

The Department of General Practice's close engagement with the 200 practices in its teaching network (Standard 1.6).

The extent of staff development undertaken in Hauora Māori to maximise integration of the Hauora Māori domain throughout the programme (Standard 1.8).

<b>2. The outcomes of the medical program</b>	<b>Met</b>
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Standard 2.2.1 is substantially met.

### *2016 condition*

Demonstrate consistency of the programme's Graduate Learning Outcomes with all AMC Graduate Outcome Statements (Standard 2.2.1).

### *2016 recommendation for improvement*

Undertake further detailed evaluation to confirm the delivery of equivalent outcomes across all domains and disciplines, and to verify parity of standards in workplace-based assessments (Standard 2.2.3).

<b>3. The medical curriculum</b>	<b>Met</b>
----------------------------------	------------

All standards are met and there are no conditions.

### *Commendations*

The Faculty and Te Kupenga Hauora Māori's vision and endeavours to embed the Hauora Māori domain across the curriculum (Standard 3.5).

The Pūkawakawa longitudinal programme, which demonstrates ongoing engagement and commitment by the Faculty and its partners including the District Health Board, and the clinical teachers involved in the programme (Standard 3.6).

*2016 recommendation for improvement*

Map course learning activities to the programme's Graduate Learning Outcomes and course objectives to expose any gaps or areas of duplication (Standard 3.4).

<b>4. Teaching and learning</b>	<b>Met</b>
---------------------------------	------------

All standards are met and there are no conditions.

*Commendations*

The 'First patient' project, involving full-body anatomy dissection for all Year 2 students throughout the year followed by a presentation on their patient (Standard 4.1).

The General Practice Office Patient Simulations teaching initiative in Year 4, and the Integrated Learning Activities such as the Human Early Life Development project which requires students to visit a mother, baby and family over two years, recording a variety of information about child development (Standard 4.1 and 4.3).

The progressive accumulation of clinical skills in a safe environment prior to use in clinical practice, including the extensive use of simulation activities (Standard 4.3).

Interprofessional learning including the Māori Health Intensive (with nursing and pharmacy students); the Quality and Safety Symposium (with nursing, pharmacy and optometry students); and 'ward calls' (with nursing and pharmacology students) (Standard 4.7).

*2016 recommendations for improvement*

Promote consistency across sites in the use of online resources by clinical / discipline teachers in their site-based teaching (Standard 4.1).

Develop and implement a coherent model for planning and support of appropriate role modelling in the programme (Standard 4.5).

Establish an interprofessional learning curriculum and structure to coordinate interprofessional learning across Faculty programmes (Standard 4.7).

<b>5. The curriculum - assessment of student learning</b>	<b>Met</b>
---	------------

Standard 5.2 is substantially met.

*2016 conditions*

Demonstrate that the assessment methods and formats in use to assess the Personal and Professional Skills domain learning outcomes are fit for purpose (Standard 5.2.1).

Complete an overarching assessment blueprint structured by phase and year (Standard 5.2.2).

#### *Commendations*

The Faculty's considerable effort and expertise devoted to implementing programmatic assessment with its emphasis on assessment for learning (Standard 5.1).

The particularly well-developed feedback from the progress testing, which ensures that students receive timely and extensive feedback after each progress test (Standard 5.3).

#### *2016 recommendations for improvement*

Provide further training and feedback to clinicians to ensure that all domains of the Clinical Supervisor Reports are assessed, to calibrate their understanding of the criteria and standards, and to promote the quality of feedback by supervisors (Standard 5.2).

Demonstrate improved formative feedback to students relating to the Personal and Professional Skills portfolio (Standard 5.3).

Embed a process of evaluation of all aspects of student assessment to ensure that the assessment programme is working as intended (Standard 5.4).

<b>6. The curriculum – monitoring</b>	<b>Met</b>
---------------------------------------	------------

All standards are met and there are no conditions.

#### *Commendation*

The Faculty's analyses of cohorts of its Māori and Pacific Admission Scheme, which have led to significant changes to the selection criteria and the processes of entrance (Standard 6.2).

#### *2016 recommendations for improvement*

Develop and implement an overarching strategy for curriculum monitoring, evaluation and research (Standard 6.1.1).

Demonstrate improved dissemination of outcome evaluations to students and clinicians (Standard 6.3).

<b>7. Implementing the curriculum – students</b>	<b>Met</b>
--	------------

Standard 7.2.4 is substantially met.

#### *2016 condition*

Demonstrate that the mechanism for appeals regarding selection is publicly available (Standard 7.2.4).

### *Commendations*

Te Kupenga Hauora Māori's well-developed scheme to attract and support Māori and Pacific students, and the Whakapiki Ake project which engages with Māori secondary school students to promote health as a career; and the Māori and Pacific Admission Scheme (Standard 7.2).

The Faculty's progress towards its goal that Māori and Pacific students should constitute up to 25% of the total medical programme student intake, with 20.3% of the 2014 intake being Māori and Pacific (Standard 7.1).

The systematic approach to student support and the measures implemented to support all students (Standard 7.3).

<b>8. Implementing the curriculum - learning environment</b>	<b>Met</b>
--	------------

All standards are met and there are no conditions.

### *Commendation*

The high degree of enthusiasm and commitment of the clinical supervisors across all sites, which is a notable strength of the programme and is highly valued by the students. This reflects the efforts and leadership of Faculty and its academic staff (Standard 8.4).

### *2016 recommendations for improvement*

Demonstrate improved integration of the resources available on the portal with the clinical scenarios, in order to facilitate student learning in all phases (Standard 8.2).

Ongoing enhancement of ICT facilities at the regional sites to ensure adequate access, bandwidth and infrastructure for learning (Standard 8.2).

Enhance the orientation process for new clinical supervisors by way of a standardised induction program and an overall framework for teaching development (Standard 8.4).

## Introduction

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### **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 *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012*, and in the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2011*. The accreditation standards list the graduate outcomes that collectively provide the requirements that students must demonstrate at graduation, and define the curriculum in broad outline, as well as 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 the 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 medical education provider's accreditation submission forms the basis of the assessment. The medical student society is also invited to make a submission. Following a review of the submissions, the team conducts a visit to the medical education provider 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 opportunity for the medical education provider to comment on the draft. The Committee considers the team's draft report and submits the report, amended as necessary, with its recommendation on accreditation to the AMC Directors. The medical education provider is provided with the report and accreditation recommendations and may confirm the report be submitted to Directors, or may ask the Committee to consider changes. The Directors make the accreditation decision. The granting of accreditation may be subject to conditions, such as a requirement for follow-up assessments.

The AMC and the Medical Council of New Zealand have a memorandum of understanding that encompasses the joint work between them, including the assessment of medical programs in Australia and New Zealand, to assure the Medical Board of Australia and the MCNZ that a medical school's program of study satisfies agreed standards for primary medical education and for admission to practise in Australia and New Zealand.

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 programme**

The University of Auckland was established in 1883 as Auckland University College, part of the then University of New Zealand, and was located in a disused courthouse and jail. In 1962, the University became independent following the abolition of the University of New Zealand. In 1968, the School of Medicine commenced teaching.

In 2015, the University of Auckland is the largest university in New Zealand, with over 40,000 students enrolled across its five Auckland campuses, including around 5,000 students enrolled for postgraduate studies, 1,200 of whom are undertaking doctorates. There are more than 6,000 international students and 4,943 staff. The University organisational structure consists of a School of Theology, and eight Faculties representing each of its main disciplines: Arts, Business and Economics, Creative Arts and Industries, Education, Engineering, Law, Medical and Health Sciences, and Science.

The Faculty of Medical and Health Sciences is organised into six schools: Medicine; Medical Sciences; Population Health; Nursing; Pharmacy; and Optometry and Vision Science (added in 2015). The Faculty is based at the University's Grafton campus in Auckland.

Three schools in the Faculty contribute to the medical programme: the Schools of Medicine, Population Health and Medical Sciences. The School of Medicine has seven clinical academic departments that span across the clinical campuses and sites. The departments are: Anaesthesiology, Medicine (including Geriatrics), Obstetrics and Gynaecology, Ophthalmology, Paediatrics: Child and Youth Health, Psychological Medicine, and Surgery. The Department of General Practice and Primary Health Care is in the School of Population Health.

The Faculty has four clinical campuses at Auckland, Waitemata, South Auckland and Waikato (Hamilton), and three clinical sites at Rotorua, Tauranga and Northland (Whangarei).

The Faculty's Bachelor of Medicine / Bachelor of Surgery (MBChB) medical programme is a six-year programme. Year 1 is an overlapping year focused on biomedical science

(for undergraduate students). Both undergraduate and graduate students undergo the selection process for the medical programme at the end of Year 1 for entry into Year 2. Phase 1 of the programme comprises Years 2 and 3 and is focused on fundamentals of clinical practice. Phase 2 comprises Years 4 and 5 and is focused on clinical placements. Phase 3 comprises Year 6 with the aim of preparation for the workforce.

In 2014, the programme had 1,123 medical students enrolled from Years 2 to 6. In 2015 there were 1,204 students enrolled. There are 284 students in Year 2 in 2015. The student society is the University of Auckland Medical Students' Association.

The AMC first assessed and accredited the Faculty's medical programme in 1995. A reaccreditation assessment was conducted in 2005. The Faculty submitted a comprehensive report in 2010, and the AMC Directors accepted the comprehensive report and found that the Faculty met the standards, extending accreditation for four years until 31 December 2015, subject to satisfactory progress reports.

In 2011 following its 2010 curriculum review, the Faculty advised the AMC of a proposal for curriculum change which aimed to update the curriculum in line with best practice in medical education, and to consider the ability of the programme to expand to accommodate an increasing domestic intake of medical students as signalled by the New Zealand government. The Medical School Accreditation Committee determined that the proposed reinvigorated curriculum changes did not constitute a major change. The Committee encouraged the Faculty in its curriculum renewal initiative. The reinvigorated curriculum was introduced to Years 2 and 4 in 2013, Years 3 and 5 in 2014, and Year 6 in 2015.

The Faculty submitted a satisfactory progress report to the AMC in 2012, as part of the AMC's ongoing monitoring process.

### **This report**

This report details the findings of the 2015 reaccreditation assessment. Each section of the accreditation report begins with the relevant AMC accreditation standards.

The members of the 2015 AMC team are given at **Appendix 1**.

The groups met by the AMC in 2015 are given at **Appendix 2**.

### **Appreciation**

The AMC thanks the University and Faculty of Medical and Health Sciences 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**

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## **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.*

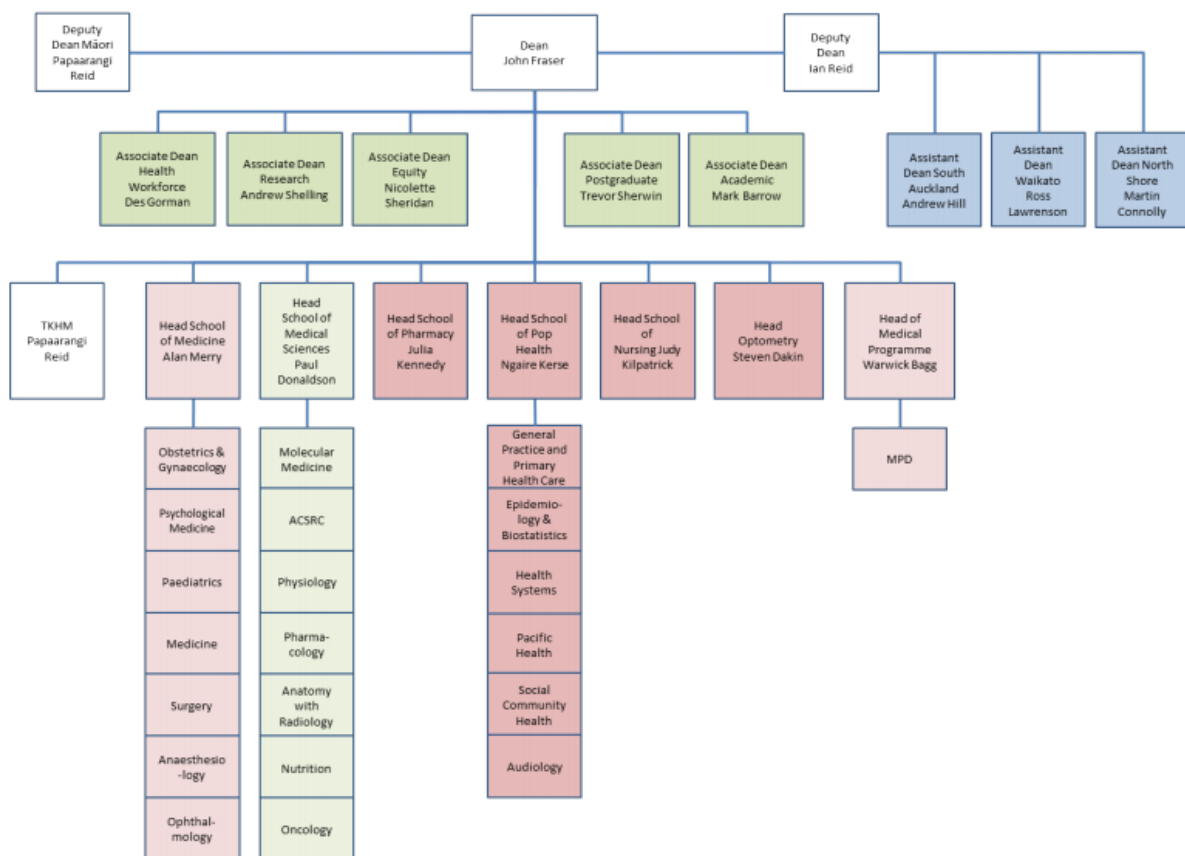
The Faculty of Medical and Health Sciences delivers the medical programme. Based at the University's Grafton campus in Auckland, the Faculty is organised into six schools: Medicine; Medical Sciences; Population Health; Nursing; Pharmacy; and Optometry and Vision Science (added in 2015).

The Dean of the Faculty reports directly to the Vice Chancellor, and is a member of the Vice Chancellor, Deputies and Dean's group that meets weekly, and a member of the University Senior Management team. The team found the Vice Chancellor to be most supportive of the Faculty. The Faculty has staff who are representatives on a variety of University-wide committees.

At Faculty level, the Faculty executive is chaired by the Dean and includes heads of schools, the Head of the Medical Programme, the Tumuaki (Deputy Dean Māori), and directors of finance, operations and human resources. It meets fortnightly to discuss strategic and budgetary matters. The major Faculty Committee meets monthly. The Faculty Education Committee chaired by the Associate Dean (Academic) is the committee to which the programme must provide an annual summary report. The Faculty governance structure is at Figure 1.

The Faculty's medical programme is primarily the responsibility of the School of Medical Sciences; the School of Medicine and the School of Population Health. These Schools are provided with additional support for the programme through Te Kupenga Hauora Māori, the Clinical Skills Centre, the Learning Technology Unit and the Centre for Medical and Health Sciences Education, which each provide Faculty-level services. The Faculty's governance structures for the programme are largely unchanged since the 2005 AMC accreditation assessment, and while the structures are inevitably complex they appear to function well.

**Figure 3: Faculty academic governance 2015**

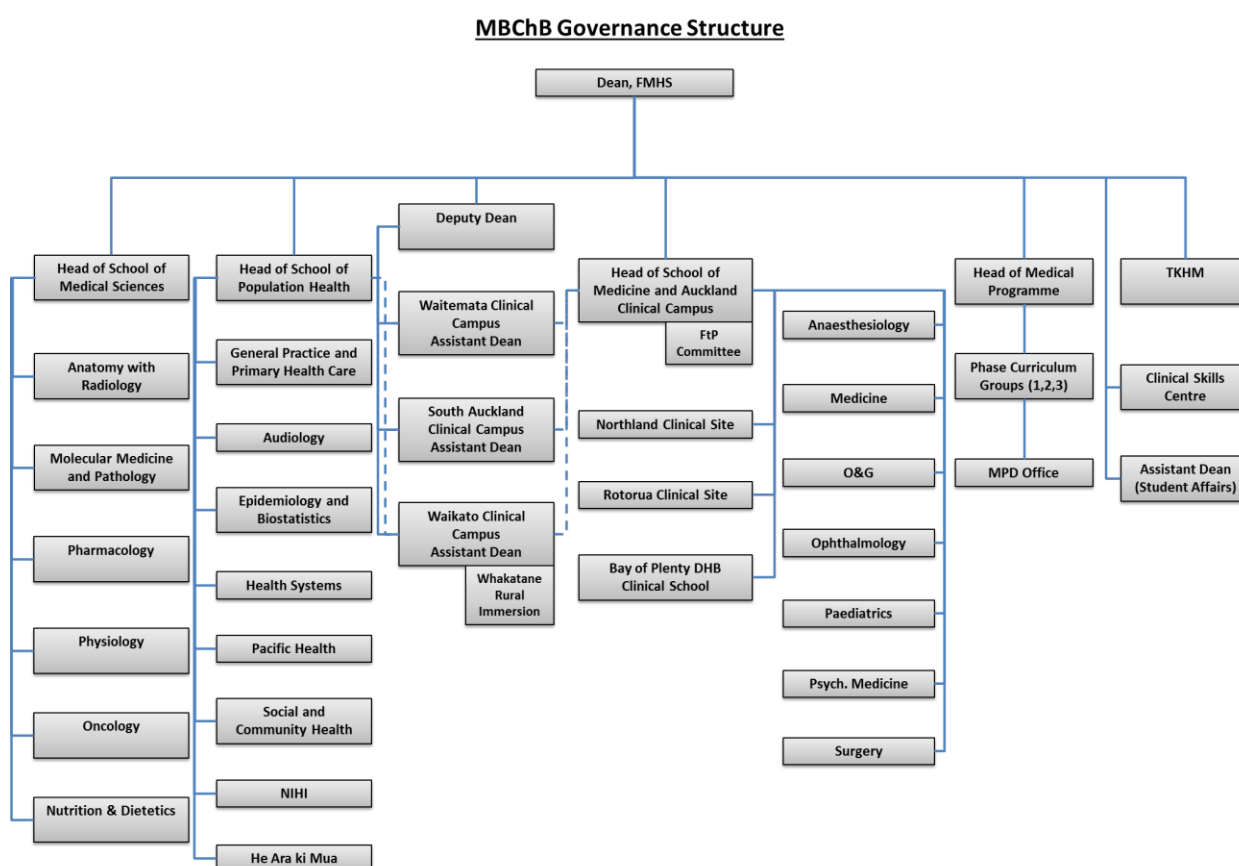


The Te Kupenga Hauora Māori (TKHM) academic group, established in 2005, comprises around 40 academics and professional staff. The group is responsible for teaching, research and service on behalf of the Faculty, as well as supporting the Office of the Tumuaki and the goals of 'Vision 20:20', which is the Faculty's articulation of its goal to support and educate Māori students from secondary school through to graduation. The long-term strategy of TKHM is to build awareness of the cultural and health needs of Māori among staff, students and graduates and provide opportunities to those who wish to contribute to its goals, by way of teaching, mentoring or research.

The medical programme organisational governance structure is shown in Figure 2.

The School of Medicine academic departments are medicine, surgery, anaesthesiology, ophthalmology, obstetrics and gynaecology, psychological medicine, and paediatrics. The Department of General Practice and Primary Health Care is positioned in the School of Population Health, though the Head of Department is a member of the School of Medicine Heads Group.

**Figure 4: Medical programme organisational structure 2015**



The Faculty moved from a clinical school structure to clinical campuses and sites in 2013. There are four clinical campuses which each have an assistant dean and an active group of research academics, and there are three smaller clinical sites each overseen by an academic coordinator. The School of Medicine governs the clinical campuses and sites, although the clinical campuses have a reporting line to the deputy dean. The academic departments have academic oversight of the curriculum delivery, and there is an academic lead at each clinical campus or site. A summary of the clinical campuses and sites is at Table 1.

The Board of Studies and phase groups primarily coordinate the delivery of the medical programme. The membership and terms of reference for these groups appear to be entirely appropriate. The Board sets the programme vision and structure and agrees on the high-level curriculum, assessment and admission strategies (refer to Standard 1.3).

The Phase 1, Phase 2, and Phase 3 Groups are each chaired by the respective phase director and include members from departments and schools. The groups operationalise the directives from the Board of Studies in curriculum and assessment, monitor the phase and provide feedback to the Board of Studies.

**Table 1: Summary of clinical campuses and sites**

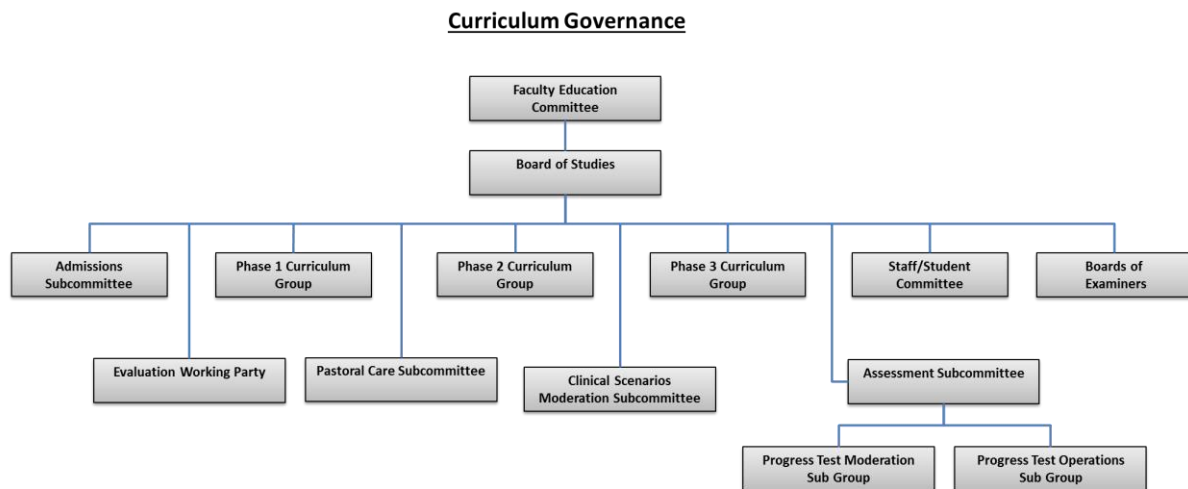
South Auckland Clinical Campus	Based at Middlemore Hospital, first established as a clinical school in 1994. Key partner: Counties Manukau District Health Board
Waikato Clinical Campus	Based at Waikato Hospital in Hamilton, first established as a clinical school in 1978. Key partner: Waikato District Health Board
Auckland Clinical Campus	Based within the University's Grafton campus and adjacent to Auckland City Hospital, first established as the original medical school. Key partner: Auckland District Health Board
Waitemata Clinical Campus	Based at Waitakere Hospital (West Auckland) and North Shore Hospital. Students placed at North Shore since 1984. Key partner: Waitemata District Health Board
Northland Clinical Site	Based at Whangarei, Northland. Established in 2007 with the introduction of the regional-rural year-long Pūkawakawa programme. Key partner: Northland District Health Board
Rotorua Clinical Site	Year 6 students placed since 2002. Year 4 students introduced in 2014. Key partner: Lakes District Health Board
Tauranga Clinical Site	Year 6 students placed since 2011. Year 4 students introduced in 2015. Key partner: Bay of Plenty District Health Board

The Boards of Examiners for each phase are chaired by the Head of the Medical Programme, and have delegated authority from, and report to, the Board of Studies. The Boards consider student assessment results, may recommend remediation, may refer to the Fitness to Practise Committee, and provide feedback to the phase groups, the admissions subcommittee, and academic services manager.

The Assessment Subcommittee, instituted in 2013, implements and monitors the assessment strategy as approved by the Board of Studies, and makes recommendations on assessment for the reinvigorated programme, including the progress testing and assessment of domains and phases. Chaired by the Director of Assessment, it reports to the Board of Studies.

The governance of the curriculum is shown in Figure 3. The Medical Programme Directorate (MPD) provides committee support.

**Figure 3 - Curriculum governance 2015**



MPD prepares agendas, writes draft policy papers, keeps track of the 'business' for all these committees.

The team found that within the Faculty there were some instances of dual and overlapping reporting lines. Assistant deans at clinical campuses are members of the Board of Studies and also report to the Dean via the Deputy Dean, and not to the Head of the Medical Programme. In practice this structure works largely as a result of the strong working relationships of the incumbent staff.

The team commends the degree of coherence in and functionality of the programme governance structure. This is a reflection of outstanding leadership at University, Faculty, School, Head of Medical Programme and departmental levels, and a hugely collaborative approach from all staff within the Faculty and externally. The University plans to move the School of Population Health from the Tāmaki campus to the Grafton campus in around five years, which will further improve this high degree of cohesion.

The Faculty consults widely at national and local levels in developing its curriculum, graduate outcomes and governance structure. The Faculty's engagement, partnership and leadership at government and health service provider levels is excellent. The Faculty has a number of both formal and informal relationships with health and research bodies and to a lesser extent local community bodies. There is strong collaboration with New Zealand-based and international universities. The inclusion of student representatives on nearly all committees associated with the delivery of the programme is applauded.

While the input of health service policy makers and providers is significant, with the exception of Te Kupenga Hauora Māori and a single lay person on the Board of Studies, there is little evidence for consultation with or input of health service consumers or local populations into the curriculum, graduate outcomes or governance processes, as required by the accreditation standards. The Faculty should establish a mechanism, such as an advisory board or other structure, to seek input from the community, including health service consumers and future patients of the medical practitioners that

are being trained. This is likely to be of increasing importance as patient expectations and health priorities change in the future.

## **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 Board of Studies has power to implement significant changes within the year-long courses without University approval. Changes to admissions procedures and major changes can require University approval, but there are clear processes to facilitate these approvals.

The academic head of the programme is the Head of the Medical Programme, who chairs the Board of Studies, and reports to the Dean. The head liaises with the three heads of schools, and works most closely with the Head of the School of Medicine. As chair of the Board of Studies, the role of the Head of the Medical Programme includes leading the design and delivery of the curriculum, leading the Medical Programme Directorate, and having delegated authority for academic decisions. The Dean confirms the decisions made by the Board of Studies. The Head's responsibilities were clearly documented, and the team found that the role was well-understood by all parties.

The Faculty advised that there had been no changes to its autonomy since the 2005 accreditation and none were foreshadowed for the next period of accreditation.

## **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 Board of Studies is the committee that sets the programme vision and structure and agrees on the high-level curriculum, assessment and admission strategies. Chaired by the Head of the Medical Programme, it is an inclusive board from across the programme. Its membership includes the heads of schools of medical sciences, medicine and population health; and members from each academic department, phase, domain, and each clinical campus.

The Board meets monthly and makes decisions by consensus. Its decisions are informed and implemented by its subgroups, which include the phase groups, assessment groups, admissions and student support groups.

The Board played a major role in the development of the reinvigorated curriculum, considering and approving recommendations from a design team formed by the Dean, and requiring the phase groups to implement the curriculum changes. The Board has

also determined changes to the subgroups including the introduction of the Assessment Subcommittee to oversee progress testing, which has two streams of moderation and operations. It introduced the Clinical Scenarios Moderation Group responsible for the suite of clinical scenarios (refer to Standard 3.3); and the Pastoral Care Subcommittee which grew from the development of the Professional and Personal Skills domain. The Phase 2 Group has also now split its functions due to its large size, with one group focused on the formal learning, and the other on clinical attachments.

The team agreed that the Board of Studies functioned exceptionally well and had been successful in drawing wide engagement across the programme. The team commends the effective change management process and broad Faculty engagement related to the introduction of the reinvigorated curriculum.

The medical programme is approved by the New Zealand Committee on University Academic Programmes and is listed by the New Zealand Qualifications Authority.

## **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 team was impressed by the degree of medical educational expertise across the Faculty, including within the Medical Programme Directorate, Te Kupenga Hauora Māori, the Centre for Medical and Health Sciences Education, and the Learning Technology Unit.

The Medical Programme Directorate is the educational and operational support unit of the programme and the Board of Studies. It meets on a monthly basis to discuss operational issues and academic coordination across sites and departments, and includes a mix of academic and professional staff.

The membership of the Medical Programme Directorate displays strong academic scholarship in relation to educational expertise. The breadth of content expertise is impressive, and includes two new positions: Director of Assessment and a psychometrician. The recent re-invigoration of the programme demonstrated a high degree of academic rigour, innovation and adherence to best practice where applicable.

Te Kupenga Hauora Māori (TKHM) is an academic group within the Faculty (refer to Standard 1.1) that provides significant input in terms of Indigenous curriculum development and research. TKHM has thirteen staff employed as academics (10.25 full-time equivalent) at levels from associate professor to senior tutor. Ten identify as Māori, one as Pacific and seven hold medical qualifications. The Faculty is to be congratulated for the leadership and commitment to Māori health through this endeavour.

The added dimension of a research centre focusing on medical and health science education is a positive initiative. The Centre for Medical and Health Sciences Education offers certificate, diploma, masters and research doctorate level qualifications in health professional education. The internal development and widespread uptake of medical

education qualifications among academic staff are strengths. The programme is also supported by the Faculty's Learning Technology Unit, which consists of a team of six staff (4.4FTE) who assist with the development of multimedia and flexible learning projects.

## **1.5 Educational budget & resource allocation**

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

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

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

Ultimate financial control for the programme rests with the Dean. Budgets are held by heads of schools and the head of Te Kupenga Hauora Māori, and the management of staff and courses is devolved to the departments within schools. An internal budget model is used to distribute budget between schools taking into account the quantity, intensity, frequency, and geography of the teaching undertaken by each school. A review process is undertaken with the head of the medical programme, and the heads of the Schools of Medicine, Medical Sciences, Population Health and the head of Te Kupenga Hauora Māori.

Income from base funding includes a per equivalent full-time student based allocation provided through the Tertiary Education Commission (TEC), and revenue earned from student fees. TEC fees are set by government by defining the level of funding and the number of students funded. This income is not subject to significant change, although TEC funding was recently revised upwards for medicine to grow student numbers, and the University was instrumental in providing data to support this increase. The growth in additional income is expected to plateau around 2020 when student numbers reach a steady-state. The only source of extra income is international students, which is capped at 10%. Domestic full-fee places are not permitted in any New Zealand programme that receives TEC funding. Income is offset by a central University contribution which is negotiated on an annual basis, and by the costs of increased delivery of the programme at dispersed sites.

The School of Medicine's budget includes the budget for operational and staffing expenses at the clinical campuses and sites, as negotiated with the assistant deans and academic coordinators. The School pays a weekly fee per student to cover clinical teaching and student supervision, and funds clinical academic time.

The Board of Studies approves the purpose and objectives of the programme and any financial costs are included in its considerations. The heads of schools as members of the Board of Studies would consider the financial implications for their schools with the Dean. An example of successful change in resource load cited was the increased



footprint of general practice that required agreement between a number of schools, Board of Studies approval and sign-off by the Dean.

The team considered that the Faculty has sufficient resources allocated to sustain it for the next period of accreditation. The Faculty has benefited from investment in infrastructure during the growth period, providing modern teaching and research facilities to the programme.

## **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 formal and informal partnerships between the Faculty and all sectors of the health service are excellent.

The University has formal memorandums of understanding with each of the District Health Board (DHB) teaching sites. These agreements include shared values and core principles, they specify student numbers and timelines, and note curriculum implementation and the requirement to meet AMC standards.

The formal agreements are supported by meetings at Faculty level with the Dean and DHB Chief Executive Officer two to four times a year, and include Faculty school heads. The assistant deans at the clinical campuses work closely with their DHB. Teaching contracts with approximately 200 individual general practices are renewed annually by the Department of General Practice and Primary Health Care, and the team commends the Department on its close engagement with the practices in its teaching network. The Faculty has links with the primary health organisations and rural health networks. There are community placement opportunities with 260 health related agencies in Auckland, Northland and Waikato.

There are Faculty staff whose roles on a range of external groups can inform the programme, with groups including the Health Quality and Safety Commission, the Taskforce for Prevocational Training, and Health Workforce New Zealand.

The Faculty has good engagement and formal agreements with health service providers in communities with significant Māori and Pacific populations. There is explicit engagement with Māori stakeholders at University level via the Pro Vice Chancellor (Māori) and at Faculty level in the role of the Tumuaki (Deputy Dean Māori). The District Health Boards are also engaged with local Māori health networks and the Māori Medical Practitioners' Association.

Te Kupenga Hauora Māori manages relationships with Māori communities and stakeholders. The kaumātua (Māori elders) and the cultural and community liaison staff member engage with regional Māori communities and also have a role in the cultural wellbeing of staff and students. Kaumātua were recipients of a 'LIMElight' award in 2013 for their role in leading Māori community engagement. Direct community feedback is encouraged, with regular feedback from students' families and community members reported to be received.

## **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.*

As New Zealand's leading research institution, the University of Auckland rates highly in a number of international rankings, and the Faculty is strong in research. It is clear that the programme curriculum is informed by research and that research regarding the scholarship of teaching within the programme is well-integrated.

The Faculty has, or is affiliated with, a range of research centres across all disciplines. Two of the New Zealand government's six Centres of Research Excellence are based at the Faculty, being the Maurice Wilkins Centre targeting cancer, diabetes and infectious disease; and Brain Research New Zealand focused on the ageing brain and brain health.

The Auckland Academic Health Alliance was launched in 2013 between the University and the Auckland District Health Board to align functions related to teaching, research and patient care, and is intended to ensure a faster translation of clinical research into patient care.

There are active research groups at the clinical campuses of Waikato and South Auckland supported by the Faculty and the District Health Boards. The Faculty reported that research at its clinical sites is variable and it planned to provide supports to promote research.

Students have opportunities to engage in research during the programme (refer also to Standard 3.6). There are a range of elective projects, and medical students can undertake the BMedSc (Hons), a one-year fulltime intercalated research degree from Year 3 onward in which nine students were enrolled in 2014. The Master of Medical Science offers postgraduate study in a chosen field.

## **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 Faculty has a full-time equivalent staffing profile of 264 academics which is sufficient to deliver the programme. Approximately, the School of Medicine has 140 full-time equivalent (FTE) academic staff, the School of Medical Sciences has 130 FTE and the School of Population Health has 82 FTE.

There are joint clinical appointments which may be either university appointments, whereby the Faculty charges the District Health Board for clinical service hours, or District Health Board appointments with Faculty buy-back of teaching time. There are also around 890 honorary clinical teachers. Table 2 shows a summary of the FTE of academic and clinical staff from the three schools that deliver the programme to illustrate the adequacy by department and discipline. This table does not include those staff who are 'buybacks' by department, of which there are 72 FTE across all departments.

The team considered that the academic staff base is stable and experienced, and noted that any vacancies are readily filled. The depth of expertise in the academic departments and at clinical sites ensures succession and will support the growth in student numbers.

The University reviewed its professional staff roles in 2014, and the Faculty maintained its professional staff numbers and protected its Medical Programme Directorate and TKHM structures. There are a small number of technical staff in the programme to support lab-based teaching and shared facilities. The team considered that the professional and technical staff profile was adequate.

**Table 2: Summary of FTE by school and clinical site**

School and Discipline	Number of Staff	Clinical (DHB, private and other) FTE	University funded FTE
<b>School of Medical Sciences TOTAL</b>	<b>175</b>	<b>8.6</b>	<b>145.3</b>
<b>School of Medicine</b>			
SOM Management	3	0.3	2.5
Anaesthesiology	17	7	7.6
Medicine	68	34.5	25.6
Obstetrics & Gynaecology	29	9.6	13.5
Ophthalmology	23	3.4	15.7
Paediatrics	39	11.4	12.2
Psychological Medicine	28	6.1	18.5
Surgery	45	21.7	18.5
CMHSE	8	0.5	4.6
<b>School of Medicine TOTAL</b>	<b>268</b>	<b>95.6</b>	<b>122.7</b>
<b>Clinical Campuses / Sites*</b>			
South Auckland Clinical Campus	5	0.7	2.4
Waikato Clinical Campus	1	0.5	0.5
Waitemata Clinical Campus	1	0	0.7
Northland Clinical Site	1	0	0.5
<b>Clinical Campuses / Sites Total</b>	<b>8</b>	<b>1.2</b>	<b>4.1</b>
<b>School of Population Health</b>			
General Practitioners & Primary Health	27	13.9	8.0
Māori Health Research	9	0	3.9
Pacific Health	4	0	4
Audiology; Epidemiology & Biostatistics; Health systems	<b>64</b>	<b>0</b>	<b>49.6</b>
<b>School of Population Health TOTAL</b>	<b>103</b>	<b>13.9</b>	<b>65.5</b>

The Faculty's success in the recruitment of 13 full-time equivalent Māori and Pacific academics is a laudable achievement. Inability to make an appointment at Professor level within Te Kupenga Hauora Māori is acknowledged and there is a clear strategy in place to address this issue. The continued commitment of the Faculty leadership to the recruitment of Māori and Pacific people is endorsed. TKHM provides leadership training for staff and students in the cultural and health needs of Māori and provides opportunities for those who wish to contribute to its goals by way of teaching, mentoring or research.

The team commends the comprehensive level of integration of the Hauora Māori domain throughout the programme and the extent of the staff development to maximise the implementation of both the learning opportunities and assessment.

The Faculty's processes in the use of patients and community members for learning and teaching are appropriate. Volunteer real patients may consent to be involved, and healthy volunteers may be used as physical examination subjects, and receive a written guide, an exam day pre-briefing and a post-exam debriefing. The Faculty has a core-team of actors paid to be simulated patients, and it also employs gynaecology teaching associates who are trained to take a teaching and participatory role.

The University has liability policies to indemnify staff for their involvement in the development and delivery of the programme. Additionally, New Zealand's Accident Compensation Corporation provides personal injury cover for all citizens, residents and temporary visitors. The Medical Protection Society, a not-for-profit mutual indemnity organisation, provides advice and indemnity for medical staff concerning legal issues arising as a result of their clinical practice.

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

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

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

The University has excellent processes for recruitment and promotion of academic staff, with a balance of capacity for teaching, research and service. This extends to clinical honorary appointments.

Opportunities for staff development are extensive. The availability of programmes of study within the domain of health professional education are exemplary.

## **2 The outcomes of the medical program**

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### **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 Māori 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 Faculty's purpose is clearly defined and seeks to respond to societal and community needs. The purpose is: 'to improve the health of our local, national and global communities through excellence in teaching, research service and engagement'. It has a clearly articulated vision as follows:

'Operating as an integral part of the University of Auckland, the Faculty of Medical and Health Sciences will:

- o produce diverse graduates who achieve excellence in their chosen fields and lead the improvement of health outcomes in New Zealand and abroad;
- o be an acknowledged equal of our peer institutions in the quality, quantity and impact of our research, and a world leader in key areas of research;
- o influence and advance positive change in the Faculty, University and broader community, through staff participation in service and leadership within and beyond the University;
- o reduce inequities in education and health through access to our programmes, our curriculum, our research, and our commitment to the principles of the Treaty of Waitangi; and
- o be a Faculty that, through reputation, attracts high quality international students seeking undergraduate or postgraduate degrees.'

The Faculty's strategic plan is aligned to the University's, incorporates the Faculty's purpose and vision, and is updated every three years. The 2014 – 2016 plan outlines its objectives and priorities to influence future investment.

The Faculty understands its responsibilities, including those relating to Māori health. Acknowledgement of the Treaty of Waitangi in the Faculty's vision and mission statements is wholly appropriate. The Faculty Strategic Plan 2014 – 2016 includes objectives designed to reduce inequity, by increasing Māori and Pacific student numbers to at least 17% of the full-time student load, and to track research outputs in Māori and Pacific health. The 'Vision 20:20' project aims to increase the proportion of Māori in the health workforce to 10% by 2020 through the recruitment, preparation and retention of Māori students, and is an outstanding example of the commitment of the Faculty to reducing inequity.

The Faculty has engaged with stakeholders in defining its purpose and vision for the medical programme. The Faculty's vision document requires the programme to be built on the needs of the communities it serves, and to recognise the social and cultural aspects of medical practice in New Zealand.

A formal consultation process has not been used to define the programme's purpose as the Faculty relies on its existing relationships with a wide range of stakeholder organisations. Although the Faculty appeared to be well-engaged with the communities it served, it was not clear to the team what formal mechanisms the Faculty utilises to gain input from these stakeholders. As noted at Standard 1.1, the team considers there is a need to enhance community engagement and lay input into the programme in a systematic way that responds to changing demographic profiles, health needs and expectations of local populations.

## **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 programme's graduate outcomes were revised as part of the curriculum review for the re-invigorated programme. The programme's 26 Graduate Learning Outcomes are grouped in five domains:

- Applied Science for Medicine – 3 outcomes
- Clinical and Communication Skills – 9 outcomes
- Personal and Professional Skills (a new domain since the revision) – 8 outcomes
- Hauora Māori – 3 outcomes; and
- Population Health (previously Population and Community-based Health) – 3 outcomes.

While comprehensive Graduate Learning Outcomes have been defined, these are not fully consistent with the AMC Graduate Outcome Statements. The Faculty states that the

AMC Graduate Outcome Statements are met through a combination of its Graduate Learning Outcomes and module and course learning outcomes across Phases 1 to 3, associated with specific learning activities within the medical programme.

The Faculty should undertake further work to demonstrate the consistency of its Graduate Learning Outcomes with all of the AMC Graduate Outcome Statements as required by the accreditation standards. This would communicate the graduate outcomes of the programme to students and other stakeholders with an interest in the programme.

Numerous anecdotal reports attested to the high quality of graduates from the programme. These reports need to be supported by systematic outcome evaluation data. The team is encouraged by the active plan of evaluation using correlation with the Medical Schools' Outcomes Database and other forms of postgraduate evaluation data. Faculty academic staff have strong links with both prevocational and vocational medical training programmes.

Each academic department has a key role in ensuring equivalence of delivery across sites within its discipline, and each clinical campus and site has an academic lead. Departments are required to monitor student assessment outcomes and make submissions to the Board of Examiners. The team noted that the Faculty had undertaken initial comparison work that demonstrated equivalence of assessment results across sites in the first iterations of the progress tests in the clinical years. Wider distribution of these reassuring findings to students and clinical Faculty staff would be appropriate.

Further work is required to review assessment results with regard to specific discipline areas. The Faculty is encouraged to develop a plan for further, detailed evaluation to confirm the delivery of equivalent outcomes across all domains and disciplines, and to verify parity of standards in workplace-based assessments. It would be an essential part of this process to report summary results back to both students and staff.



### 3 The medical curriculum

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#### 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 medical programme is six-years for undergraduate entry students or five-years for graduate-entry students.

The framework of the reinvigorated curriculum is based on 'The role of the Doctor', and the Board of Studies has developed a systematic approach to deliver the required learning throughout the programme's duration.

Year 1 is known as Overlapping Year 1. It is a preparation year for undergraduate health professional students including common foundation courses. On completion of Year 1, those students selected into the medical programme have their credit transferred into the programme. Graduate-entry students enter from Year 2 with credit from their undergraduate study.

From Year 2, the programme is organised into three phases, arranged largely as organ-system modules and clinical discipline based attachments, with integrated domain content. Phase 1 of the programme comprises Years 2 and 3 and is focused on fundamentals of clinical practice. Phase 2 comprises Years 4 and 5 and is focused on clinical placements. Phase 3 comprises Year 6 with the aim of preparation for the workforce.

The one plus five year programme model, and the three-phase structure did not change with the introduction of the reinvigorated programme. The reinvigorated curriculum was introduced to Years 2 and 4 in 2013, Years 3 and 5 in 2014, and Year 6 in 2015.

The team considered that the programme provides for delivery of a strong curriculum comprising Graduate Learning Outcomes that broadly represent the expected range of learning defined by the AMC Graduate Outcome Statements.

The programme structure and duration is outlined at Figure 4.

**Figure 4: Programme structure 2015**

<b>Phase 3 (6) 42 wks</b> Auckland, Hamilton, Rotorua, Tauranga & Whangarei	Medicine/ Surgery/Emergency Medicine/Obstetrics & Gynaecology/ Psychiatry/ Paediatrics/ General Practice/ Clinical Imaging 8 week elective and 3 week option <b>or</b> 11 week research project					
<b>Phase 2(5) 35 wks</b> Waitemata / Auckland South Auckland Mid North Island	Paediatrics	Obstetrics & Gynaecology	General Practice	Selective	Psychiatry	Specialty Surgery
<b>Phase 2(5) 36 wks</b> Pūkawakawa	Integrated Care & General Practice		Specialty Surgery	Selective	Psychiatry	Women & Children's Health
<b>Phase 2(4) 41 wks</b> Auckland South Auckland Waitemata Waikato and Rotorua	General Medicine	Specialty Medicine	Geriatrics	Musculoskeletal	Anaesthesia logy	General Surgery GP/OP Emergency Medicine & Acute Care (GP)
<b>Intercalated</b>	C4.3.4 <b>BMedSc(Hons)</b> which may lead to PhD					
<b>Phase 1 (3) 26 weeks</b>	Professional and Clinical Skills 2		Professional and Clinical Skills 2			
	Nervous System	Reproduction & Development	Sensory Systems	Blood, Immunity & Infection Regulation of Body Function		
	Medical Humanities					
<b>Phase 1 (2) 26 weeks</b>	Principles of Medicine		Principles of Medicine			
	Professional and Clinical Skills 1		Professional and Clinical Skills 1			
	Musculoskeletal System	Digestive System	Respiratory System	Respiratory System	Cardiovascular System	Genitourinary System
	Human Anatomy, Pathology, Physiology laboratories, ILAs					
<b>Year 1 24 weeks</b>	BIOSCI: Cellular Processes and Development (15) POPLHLTH: Population Health (15) CHEM: Chemistry of the Living World (15) Central Concepts of Biology / Health and Society (15)			MEDSCI: Organ Systems (15) Physics for the Life Sciences / Behaviour, Health & Development (15) Foundations of Biochemistry / Health Systems 1 (15) General Education Option (15)		

## 3.2 The content of the curriculum

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

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

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

### 3.2.2 Clinical Practice: The medical graduate as practitioner

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

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

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

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

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

The curriculum is organised around five domains, which provide a coherent structure for the programme. As shown in Table 3, four of these align approximately with the AMC domains while the Hauora Māori (Māori health) domain is separate, but integrated with the others in its delivery. This design specifically recognises the imperative of medical education both for, and about, the Māori population. Identification of Hauora Māori as a stand-alone domain is considered a strength of the curriculum, providing a focus for development of a range of initiatives throughout the programme.

**Table 3: Alignment of the programme's domains with the AMC domains**

Programme domains		AMC domains
Hauora Māori	Applied Science for Medicine	Science and Scholarship
	Clinical Practice and Communication Skills	Clinical Practice
	Personal and Professional Skills	Professionalism & Leadership
	Population Health	Health & Society

The scientific foundations of medicine are introduced in Overlapping Year 1, which is undertaken with a large cohort of students, many of whom will pursue other career paths in the health and medical sciences. Students choose from a range of courses, including four compulsory courses that provide a basis for learning in cell and organ biology and physiology. The Applied Science for Medicine domain is well-established in Phase 1 of the programme, with organ system modules taught in Years 2 and 3, though with enhanced clinical relevance in Year 3. These concepts are reinforced in Phase 2.

Phase 1 students are required to develop an understanding of research activities, and research opportunities are available during the programme for interested students (see Standard 3.6).

The Population Health domain has a strong basis in Overlapping Year 1 with a compulsory population health course. Students spoke highly of their population health learning in this year and the perspective it provided for them on their future as doctors. The early experience in population health is a driver for learning in Phases 2 and 3 of the curriculum, through activities that are well-integrated with other areas of the curriculum and drawn together in Year 5 in the Population Health Intensive. Although graduate entry students do not undertake the Year 1 population health course, the Faculty considered that the integration of population health in the programme allowed them to attain the required outcomes.

The team was impressed by many aspects of the Personal and Professional Skills domain, which runs as a longitudinal, coherent thread throughout the programme. This domain prepares students for their roles as junior doctors, role models and advocates. The reinvigorated curriculum in Year 2 added Health and Wellbeing to the domain, strengthened the Year 3 modules, and introduced the portfolio (refer to Standards 4.1 and 5.3). In Year 5, a clinical leadership week has been introduced. The domain is under active development, in consultation with the phase committees with a view to further developing the Personal and Professional Skills curriculum vertically, and with other domain groups to ensure optimal horizontal integration of learning.

The introduction of Clinical Practice and Communication Skills in Phase 1, and its staged development throughout the programme, is also a strength. Phase 2 allows students to apply their knowledge and skills in clinical environments. The Year 6 procedural skills was moved to Year 4, and more targeted procedural skills have been introduced to Year 6 in 2015. The reinvigorated programme has seen an increase in the geriatrics and the emergency attachments.

The team considered that the curriculum content enables graduates to achieve the specified AMC graduate outcomes through a combination of content that maps to the Graduate Learning Outcomes and content that maps to lower-level learning outcomes associated with specific learning activities.

### **3.3 Curriculum design**

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

Overlapping Year 1 has been designed with the involvement of a diverse range of teachers, and Faculty staff teach in three of the Year 1 courses. This involvement facilitates articulation with Phase 1 for students continuing into the medical programme.

In Phase 1 (Years 2 and 3), the modular, organ-based structure provides for effective horizontal integration of related learning between disciplines. More deeply embedded

topics, like biochemistry and molecular biology are covered in Principles of Medicine which runs in parallel, as does learning in Professional and Clinical Skills (see Figure 4 Programme structure 2015). Learning in these domains spirals through to placements in Phase 2. This is particularly evident with Professional and Clinical Skills where clinical skills are built upon throughout the programme, initially in a very structured fashion via simulation.

Students in Phase 2 (Years 4 and 5) are exposed to a variety of clinical contexts, with cohorts of students placed at clinical sites where the goals are to gain experience in a range of different settings, to develop clinical skills and to engage in apprentice-type learning from consultants and teams. Small-group sessions and formal learning weeks promote interaction across disciplines to reinforce evidence-based and scientific principles, and optimise consistency across the cohort. The scope of the formal teaching topics is comprehensive.

Phase 3 (Year 6) is structured as a 'pre-internship' year with ongoing threads of all domains evident in 42 weeks of clinical experience, combined with formal teaching and assessment. The Advanced Cardiac Life Support course exemplifies this with content covering multiple domains. An expectation of high levels of clinical involvement under the supervision of qualified clinicians provides a safe environment for workplace learning.

There is excellent articulation in Phase 3 with subsequent stages of training by way of its focus on preparing students to enter the workforce. Students, alumni and supervisors whom the team met across teaching sites reported that graduates were well-prepared for clinical work.

The Faculty has introduced a large suite of clinical scenarios (>180) with the reinvigorated programme. The clinical scenarios are a re-useable web-based and open-access resource that range across all areas of the curriculum. They integrate the five domains of the programme and provide a basis for longitudinal learning. Teachers of any discipline may select a scenario/s as a basis for learning, and students in all phases access the same scenarios. It was clear that a great deal of planning and work had gone into the development of these scenarios using a cooperative approach between phase groups, the disciplines and domains.

The team recognised that the clinical scenarios are an emerging tool that the Faculty hopes will facilitate vertical integration and enhance learning. It was evident for example that in the later part of the programme, the clinical scenarios reinforce the need for students to re-visit basic science learning. The Faculty acknowledged that the existing clinical scenarios were still being refined and new scenarios being developed. Updates in future progress reports will be of interest.

### 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.*

Course learning outcomes are provided in the course guides developed for different parts of the curriculum and are available to students via the web portal. In some cases departments provide additional course learning outcomes, e.g. for some elements of teaching delivered in the modules, and in *MyPsychiatry* and *MyPaediatrics* in Phase 2. While the Faculty is diligent in providing course guides, these are not always accessed or utilised by students to the fullest extent possible.

The team found that at times it was difficult to determine how the different learning opportunities and activities provided to students reflect a higher-order educational strategy. This lack of clarity includes the clinical scenarios, which students are uncertain of how to use effectively as they progress through the three phases.

The team recommends that the Faculty map learning activities to Graduate Learning Outcomes and course learning outcomes, to expose any gaps or areas of duplication. This would more easily identify different learning streams, improve opportunities for communicating both the broad and specific learning goals, and facilitate assessment blueprinting.

Such an approach may also improve the utility of the clinical scenarios, by allowing students to more readily identify the resources best suited to their individual learning needs. Clear articulation of the pedagogical principles driving development of the scenarios, and how they relate to students in different phases of the curriculum, will help students, lecturers and teachers make best use of the resources they provide.

### 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).*

The programme's Hauora Māori (Māori health) domain has been a component of the curriculum since 2002. Hauora Māori addresses the imperatives of education both for and about Māori and Pacific peoples.

It is evident that the Indigenous curriculum is highly valued across the Faculty. The Faculty's academic group Te Kupenga Hauora Māori (TKHM) has strong support from the Faculty's Board of Studies, and continues to develop and incorporate new initiatives into the curriculum, both in the Hauora Māori domain and in other domains.

At a foundational level there is a clear recognition of and respect for cultural practice and guardianship. In Year 2, students receive a seminar on the cultural aspects of death and take part in the Whakanoa cultural activity before entering the anatomy laboratory. The Māori Health Intensive week, also in Year 2, is an excellent initiative that was first established in 2002. Students attend a series of lectures and seminars, and small interprofessional groups of 10-12 medical, pharmacy and nursing students participate

in interactive workshops, case-based learning sessions, problem solving and poster development sessions. Students discuss a range of issues including concepts of ancestry and ethnicity, and the relationship of these to racism, health and access to healthcare.

In Phases 2 and 3, there are formal Hauora Māori learning sessions that reflect the learning outcomes for the domain. The Māori Health Intensive is followed up in formal sessions presented in Years 4 and 5. TKHM staff have approved all domain-related aspects of the clinical scenarios, and the domain descriptors and criteria on the Clinical Supervisor Report that is used in Phases 2 and 3. The responsible staff have done a superb job of communicating the ethos to the various clinical sites.

There is evidence that the initially high standard of clinical performance of students in the Hauora Māori domain following the Māori Health Intensive declines over time in the programme. In some instances, students have adopted leadership roles to compensate for perceived shortcomings of clinical teachers. In others it appears that students in the later phases of the programme are not applying their early learning. These issues have been identified and acknowledged by both Faculty and students, and steps are being taken to address problem areas.

In the reinvigorated Phase 3 in 2015, formal learning has been revised and will include a Māori health session, sessions on addressing bias, and student reflection on practice. The team encourages the Faculty in its steps to address this challenge and looks forward to further reports on developments in teaching and learning, particularly in Phases 2 and 3 of the programme, including positive role modelling by the clinical leaders.

The team commends the Faculty and TKHM on their vision and endeavours to embed the Hauora Māori domain across the curriculum.

### **3.6 Opportunities for choice to promote breadth and diversity**

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

There are significant opportunities for breadth and diversity in the reinvigorated programme. Undergraduate entry students have course options in Overlapping Year 1 which are mainly science-based, but must also include one general education option. Following this, in the first semester of Year 3 students choose a medical humanities option from an offering that includes units in medical ethics, comparative literature, medicine and the law, art history and spirituality.

The University's strong research culture provides a range of opportunities for students to observe, participate in and undertake options in research. These range across a variety of disciplines within medical science, and outside medical science including mental health, child and family studies, Māori health and culture.

Phase 1 students are required to develop an understanding of research activities, and interested, talented students may elect to undertake a Bachelor of Medical Science year

of study, between Phases 1 and 2. From 2014 able students, selected on grade-point average basis, may select a research option within the medical humanities in Year 3. Further research opportunities are available with an optional ten-week summer scholarship predominantly for Phase 1 students (in 2013/14, 91 medical students elected to complete it), and in Year 6 in the form of an eight-week elective or a more substantial eleven-week research project.

Students in Year 5 undertake a five- or six-week selective in order to improve their knowledge and skills in an area of interest, or known or perceived weakness. This selective may be undertaken in any discipline and in a number of countries. A small number of students are required by the Board of Examiners to undertake a directed selective.

In Year 5, students may apply for the Pūkawakawa programme. The programme runs for the entire year (36 academic weeks) in the Northland regional communities, and is based at Whangarei Hospital. While the curriculum content and assessment are identical for this programme, the delivery is adapted for the region and includes integrated care rotations to smaller Northland communities encompassing both hospital and community (general) practice.

The Faculty and its partners, including the District Health Board, have spent significant effort on planning and ongoing support for this programme. The team was impressed by the high level of engagement and commitment of clinical teachers and Health Board staff involved in the programme. Pūkawakawa is well regarded by students, so selection for this program is highly competitive. The Faculty might consider developing further innovative models of learning and programme delivery in rural and regional contexts.



## 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 Faculty utilises a wide range of teaching and learning methods throughout the varied contexts and settings in the programme. With an increased number of students and sites, more on-line resources have been developed.

In Overlapping Year 1, the large cohort size of over 1,100 health professional students requires lectures to be given in two streams. Students have small group tutorials and laboratories led by teaching assistants, who are often post-graduate students or may be medical students.

Phase 1 core material is delivered largely in lecture format comprising around 58% of formal learning hours. The Phase 1 Committee reported that this reflects a reduction in the proportion of lecture-based delivery of core material in the re-invigorated programme and has been achieved in the context of increased clinical content in Phase 1. Staff were aware of the growing need to address new ways of engaging increasingly digitally-oriented students, as reflected by the clinical scenarios initiative.

Other methods of teaching and learning in Phase 1 include medical science laboratory sessions, practical skills tutorials and anatomy dissection. The team commends the 'First Patient' project, which involves a full-body anatomy dissection for all Year 2 students throughout the year followed by a presentation on their patient, as an excellent teaching initiative.

Phase 1 contact hours are displayed in Table 4.

**Table 4: Phase 1 contact hours**

Phase 1 Hours 2014	Lectures	Laboratories	Clinical Problems/ Tutorials	Clinical Skills	Small Group Activities	Wards	Special activities*	Total
Year 2								
Hours	259	80	23	18	28		35	443
Hr/Week	9.3	2.9	0.8	0.6	1		1.3	15.9
Year 3								
Hours	264	39	16	26	16	30	50	441
Hr/Week	10.2	1.5	0.6	1	0.6	1.2	1.9	17

\* Special activities include in Year 2 - Māori Health Intensive and General Practice visits, and in Year 3 - Basic Life Support training, Quality and Safety Symposium and Medical Humanities option.

The Faculty has made a concerted effort to deliver content in an interdisciplinary manner. Learning modules in Phase 1 are organ-based, to co-ordinate and focus the relevant subject material from the different disciplines. This approach is reinforced by use of five Integrated Learning Activities, which are highly appreciated by students. The

team acknowledged the high-level development that had gone into these activities, and the valuable learning experiences they provide for students, particularly in the Human Life and Early Development module.

The design of the reinvigorated programme has provided increased opportunities for small group learning. In the Personal and Professional Skills domain open discussion, role-play, simulated consultations and interactive exercises are used. Students expressed some concern that their experiences could vary considerably between small groups. However, the team was satisfied that the learning outcomes are well defined, and that the tutor guides clearly describe the required learning. The Personal and Professional Skills tutors whom the team met were committed to delivering the defined curriculum. Communication with students to address this perception is encouraged.

In the Clinical Practice and Communication Skills domain students engage in patient-focussed problem-solving sessions facilitated by clinical teachers, and have small clinical skills group practice with peers and simulated patients. There is consideration being given to developing further small group learning activities for use in lecture slots where application of student learning is the focus of activity.

Phase 2 prioritises learning in the clinical context with three methods of delivery of formal learning: campus (approximately 55 hours per year); synchronous (15 x 2 hours in Year 4) and asynchronous (20 hours in Year 4 and 21 hours in Year 5).

**Table 5: Phase 2, formal learning weeks in Auckland**

<b>Formal Learning Weeks 2014</b>	<b>Lectures/seminars</b>	<b>Tutorials; clinical problems in small groups</b>	<b>Clinical visits / instruction</b>	<b>Total</b>	<b>Orientation/evaluation/Other</b>
<b>Year 4</b>					
Formal Learning 1	12	10		24	2
Formal Learning 2	28			30	2
Formal Learning 3	22	5		27	
Formal Learning 4	24	8	1	31	2
<b>Total Year 4</b>	<b>86</b>	<b>23</b>	<b>1</b>	<b>112</b>	
Mean scheduled hours per week					28
<b>Year 5</b>					
Formal Learning 1	23	8.5		32.5	1
Formal Learning 2	23	6		28	
<b>Total year 5</b>	<b>46</b>	<b>14.5</b>		<b>60.5</b>	
Mean scheduled hours per week					30.12

Clinical practice and communication skills are acquired in a wide range of clinical settings including hospital and community placements. Students are assigned to a site for a year and are not placed in one site for more than a year. Within these sites,

students are able to access hospital and community-based formal learning opportunities. A typical clinical attachment week is shown in Table 6.

**Table 6: Phase 2 - a typical clinical attachment week**

Monday	Tuesday	Wednesday	Thursday	Friday
See patients and clinical activities with team	See patients and clinical activities with team	Case presentations Clinical tutorials	See patients and clinical activities with team	See patients and clinical activities with team
			Practice or hospital teaching session	Practice or hospital meeting session
Ward or clinic activities  On call with team	Synchronous learning, own learning time, seeing patients, practising skills, case reports	Ward or clinical activities	Case presentations Clinical tutorials	Own learning time seeing patients, practising skills, projects, case reports

The Faculty has taken a pragmatic but innovative approach to campus-based learning to minimise time required and maximise learning opportunities. Sessions attempt to cover all domains in the curriculum, and there was excellent student feedback on some sessions, particularly the multidisciplinary symposia. Another example is the Year 5 clinical leadership week, in which two days are devoted to leadership skills, and two days to 'ward calls', an interdisciplinary simulation based teaching. Students reported the 'ward calls' were particularly useful.

The team noted attendance issues at some of the campus-based teaching, attributed by students to two separate issues. First, in Year 4 in particular, the campus-based teaching occurs as lecture-based fortnightly blocks. While students appreciated this when the information was patient-based or not well-covered elsewhere, some sessions were less useful and the lengthy lecture format was hard to remain focused on. Second, the compulsory nature of the Hauora Māori teaching was seen to imply that other teaching was not as valued by the Faculty.

Synchronous learning was well-structured and relatively consistent across sites. This had been aided by the availability of online resources for teachers. Variability of delivery of teaching at different clinical sites was noted as a concern by some students and staff. Within some disciplines this site-based teaching was reasonably consistent and coordinated through the discipline leads, though in other disciplines there appeared to be significant variation. Consistency appeared related, in part, to the availability and use of on-line resources for teachers. The team recommends that the Faculty promote consistency across sites in the use of online resources by clinical/ discipline teachers and students in their site-based teaching and learning.

In Phase 3, students become increasingly responsible for patient care as the year progresses. There are a few formal learning sessions (Advanced Cardiac Life Support;

procedural skills and Hauora Māori) along with some small group tutorials, student-led seminars and projects.

Year 6 students have been placed at Whangarei, Northland for the first time in 2015. While Year 6 students at this site generally felt well-supported in the clinical setting, they had not been able to access any site-based formal learning opportunities and felt their learning may be compromised by this.

The clinical scenarios (refer to Standard 3.3) are designed to be used and re-used during the programme for self-directed learning by students. Students who found the scenarios useful appreciated the increasing links to other learning resources as well as the clear links from progress test feedback to specific scenarios. However, Faculty data demonstrated that students were not widely using them, as they were not clear on their purpose or utility. The team encourages the Faculty to continue developing the quality and quantity of the associated content of the scenarios to improve their utility for students.

By contrast, there was good evidence of integrated use of scenarios by teachers. Scenarios are included as the basis of both on-line and face-to-face teaching material, with many teachers understanding the same scenario could be used at different stages of the programme. This was evident in elements of Phase 1 and some disciplines who incorporated scenarios into their on-line learning materials, formal teaching and, at times, clinical teaching. Scenarios are also used in attachments such as the General Practice Office Patient Simulations. Not all clinical teachers were familiar with the scenarios and/or their intended use. This is to some extent unavoidable with a large group of potential end-users. Ongoing communication with teachers will assist in reinforcing the utility of these resources to students and teachers alike.

Another innovation is the use of a portfolio as a teaching, learning and assessment tool for the Personal and Professional Skills domain (introduced to Year 2 in 2013). The team viewed some impressive examples of students' written works. However, students reported that understanding of the portfolio was low and students often felt disengaged from the process of reflection as they received no short-term feedback (refer to Standard 5.3). The team encourages the Faculty to explore additional means of timely feedback, such as small-group discussions and/or mentoring arrangements.

Overall, it was apparent that each of the teaching and learning methods employed has a rationale, and the Faculty is congratulated on many of its teaching and learning innovations, and changes made in the reinvigorated programme. However, the team considered that the way in which the choice and mix of learning methods was composed is not well-described, and the choice of methods not clearly related to an underpinning philosophy of learning and teaching. The Faculty may wish to consider developing and making explicit such a framework.

## **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 Faculty acknowledged the tension between the goal of encouraging lifelong learning and providing appropriate resources and tools for students to acquire a relatively large body of knowledge during the programme.

Electronic resources available for self-directed learning include the asynchronous learning materials and the clinical scenarios. As outlined above, the use to date of clinical scenarios by students for self-directed learning has not been as successful as hoped, although with guidance students currently in the earlier phases of the programme are likely to begin better utilising this resource.

The team was impressed with the use of progress testing feedback to encourage students to self-remediate. Many students found this approach provided an incentive towards consistent learning, as progress testing questions could not be predicted and success was related to embedding learning over time. Students indicated that the feedback received was sometimes not sufficiently detailed to provide them with adequate self-learning direction. This seemed to relate, at least in part, to the perceived lack of content in certain scenarios.

During Phase 2, students have study half-days for self-directed learning. However, students at some sites reported that they were not provided with their allocated self-directed study time, instead being allocated clinical duties.

## **4.3 Clinical skill development**

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

The programme promotes the progressive accumulation of the students' clinical and technical skills in a safe environment prior to use in clinical practice. Students accumulate significant experience with simulated patients, in other simulation settings, with peers and with real patients under close supervision, before interacting regularly with patients. The team commends this approach that promotes patient safety, and students regard the staged development of their clinical skills as a strength of the programme.

The team was impressed by the approach to teaching of core skills. Core clinical skills are taught using manikins, peers and simulated patients in the Clinical Skills Centre in Phase 1. General Practice Office Patient Simulations in Year 4 are designed to prepare students for more significant exposure to patients in the general practice setting. Improved sensitive examination technique is promoted with the use of Gynaecology Training Associates in Year 5. Procedural skills are taught in the simulation lab throughout the programme. For example, venepuncture is first performed on a manikin, then on a peer before it can be performed in the clinical setting.

It was noted that the changes to discipline time allocations in 2015 mean that fewer than half of the Year 4 students this year will undertake General Practice Office Patient Simulations prior to their clinical attachment in general practice. Consideration should be given to assessing the effects of this change.

Students must pass assessments in simulation settings prior to using critical skills with real patients. Patient safety is significantly promoted by this approach.

#### **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.*

Students' interaction with patients starts in Year 2 with sessions with a general practitioner as well as during the Human Early Life Development project. In Year 3, students spend ten half-days in the hospital setting with one hour of each session devoted to bedside teaching predominantly aimed at refining basic clinical skills. Students highly value the teaching in this area which also includes a progression from simulation to real-life practice.

In Phase 2, students work in relatively small numbers (usually four or fewer) with clinical teams for the vast majority of the academic year. Often, the student team consists of students from different year levels. This allows both a high level of supervision which progresses towards more independence, and opportunities for peer mentorship. The use of Phase 3 as a 'pre-internship' is seen as a positive towards creating more independence as well as encouraging self-directed learning.

Senior (specialist level) supervisors were mostly highly aware of their role in mentoring, teaching and supervising students. Many had accessed courses and on-line resources. It was clear that the Faculty provides significant assistance for new teachers in the form of courses, site visits and accessible senior staff at all learning hubs.

Students indicated that they were often directly supervised by more junior members of the clinical team and/or other health care professionals, but considered this approach provided them with a variety of learning opportunities. This has been supported by the provision of a 'residents as teachers' program.

The team noted a wholly appropriate increasing level of participation in clinical care as students progress in the programme. This is particularly evident in Year 6 when students are expected to be responsible for the care of a proportion of patients with assistance from others as and when required.

#### **4.5 Role modelling**

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

The team encountered many instances of positive role modelling which were often supported or promoted by the Faculty. During Phase 1, clinicians of all levels are

frequently involved in teaching, in particular modelling clinical skills. This continues through Phases 2 and 3. Researchers are encouraged to share their work in formal learning opportunities with students at all stages of the programme.

The team noted that where there had been feedback to the Faculty from students regarding underperforming supervisors, this was often related to supervisors' negative role modelling behaviours. The fact that this was detected by students and promptly dealt with by Faculty suggests that the strong grounding in ethics and professionalism equips and encourages students to detect and report poor role models.

The Faculty have evidence that students were acting as role models for others related to cross cultural awareness particularly with Māori. While this is to be lauded, it cannot be relied upon as the sole means of promulgating positive behaviours.

The team encourages development of a coherent approach to planning and support of appropriate role modelling, including strategies to increase staff awareness that role modelling is a learning process that occurs constantly.

#### **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.*

There are many formal aspects of teaching which promote the concept of patient centred care. The introduction of clinical scenarios is seen by both teachers and students as supporting the earlier and more consistent introduction of a patient centred approach during Phase 1. The Māori Health Intensive introduces the concept of a collaborative approach with Māori patients which can be applied to all patients. This is reinforced during further teaching in the Hauora Māori domain. Many clinical teachers also demonstrated a high degree of understanding of this concept.

However, the Faculty acknowledged that maintaining focus on a patient centred approach and collaborative engagement during clinical exposure is largely dependent on the clinical teacher. The team was exposed to instances where the level of appreciation of these concepts among students was high. In contrast, circumstances have occurred where investigations have led to remediation of supervisors with both positive and negative outcomes for the supervisor.

#### **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.*

There were many commendable examples of interprofessional learning. Formal programmes include the Māori Health Intensive (with nursing and pharmacy students); Quality and Safety Symposium (with nursing, pharmacy and optometry students); 'ward calls' (with nursing and pharmacology students) and Advanced Cardiac Life Support training (with nursing students for Auckland-based students). These programs were

well-received by students who consistently valued the opportunity to relate to and train with peers in other disciplines.

In addition, excellent examples of students learning from other professions during their clinical attachments were noted in a variety of settings and sites. Students are immersed with their clinical teams in Phases 2 and 3 including attendance at interdisciplinary team meetings. On some rotations, students learn directly from other professions (e.g. child health nurses, midwives, nurse practitioners, respiratory scientists).

The team noted the recent initiation of the Faculty Interprofessional Learning Group and recommends that this have a strategic oversight function for interprofessional learning across Faculty programmes.



## 5 The curriculum – assessment of student learning

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### 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 reinvigorated programme (introduced to Years 2 and 4 in 2013, Years 3 and 5 in 2014, and Year 6 in 2015) has retained aspects of its standards-based assessment philosophy while introducing progress testing, longitudinal assessment of domains, and a stronger programmatic approach. The team was impressed by the direction of these developments in assessment.

The Board of Studies approves assessment policy and progression rules. The programme's assessment strategy has five key principles to guide assessment and practical statements to guide implementation, including transparency, fairness, and linking assessment to the learning outcomes. The strategy includes in detail the process for assessment of domains, the assessment modalities in each phase, and the grading philosophy. This document is available to staff and students on the portal. The assessment and progression requirements are included in the Year Guidebooks, which are also available on the portal. Each year's Board of Examiners applies these rules while having authority to make decisions about individual students using the rules as guidelines.

The Assessment Subcommittee was established in 2013 to develop longitudinal aspects of assessment and oversee progress testing. The team commends the Faculty's work to date to implement programmatic assessment noting that it has devoted considerable effort and expertise to transition towards programmatic assessment as its underlying philosophy with an emphasis on assessment for learning, rather than just assessment of learning.

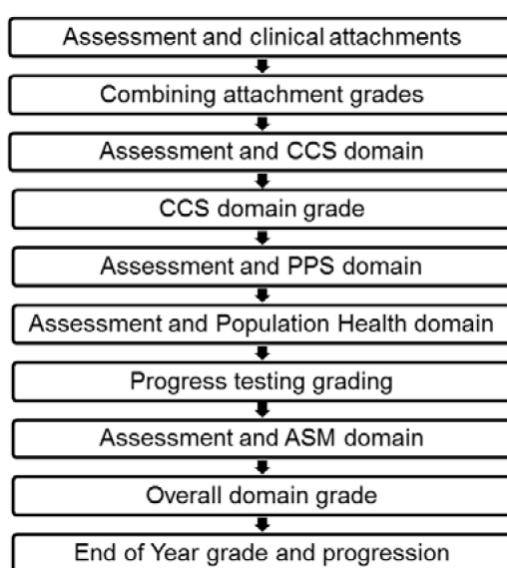
The rationale for programmatic assessment is sound. It emphasises the importance of longitudinal monitoring of students, collection of multiple sources of evidence to inform decisions and the goal of maximising feedback to guide learning. Good progress has been made in all these aspects. Particular developments are the introduction of progress testing, the transition to making progress decisions by domain, and the development of draft rules around progression. The reinvigorated assessment programme was introduced for all phases in 2013, with minor modifications made following review.

Such a philosophy and approach can be more difficult when assessments are given weightings and contribute to a grade. In this regard, the process is easier in Phases 2

and 3 where end-of-year decisions are pass, fail or distinction. Recognition of achievement in Phase 1 is by A-E grades informed by numerical results. This is due to University policy but it does place constraints in the progress towards programmatic assessment.

The transition to making progression decisions by domain rather than by module or attachment is proceeding. The Faculty emphasises the primacy of domain over module/attachment, and the Board of Studies has developed policies to determine how final domain grades are formulated and the rules for progression. These rules, in the main, seem appropriate but some may need to be refined over time. Assessment in Phases 2 and 3 follows the order shown in Figure 5:

**Figure 5: Assessment order in Phases 2 and 3**



Under a programmatic approach, the dichotomy between formative and summative becomes blurred. Instead students are given opportunities to repeat assessments where they have not met the required standard. As such, many assessments can be formative until the standard is reached and then become summative. When assessments have been repeated because of poor performance on the first attempt, deciding which result to use must be carefully considered (the first result which is below the standard, or the second result which is above the standard), particularly if these are numerical, have a weighting and contribute to a graded pass. When final decisions are pass or fail, such issues become minor, but when final decisions are graded, more explicit rules are needed. This is an area still under discussion and development by the Faculty, and updates should be included in AMC progress reports.

The decision to make progression decisions within the Clinical and Communication Skills domain by aggregating results from in-course assessments (particularly Mini-CEX) and end-of-year assessments (OSCE) is sound. There is the theoretical risk of compensation within this domain, for example the current policy could allow a student to pass this domain, yet either not be assessed (by Mini-CEX) or have failed all samples

(by OSCE) of history taking or of examination skills. This is an example where blueprinting within a domain may be helpful.

The alignment of the assessments with the learning outcomes (Standard 5.1.2) is discussed under Standard 5.2.2.

## **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 programme uses a range of assessment methods that vary across the three phases to reflect the curriculum and the emphasis on domains. In the Overlapping Year 1, assessment is predominantly by examinations with a mix of workshops and practical reports. In Phase 1, summative assessments include a mix of SAQ tests, MCQ progress tests, laboratories, and projects. Professional and clinical skills assessments include a portfolio, OSCE, histories, and clinical and communication skills assessment.

Phases 2 and 3 include clinical attachment assessments and longitudinal domain assessments. Each clinical attachment has discipline specific assessment requirements such as Mini-CEX, case reports, presentations, competency assessments; and all require clinical supervisor reports. In Year 4, there is a six-station end-of-year clinical skills assessment, and for borderline students, a Year 5 clinical skills assessment, also with six stations.

Students across all years sit the same progress test at the same time, three times a year. The progress test weighting is gradually increased as students' progress through the program.

While the team saw no evidence to suggest the programme's assessment methods did not assess the Faculty's Graduate Learning Outcomes, it did not see clear evidence that they did. The Faculty advised that the blueprint from the previous curriculum was used to inform the choice of assessment tools, however it was harder to discern how the choice of tools for the reinvigorated curriculum was taken. The progress testing has a well-described blueprinting process, and initial steps have been taken to blueprint other assessment tools against the programme's learning outcomes, but the team found that there was no finalised blueprint for each year or phase as required by the accreditation standards.

The further development of an overarching assessment blueprint for the programme, structured by phase and year, will support a programmatic approach to assessment. This will improve confidence that all the programme's Graduate Learning Outcomes, and in turn the AMC Graduate Outcome Statements, are being fully and appropriately assessed. It will also assist in ensuring balanced coverage of learning outcomes, clarify

how the assessment tools are deployed across the curriculum, and highlight which tools are particularly critical to assessing which outcomes.

As an example, this was brought into focus within the Personal and Professional Skills (PPS) domain for which the team noted an initial draft of a blueprint matching broad learning outcomes to tools. Teaching and learning aspects of the PPS domain are innovative, but development of assessment within this domain is ongoing. The team was concerned that the chosen tools do not robustly assess all five sub-domains and domain outcomes. The portfolio and the Clinical Supervisor Reports are the key assessment tools, and while both are appropriate, the particular aspects of the portfolio that contribute to summative decisions and how these are utilised along with the results from Clinical Supervisor Reports remain under development.

The team encourages the Faculty to continue enhancing the PPS portfolio (refer to Standard 4.1) as an assessment tool. The portfolio contains relatively light information on direct observations of students by staff members. Refining the focus of the portfolio has potential to further promote students' reflective practice, and may address students' concerns regarding the time burden, perceived problems with assessment reliability, and the quality of narrative feedback. Portfolios are heterogeneous in form and function so it is important not only to define the exact purpose of the portfolio in use, but also how it fits within a programme of assessment. Blueprinting within the PPS domain could inform such decisions.

There were reports across the clinical campuses/sites of variation in the thoroughness of completion of components of the Clinical Supervisor Reports (CSRs), and in the quality of feedback by supervisors at the time of completion of the reports. Students noted that CSRs did not always accurately reflect their performance, with both under-reporting (missing assessments) and over-reporting (boxes ticked uncritically) being cited. There was variation in whether all domains were assessed (particularly Hauora Māori and Population Health), in the standard expected, and in the quality and quantity of the discussion between supervisor and student explaining its results. It was clear the Faculty had applied effort to ensuring clinical supervisors understood the critical role of the CSRs in student assessment, though further development on the appropriate uses and interpretations of CSRs is required. Other evidence will also need to be gathered to avoid over-reliance on this tool as assessment evidence for some domains.

Given that the portfolio and Clinical Supervisor Reports contribute substantially to progression decisions for the PPS domain, and other domains, it is important to ensure the evidence is robust. The Faculty acknowledged that these are areas under development. These factors may provide some explanation as to why no student had yet been failed on the PPS domain. The Faculty should demonstrate that the assessment methods and formats in use to assess the PPS domain learning outcomes are fit for purpose.

In relation to assessment in the Hauora Māori domain, the team was encouraged by the work being undertaken, and noted further development was planned, particularly in relation to the assessment of students' application of their learning in clinical situations.

A variety of standard setting techniques are being used or developed, particularly in relation to the progress test, and to some extent with the other tools. The Board of Examiners' process by which failing or borderline performance students are discussed is well outlined. For such students all evidence is used and considered by a body of people and the narrative information from various tools strengthens the evidence that guides decisions. If the narrative information is rich, this process has the potential to moderate the effect of examiner variation.

Nevertheless, there are some tools with inherently poor reliability, with the clinical supervisor reports as described above being the most notable. This is seen in many contexts in education programmes and is not unique to this Faculty. Variation is also seen to a lesser extent with the Mini-CEX. The team noted the efforts to create calibration videos although many assessors were unaware of this resource. Amongst those who had viewed them, it was unclear if any change in practice had occurred. This issue is also common to many programmes. The team recommends further work to enhance appropriate use, calibration and interpretation of tools used in student assessment.

The Faculty recognised that when tools with such variability are to be used in summative decisions, there needs to be sufficient observations by a sufficient number of observers. Reassurance on any variation could be gained by an evaluation process. Robustness of determination of standards can also be gained by considering the narrative that is associated with such assessment results. It was noted that the Board of Examiners is using narrative information to guide decision-making and this is to be encouraged.

### **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.*

The Board of Studies is responsible for approving the student assistance and remediation processes in the programme. The reinvigorated programme has improved processes for the timely detection of underperforming students, allowing the Faculty to address remediation for students with performance concerns earlier. Improved remediation in Phase 2 has resulted in fewer students commencing Year 6 with performance concerns.

Phase directors and year coordinators monitor student progression and meet with failing or borderline students, so students are aware in advance of any issues and are offered assistance. Students are also informed that they can access informal support through their phase director. Students can access a projected, indicative grade from the portal as soon as assessment scores start accumulating. There is a handover process between year coordinators for struggling students.

The remediation process outlined within each Board of Examiners is sound and largely effective. It is able to collate information in order to identify underperforming students and implement remediation. Remediation may include additional formal assessments, a directed selective at the end of Year 4, or a remediation period at the end of Year 5.

The team commends the Faculty on the particularly well-developed feedback from the progress testing. Students receive timely and extensive feedback after each progress test, with the first progress test being held in April in Year 2. Feedback includes the student's standing in the class, and a result for each question together with links to the relevant learning outcomes and clinical scenarios. Students value this approach. The assessment for learning philosophy is reinforced as students can easily review the content for incorrect items.

Feedback on the portfolio generally comes at the end of a year which limits its formative utility and the Faculty's goal of assessment for learning. Refining the focus of the portfolio has potential to further promote students' reflective practice, and may address students' concerns regarding the time burden, perceived problems with assessment reliability, and the quality of narrative feedback. The team noted moves towards more frequent submissions and assessment of the portfolio. The team recommends that the Faculty consider how to improve formative feedback relating to the portfolio.

Feedback from other assessments, particularly some in-course assessments, is variable with lengthy delays noted for some assignments. The Faculty has a four-week feedback policy on clinical attachments, and clinical supervisors are expected to provide feedback in the last week of the attachment.

The lack of a clear plan of evaluation of the assessment programme is discussed at Standard 5.4. It was noted that the conveying of results of assessment by cohort to staff and students is patchy and discipline dependent. This likely contributes to some of the students' anxieties around variability in assessment standards. Provision of such evaluations in a timely manner could alleviate many of these anxieties as variation in individual assessments may have less consequence once collated with other assessments and used to inform decisions.

Inconsistent and variable feedback to students from clinical supervisors is a challenging problem. The Faculty had attempted to address this by sending orientation material to clinicians and encouraging feedback at staff meetings. There had also been workshops convened where clinicians are encouraged to develop the skills of giving constructive feedback.

## **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 Faculty's detailed curriculum and assessment review undertaken in recent years and subsequent implementation of the reinvigorated curriculum has naturally been a primary focus. While the Faculty evaluates many of its assessment tools (particularly the progress testing), a clear strategy to evaluate the overall programme of assessment is less apparent (see Standard 6.1). At a time of significant change in assessment policy and practice, it will be important to embed a programme of evaluation for all aspects so that the Faculty is reassured that the assessment programme is working as intended.

The Faculty's academic department model works to ensure consistency in the assessment of any given discipline across sites, with common assessments and processes used. The Faculty uses a common Clinical Supervisor Report form that aligns with the learning outcomes across all attachments, and a Mini-CEX training resource for assessors has been developed.

The Faculty analyses progress test results, clinical skills performance, clinical year grades, and overall year grades across cohort sites in Phases 2 and 3, and reports found no significant differences between sites observed.

Many students were anxious about variation in assessment results by site, and could be reassured by showing them these findings.

## 6 The curriculum - monitoring

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### 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 the 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 Faculty had recently formed an Evaluation Group, and the team supports its intention to establish a permanent Evaluation Subcommittee. The Faculty has a range of methods for monitoring and reviewing the medical programme. The current evaluation activity encompasses both evaluation and research projects. Projects are designed to receive input from staff and students over an extended period of time and to produce and disseminate results more broadly than evaluation activities. The team encourages these activities.

The Board of Studies regards the University's policy on course and student evaluation as a minimum standard, which is routinely met by the Faculty. Course evaluations by surveying student opinions proceed on a three-year timetable: Years 2, 3, 4 and 5 student evaluations were completed by the end of 2014, and Year 6 is scheduled for 2016. All new courses are evaluated in the first year they are introduced. In the Medical Humanities course, written assessment evaluations by students were carried out in 2013. Focus groups were also held in 2009, but less successfully repeated in 2011 and are scheduled again for 2015 (a four year gap). Improvements in the process and (semester) timing should contribute to better participation, but focus groups may not be an effective way of gaining feedback from all groups of students.

Ineffective feedback to students regarding what actions are taken as a result of their evaluations has been a concern. Although the Board of Studies has student members who are free to distribute the summary evaluation reports that are discussed, this does not appear to be a common practice. Aspects from evaluations are also considered at some Staff: Student Committee meetings. While the year guide books summarise changes which have been made as a result of feedback and evaluation, the existing standing agenda item on student feedback in the Board of Studies should be progressed and perhaps introduced for all committees.

The Faculty has a range of techniques and methods for monitoring assessment and student progression. There is a Clinical Scenarios Moderation Subcommittee that monitors the content of the clinical scenarios, reviews feedback received, identifies overlaps or gaps in content, and makes decisions on new scenarios.



The student portfolio has been moved to an e-portfolio, which has addressed some of the weaknesses of the previous paper-based portfolios, yet a full evaluation of the portfolio method of assessment is required.

Curriculum pilot projects (e.g. the introduction of progress testing from 2012) have been evaluated and there is evidence that projects are adopted, rejected or adapted based on the student experience.

The Centre for Medical and Health Sciences Education run workshops and classes for staff, and a peer-review process was introduced in 2014 to provide feedback to staff about the quality of teaching. The Māori Health Intensive was given as an example of the programme responding to evaluations which identified positives, negatives and student 'wants'.

The Curriculum Conference was held in 2010 and the re-invigorated curriculum rolled out from 2013. The team noted that a high-level over-arching strategy for curriculum monitoring, evaluation and research of the reinvigorated curriculum would be valuable. This would reduce the risk that some areas are over-evaluated while others could be neglected. It would also promote systematic synthesis of results from diverse evaluations, and the effects of resulting actions to be monitored. An overarching strategy for curriculum monitoring, evaluation and research is recommended.

Further, results from diverse evaluations may not systematically be synthesised, and the effects of resulting actions not systematically monitored. An overarching strategy for curriculum monitoring, evaluation and research is required.

The focus of such a strategy could include the synthesis of findings from the evaluations undertaken, and monitoring of the impact of the re-invigorated curriculum and increased student numbers. In addition, a more systematic approach would facilitate dissemination of findings from local evaluations across the programme to inform quality improvement within other areas, and to focus on specific audiences such as students and other stakeholders.

The Faculty regularly seeks feedback from its students and teachers. Departmental staff meetings and course report forms are the main methods used to gain feedback. Previous audits have seen the course report forms as a strength. Students are asked to undertake a number of surveys in Years 2 and 4 of the programme. In 2013 the Year 2 students were given time in class to complete a paper-based survey yielding a higher response rate of 79%. This survey resulted in a number of changes to the programme and the subsequent 2014 survey showed improved perceptions from students (albeit with a much smaller response rate of 49%). It will be important to continue regular course evaluation in future.

The Faculty collaborates with other education providers in monitoring outcomes, teaching and learning methods and assessment. It is an active member of the Australian and New Zealand Association for Health Professional Educators, and Medical Deans

Australia New Zealand (MDANZ), and participates in some of the MDANZ benchmarking projects.

## **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 committee responsible for student selection, curriculum and student support.*

The Faculty has produced both longitudinal and cross-sectional analyses of the performance of students in the programme. The move to the reinvigorated programme and the introduction of progress testing from 2012 make comparisons with previous cohorts more challenging, but overall pass rates have been maintained. Progress testing is providing new data for the programme and the early trends show the expected improvements in knowledge according to a student's stage in the programme.

Student progress from the regional-rural Pūkawakawa cohort has been analysed and compared with progress within the metropolitan cohorts. No significant differences in perceptions of preparedness for Phase 3 have been found.

A research project has been commissioned to ask District Health Boards if graduates employed are 'fit for purpose'. The Faculty has a career intentions project across the health curriculum which has been tracking students since 2006, and has also joined the Australia and New Zealand Medical Schools Outcome Database longitudinal tracking project. Specifically the Faculty is tracking the careers of those who participate in the Pūkawakawa programme.

The Faculty has a good record in analysing the performance of cohorts of students to inform the programme. The evaluation of the Māori and Pacific Admission Scheme (MAPAS) cohort is of particular note and the team commends the Faculty on its analyses of cohorts of MAPAS entrants which have led to significant changes to the selection criteria and the entry processes. Further evaluation could now focus on the broader admissions strategy.

## **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 results of outcome evaluations appear to be distributed well within the Faculty. It was less clear how students receive the results. The Faculty provides departmental- and campus-level feedback, and feedback to clinical teams however the team noted the

desire of clinicians to receive feedback about their individual teaching performance. The Faculty advised that at a programme level it is difficult to gather data on individual teaching as students are integrated in teams and multiple health professionals contribute to student learning. Feedback appeared to be inconsistent across disciplines. The team recommends that the Faculty improve dissemination of feedback to students and clinicians.

While the Faculty receives considerable informal feedback from a range of clinical supervisors, it has remained a challenge to implement effective or systematic methods to gather and synthesise such information.

The team noted a number of publications reporting research and evaluation into elements of the curriculum. While these are a valuable mode of dissemination to stakeholders, the Faculty had not taken a systematic approach to reporting outcomes to stakeholders in other ways. The Faculty indicated that items of interest generally become widely known given the small size of New Zealand. The team nevertheless suggests that a more systematic distribution strategy for stakeholders would be of value.

The Faculty has excellent relationships and dialogue with District Health Boards and other stakeholder organisations that have an interest in graduate outcomes, and consults widely at national and local levels in developing programme. However, with the exception of Te Kupenga Hauora Māori there is little direct input from health service consumers or local communities into the curriculum (refer 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 Māori 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 student intake has increased from 148 in the 2005 cohort to 286 in the 2015 cohort. The New Zealand Government funds approximately 80% of domestic student fees and it has progressively increased the domestic cap in order to increase medical graduates. The Faculty projects total student enrolment will reach a steady state by 2019, and has determined that the maximum class size will be 300. The Faculty's projected estimate of student numbers to 2019 is shown in Table 7. There is capacity to accommodate the projected numbers across all phases, both on campus at Grafton in the expanded Faculty facilities, and at the clinical sites and campuses.

**Table 7: Projected number of students from 2013 to 2019**

	Year 2	Year 3	Year 4	Year 5	Year 6
2013	245	235	202	204	192
2014	259	235	236	199	194
2015	284	252	235	230	202
2016	284	275	248	234	228
2017	284	275	271	247	232
2018	284	275	271	270	246
2019	284	275	271	270	268

Entry into the programme is mostly following a common first year at university, known as Overlapping Year 1 (OLY1), or via graduate entry direct into Year 2. Graduate entry students are approximately 30% of the class. Some graduates are required to complete some OLY1 papers prior to final acceptance.

There are three targeted entry schemes: the Māori and Pacific Admission Scheme (MAPAS), the Rural Regional Admission Students for students from rural origins; and the Undergraduate Targeted Admission Scheme (UTAS) available to students of low socio-economic status, refugee students and students with disability. The team considered that the targeted entry students were well-supported by the Faculty.

The Faculty project 'Vision 20:20' aims to increase the proportion of Māori in the health workforce to 10% by 2020. It aims for the student intake to reflect the population demographic, and it has set the goal that the intake of Māori and Pacific students should constitute up to 25% of the total intake. The team commends the Faculty's good progress towards its goal, up from 14.9% in 2005 to 20.3% in 2014.

The Faculty admits approximately 20 international students annually into Year 2 of the programme, from Overlapping Year 1 or as graduate entry, equating to just over 7% of student intake. There were no plans to increase the size of the international student intake.

Concern was expressed to the team regarding the implications of the New Zealand Government's 'Seven EFTS (equivalent full-time student)' proposal whereby students are eligible for financial support for only the first seven years of their university study from 1 January 2011. While this does not impact on students entering through the Overlapping Year 1 pathway, this could disadvantage graduate entry students. The team would be concerned if this policy were to reduce the desired diversity of the student cohort and encourages the Faculty to explore ways to counteract this.

Attrition rates are low and mostly predicted by grade-point average.

## **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 Māori.*

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

The selection policy and procedures are well outlined. The selection committee has a representative from the Vice Chancellor's office to oversee procedural fairness. The system is well-documented and implemented, and the evaluation of the selection process is adequate.

The selection process uses grade point average (GPA) usually as threshold. All graduate entry applicants who meet the GPA minimum are offered an interview, while undergraduates in Overlapping Year 1 are ranked using a rubric that weights GPA 60%, UMAT 15% and multiple mini interviews (MMI) 25%. This applies to all categories but the GPA threshold is lower for targeted groups. This is working well.

The Faculty previously used a single interview for selection, which it has now ceased. It commenced the use of MMI in 2006 for the Māori and Pacific Admission Scheme, and for 2015 entry commenced use of a generic eight-station MMI applicable to the three Faculty programmes of medicine, pharmacology and optometry. The questions are designed around desired attributes that are consistent with learning outcomes. International students have a traditional interview with two experienced Faculty staff via Skype or telephone, either for selection into Overlapping Year 1 or for graduate entry.

The team commends Te Kupenga Hauora Māori on its well-developed scheme to attract and support Māori and Pacific students. The Whakapiki Ake project engages with Māori secondary school students to promote health as a career and provides advice regarding application, support in preparation for application and support for the successful applicants.

The Māori and Pacific Admissions Scheme (MAPAS) consists of a MAPAS interview that includes a MMI, a maths and English test, and evaluation by a MAPAS team to determine the student's best starting point for academic success. The Faculty offers a Certificate in Health Sciences as a foundation program for Māori and Pacific students who require preparation for tertiary study in the health sciences.

Through its focus on building the skills of students entering tertiary education, and through its ongoing pastoral and academic support, the Faculty has graduated 166 Māori students in medicine (2001-2014), and had 133 enrolled in 2015.

The team was impressed by the well-developed plan for evaluation of the Māori and Pacific Admission Scheme. The Faculty collaborates with other medical schools to evaluate the effectiveness of UMAT. There were no overarching plans for a programme of evaluation of the selection process for all students and this is an area that could be considered.

The policies on the admission of students with disabilities and students with infectious diseases, including blood-borne viruses, are well outlined and appropriate.

Information about the selection process for the programme is available on the Faculty website including the contact number for admission enquiries. The Faculty does not provide full details of the appeals mechanism in public documents expecting students to contact the admissions office for details. The process requires students to write to the Director of Medical Admissions within 14 days to request a review of the selection decision. The team considers that the Faculty should ensure that the mechanism for appeals regarding selection is publicly available.

### **7.3 Student support**

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

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

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

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

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

The team commends the Faculty on its systematic approach to student support. The Pastoral Care Subcommittee was formed when the reinvigorated programme was introduced. It has a joint action plan across all sites and reports to the Board of Studies. There is an Assistant Dean (Student Affairs), a Pastoral Care Coordinator and student welfare representatives. There are strategies in place to address issues of mental health, physical disability and infection.

Student support has not only been systematically included within the curriculum (within the Personal and Professional Skills domain) but, in parallel, there have been measures to make it clearer to students when and how to get help if needed. Examples include accessible flowcharts for various sites, information at annual orientations sessions, and seminars. The team regarded student support as a good example of an activity that had not only been implemented but which has a longer-term plan. It is reactive to student feedback, and the students indicated that they felt supported.

Medical students can access University health and counselling services at the Grafton campus five days a week and also have two days of medical student counselling allocated each week. Services extend to the longer study periods for medical students. Optional group counselling sessions are also run to deal with issues such as healthy eating, exam stress, self-harm, anxiety, and grief and depression.

Academic support is available at the University library, and students can access academic and general advisors in the Faculty. Financial assistance is available through the University, and the Faculty also offers scholarships and emergency fund assistance.

There are Faculty Student Services staff allocated for student support to rural students, international students, and students in targeted admission schemes. Staff from Te Kupenga Hauora Māori support Māori and Pacific students, including access to tutoring, small group teaching and study supervision.

There is good separation of the processes for student support from the processes for academic progression decision-making. The Board of Examiners is responsible for academic progression decision making, and while students are advocated for, the nature of student concerns are not divulged to the Board. Additionally, the team explored the roles of the Pastoral Care coordinator who chairs the Pastoral Care Subcommittee and also leads the Professional and Personal Skills domain, and were satisfied that transparent systems were in place to prevent conflict between these roles.

### **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.*

The Faculty developed its Fitness to Practise policy before the 2005 AMC accreditation. The policy has had few changes since it was first approved and is working well. The Fitness to Practise Committee oversees the policy. An evaluation of the scheme has been published. The development of assessment within the Personal and Professional Skills domain has overlap with the Fitness to Practise process but this overlap has been considered. It is acknowledged that there may be areas where the margin is blurred between whether a student is considered through the Personal and Professional Skills domain assessment or through Fitness to Practise, or both. There is an opportunity for clinicians who complete the Clinical Supervisor Report form to notify the Faculty of students with fitness to practise issues. The team noted that some clinicians were unclear on how to use this section and the Faculty should address this (refer also to Standard 5.2).

## **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 Faculty has provided extensive opportunities for students to contribute to the curriculum and to the life of the programme and the Faculty. Students are represented on key bodies. The Auckland University Medical Students Association President and Vice-President Education (or their nominees) are members of the Board of Studies. Students have been regular members of all phase groups since 2006. There are numerous opportunities for informal meetings between staff and students. The students reported that they find the staff to be approachable, and are satisfied that the systems in place work well for them.

## **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 Faculty has mechanisms to ensure medical students are adequately indemnified and insured for all education activities. Since 2013, students have been required to take out membership with the Medical Protection Society from their first semester in the programme. The Medical Protection Society is a not-for-profit mutual medical protection organisation and its free student membership is administered by the New Zealand Medical Association. Student membership includes free professional indemnity for properly supervised electives anywhere in the world, a free 24-hour emergency telephone line, and free medicolegal advice.



## **8 Implementing the curriculum – learning environment**

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### **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 physical facilities offered by the University of Auckland are a major strength of the programme. The University has invested significant resources in providing a modern learning environment and has planned well for the increase in student numbers provided by additional government investment. The number of clinical sites available across the several campuses exposes students to a broad range of generalist and specialist clinical settings, and to diverse populations, in which to train and practise their learning.

The main Faculty campus is at the University's Grafton campus in Auckland. A major upgrade of the Grafton site in 2013 included refurbishment of all existing buildings and the addition of a new building, increasing floor space by 50%. Students appreciate the high quality facilities now provided at the main Grafton campus. Lecture theatre capacity has increased, there are modern student-learning spaces with Wi-Fi, and the computer laboratories, library, anatomy and multidisciplinary science laboratories are viewed positively. The innovative 'double-bunk' cadaver tables in the large anatomy lab increase capacity to over 280 students for the Year 2 'first patient' full-body dissection project.

The upgraded Clinical Skills Centre provides an important teaching venue with some potential for interprofessional learning. Its teaching space has increased, and although the team queried if it was too small for the cohort size, students and staff reported it adequate. Additional skills space is available at Tāmaki and at the nearby Mercy Hospital.

While generally praised, the students indicated that the Grafton campus student facilities can become crowded as they support medical students together with other health sciences students.

The Tāmaki campus provides an excellent facility for both staff and students. The co-location of Population Health with General Practice, and the impressive Simulation Centre for Patient Safety provide a varied environment for students.

The University's medium-term plans to re-integrate the Grafton and Tāmaki campuses are encouraged, particularly given the place of Population Health as a domain in the curriculum. The team noted the new Grafton facilities are already approaching capacity and this re-integration offers the opportunity to address capacity concerns through additional building. The presence of students from across the health sciences curriculum is seen as a strength and enhances the interdisciplinary learning and teaching environment.

Students rotate across eight clinical campuses and clinical sites. To accommodate the increased student numbers, existing sites have expanded capacity. Additionally, the Auckland population has expanded, meaning increased and adequate patient contact at the three Auckland sites. An overview of the location of clinical campuses and sites and respective student numbers is shown in Table 8.

**Table 8: Clinical campus/sites and student numbers**

Location	2015 Year 4	2015 Year 5	2015 Year 6	2015 Total
<b>Clinical Campus</b>				
Auckland	60		48	108
Waitemata/Auckland		106		106
South Auckland	66	61	47	174
Waitemata	45		33	78
Waikato	36	48	36	120
<b>Clinical Site</b>				
Northland		24	10	34
Rotorua	12		12	24
Tauranga	24		16	40

Auckland Hospital is adjacent to Grafton facilitating a practical working relationship between the Faculty and the DHB. The Starship Hospital provides excellent teaching opportunities in paediatrics and is handling increased students loads with careful management. The Faculty has responded to concerns regarding crowding in some of the clinical rotations by offering some weekend sessions. Clinicians indicated the student numbers were being managed and the site's good communication with the Faculty assisted in addressing any concerns.

The North Shore/Waitakere campus has adequate student common space, though the site acknowledged that there were currently few other spaces for students. The Waitemata DHB plans to improve this in the medium term (approximately three to four years) confirming that Stage 1 of the development had been approved, with Stage 2 approval being sought in 2015. The development will increase tutorial room space and add a clinical skills facility. The movement of academic positions and students to this campus needs to be accompanied by facilities consistent with the quality and quantity seen elsewhere. The team recommends that the developments with the DHB should be encouraged and monitored closely by the Faculty.

At the South Auckland Clinical Campus, Middlemore Hospital provides a high quality environment for student learning with the Ko Awatea teaching centre being an impressive addition. The partnership model for the development of Ko Awatea, that includes other tertiary education providers, was notable, with students and academic staff both being beneficiaries. Staff and students felt that the lack of local student accommodation created logistical issues for some students who often had to travel some distance across the city.

In Hamilton, the Waikato Clinical Campus facilities were considered well-managed, and the physical facilities were described as adequate by students and staff. The site has a new library accessible to students. The Waikato DHB advised that some student facilities pose an earthquake risk and will be demolished and rebuilt. Given its 150 km distance from Grafton, and the increased student numbers, larger facilities will be necessary. Students find Hamilton an attractive placement so pressure is likely to increase. The team applauds the DHB's vision in seeing the potential to develop extended facilities to house more students and provide additional space for clinicians undertaking research.

The team was unable to visit the Tauranga and Rotorua clinical sites due to weather disrupting flights, so teleconferenced instead. At Tauranga, students have access to a large clinical library with study space, access to tutorial rooms, and an open-plan student lounge. The Bay of Plenty DHB acknowledged the desirability of providing clinical and teaching spaces all under one roof. The staff and clinicians enthusiastically indicated capacity to take more students. Students valued the additional opportunities that small sites provided in clinical supervision terms.

Rotorua has taken Year 6 students since 2002 and in 2014 accepted its first Year 4 cohort. Facilities seemed adequate, although staff indicated space was 'tight' even for the small number of students. The clinical site indicated it was not well-placed to accept any additional student numbers.

The Northland Clinical Site is based at Whangarei Hospital with four linked rural sites. In addition to 24 Year 5 students, Whangarei is taking 10 Year 6 students in 2015. The Whangarei resources for students are rated highly, and the smaller rural sites are judged as being 'extremely accommodating' to students. There is onsite accommodation available at each site, a library at Whangarei plus online library access and library couriering.

Overall, the team found that students and staff have access to safe and well-maintained physical facilities, and encourages the Faculty in its efforts to ensure consistency of facilities across sites.

## **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.*

Students and staff were generally positive about the developments in ICT infrastructure across the broad Faculty and learning sites. The programme's portal and CECIL (the university's learning management system) were both praised and criticised, and seem to be meeting needs if not all expectations. CECIL is used to access programme materials and information, and the team heard it worked well overall, though could benefit from timelier uploading of some material by academic staff. The team noted that the University was intending to upgrade/replace CECIL in the short term, and that cleaner integration with the learning portal was anticipated.

The portal was seen to be growing in popularity with students and contains some resources that students rated highly such as *MyPsychiatry* and *MyPaediatrics*. The portal is difficult to navigate on all platforms however, and new or updated resources are hard to identify. The team recommends that the resources available on the portal be better integrated with the clinical scenarios to provide further learning opportunities for students at all phases of the curriculum.

The Learning Technology Unit has coped well with the pressures of the reinvigorated curriculum, but is dependent on teaching staff providing appropriate and timely content. The unit is shared across the Faculty and not dedicated solely to the medical programme meaning that future resourcing of the group may require the Medical Programme Directorate negotiating adequate support from the Faculty Executive. The unit is heavily involved in providing the e-platform for future student portfolios. As the reinvigorated curriculum becomes established there would be considerable benefit in reinforcing the shared pedagogical underpinning of both the new curriculum and the applied learning technology.

Students generally rated the available ICT learning facilities highly, particularly those available on the main campus at Grafton. However there are sometimes crowding issues at Grafton at peak times.

Student ICT facilities at Tauranga, Rotorua and Waikato would benefit from improvement, as students reported difficulty with accessing adequate ICT facilities. At Tauranga, the Faculty has increased Wi-Fi access, though students indicated that improved access to University computing facilities was required. At Rotorua, enhanced Wi-Fi access and improved videoconferencing quality would assist students. At Waikato, the ICT space available for students was quite small, albeit adequate. Continuing upgrades to the ICT infrastructure are planned by the Faculty and the team recommends this occur as a priority.

The Faculty should ensure the otherwise high-quality ICT environment is equally shared across the campuses, and address shortcomings in some of the regional sites. The increasing prevalence of 'bring your own device' provides both an opportunity and a challenge for the Faculty as student and staff expectations change.

Electronic access to library and other resources was seen as satisfactory. The Faculty and the District Health Boards provide access to complementary resources, meaning students have access to a greater set of resources than just those provided through the

University library. Clinical staff who have academic appointments particularly value their ability to access the University e-library 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 Māori.*

*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.*

Students have excellent and diverse opportunities for clinical involvement with patients due to the large number of hospitals and placement opportunities across the campuses and sites compared with a relatively small number of students. Students rated most of the clinical facilities highly, although there appeared to be some crowding of students at Auckland City Hospital, which is being managed. In some of the regional sites the small number of students means that access to clinical supervisors is especially easy, with some students benefitting from considerable one-on-one supervision.

The range and variety of available models of care across the teaching sites is a strength of the programme. The Faculty actively manages students in cohorts and rotates them across the metropolitan, provincial and rural sites to ensure broad exposure to patients and clinicians. The general practice placements now occur over three clinical years and it was clear that the GP supervisors and students both benefit from and value the support given by the Department of General Practice and Primary Health Care and Faculty. Managing approximately 200 GP placement practices is challenging, and the small number of negative issues which have arisen are effectively managed by the Department and Faculty staff.

It was clear that some of the sites (Northland, Middlemore and the Mid-North Island) are able to offer ready access to Māori patients due to the local demography and relatively high number of Māori presenting for health care. While students are able to apply their prior learning, there was some concern that the gap between the Māori Health Intensive in Year 2 and the clinical placements from Year 4 onwards meant that students had to re-learn some aspects relating to cultural competence.

Although the programme does not overlap physically with the Otago medical programme, as Auckland and Otago have an agreed geographical boundary, there appear to be good relations and collaboration between the two New Zealand medical programmes. When required, the Faculty shares its available general practice

placements with Otago, and has a student 'swap' arrangement in Phase 3 for students who need to change locations. Where the Faculty is collocated with other university health programmes there was evidence of positive engagement. The Ko Awatea facility at Middlemore Hospital is a notable example of how the University of Auckland had worked with other health professional education providers in order to provide a high quality and effective learning environment.

#### **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.*

During the site visits the team met many enthusiastic and dedicated clinical supervisors. They reported strong relationships with their academic colleagues and departments, and described effective processes for communicating information about curriculum changes and expectations to them. Many valued the face-to-face and on-line supervisor development activities available to them. Supervisor performance is monitored and the team was satisfied that sub-optimal performance is effectively addressed.

The Faculty had identified induction of clinical staff as an area for improvement, and newer clinical staff indicated that orientation was brief and variable. The team encourages the Faculty to improve the induction of clinical staff. Staff provided feedback that the weaknesses include the absence of both a standardised induction programme and an overall framework for teaching development for clinical supervisors/teachers.

The Centre for Medical and Health Sciences Education and some academic departments provide teacher-development workshops which clinicians and others can attend, while the Centre has also developed online resources for clinical teachers. Those who had attended generally rated the workshops positively.

Assistant deans at clinical campuses and academic coordinators at clinical sites have responsibility for coordinating clinical attachments at their site and clearly play an active and effective role as the intermediary between the District Health Boards and the Faculty. A number of initiatives have been implemented to reward and acknowledge the contribution of clinical teachers including honorary appointments, training, and supervisory opportunities at MD/PhD level. The University of Auckland runs an annual awards scheme to recognise outstanding contributions.

Some clinical supervisors expressed the view that the University policy on honorary appointments and promotions was too restrictive meaning clinicians were had difficulty

in meeting the same criteria as full-time academic staff. However the team's reading of the University policy is that it is enabling, allowing the Faculty to identify and reward clinicians academically having consideration of their opportunity to undertake teaching and research together with clinical leadership.

The team was impressed with many testimonies to the high quality of the relationships between the Faculty and the various health care providers, most citing significant improvements over recent years. The Faculty's mechanism for identifying and managing time pressure on clinical supervisors is via high-level negotiations with the District Health Board (DHB). The Faculty is satisfied its expectations are being met, identifying good-will with DHBs as a critical ingredient.

An important aspect of this relationship is where the Faculty pays for time, or buys-back clinician time for specific teaching, research or post-graduate supervisory roles. While a small number of clinicians reported that clinical loads sometimes eat into academic time, most reported that the mechanism worked well.

The team was most impressed by the high degree of enthusiasm and commitment of the clinical supervisors across all sites. This is a notable strength of the programme, reflects the efforts and leadership of Faculty and its academic staff, and is highly valued by the students.

## **Appendix One      Membership of the 2015 assessment team**

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**Professor Tim Usherwood (Chair)**, BSc, MBBS, MD, DMS, FRCGP, FRCP, FRACGP, FAICD

Head, Department of General Practice, Sydney Medical School Westmead, The University of Sydney

**Professor Simon Broadley (Deputy Chair)**, BSc (Hons), MBChB, MRCP, PhD, CCST, FRACP

Dean and Head, School of Medicine, Griffith University

**Professor Chris Cunningham** BSc PhD

Director of the Research Centre for Māori Health and Development, Massey University

**Associate Professor Bronwyn Peirce** MBBS FACEM

Medical Coordinator, Rural Clinical School of Western Australia (Bunbury), The University of Western Australia

**Professor Jan Provis** BSc (Hons), PhD

Professor of Anatomy, Associate Dean Phase 1 (Teaching & Learning), College of Medicine, Biology & Environment, The Australian National University

**Professor Tim Wilkinson** MBChB, PhD, MClined, FRACP, MD, FRCP

Director, MBChB Programme, Faculty of Medicine, The University of Otago

**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 2015 assessment team**

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### **Senior Leadership**

Vice Chancellor

Dean, Faculty of Medical and Health Sciences

Deputy Dean, Faculty of Medical and Health Sciences

Head of School of Medical Sciences

Head of School of Medicine

Head of School Population Health

Head of the Medical Programme

### **Faculty of Medical and Health Sciences staff**

Academic Director, School of Medical Sciences

Academic Director, SOPH

Assistant Dean (Student Affairs)

Assistant Dean, South Auckland Clinical Campus

Assistant Dean, Waikato Clinical Campus

Assistant Dean, Waitemata Clinical Campus

Associate Dean (Academic)

Associate Dean (Research)

Chair and Director of Medical Admissions Subcommittee

Chair, Clinical Scenarios Moderation Subcommittee

Co-Coordinators, PPS Domain

Coordinator for Dermatology

Director of Assessment

Director of Clinical Skills Centre

Director of Faculty Finance

Educational Project Manager

Head of Department, Anaesthesiology

Head of Department, Anatomy with Radiology

Head of Department, Paediatrics: Child and Youth Health

Head of Department, General Practice and Primary Health Care

Head of Department, Medicine

Head of Department, Molecular Medicine and Pathology

Head of Department, Obstetrics and Gynaecology

Head of Department, Physiology

Head of Department, Psychological Medicine  
Head of Department, Surgery  
Head of the Simulation Centre for Patient Safety  
Phase 1 Director  
Phase 2 Director (acting)  
Phase 2 Director  
Phase 3 Director  
Tumuaki and Head of Te Kupenga Hāuora Māori

### **Medical Programme Committees and Groups**

Assessment Subcommittee  
Board of Examiners  
Board of Studies  
Clinical Scenarios Moderation subcommittee  
Evaluation Group  
Formal Learning oversight sub-committee  
General Practice teaching staff  
Interprofessional Learning Group  
Learning Technology Group  
Medical Admissions Subcommittee  
Medical education expertise subpanel  
Medical Programme Directorate  
OLY1 Staff  
Personal and Professional Skills Domain staff  
Phase 1 Curriculum Group  
Phase 2 Curriculum Group  
Phase 3 Curriculum Group  
Population Health Domain  
Research Group  
Student Support Group  
Te Kupenga Hāuora Māori  
Teaching fellows

### **Medical Students**

Auckland University Medical Students Association representatives  
Student representatives from all clinical sites

Student representatives from all years of the programme

## **Stakeholders**

### Health Workforce New Zealand

Chair of Health Workforce NZ and FMHS Associate Dean (Workforce)

General Manager for Health Workforce New Zealand

## **Clinical sites**

### Meadowbank Medical Centre

Teaching General Practitioner

Practice Manager

### Northland Clinical Campus

Academic Coordinator

Clinical Teachers

Executive of Northland District Health Board

Faculty staff

General Manager, Māori Health, Northland District Health Board

Whangarei Clinical Teachers

### Rotorua Hospital

Academic Coordinator

Clinical Teachers

Executive of Lakes District Health Board

Faculty Staff

### South Auckland Clinical Campus

Assistant Dean and Head of South Auckland Clinical Campus

Clinical Teachers

Senior Executive of Counties District Health Board

Faculty Staff

### Tauranga Hospital

Academic Coordinator

Clinicians

Executive of Bay of Plenty District Health Board

Faculty Staff

Waikato Clinical Campus

Assistant Dean, Waikato Clinical Campus

Clinical Teachers

Executive of Waikato District Health Board

Faculty Staff

Waitemata Clinical Campus

Clinical Teachers

Faculty Staff

Assistant Dean, Waitemata Clinical Campus

Executive of Waitemata District Health Board



