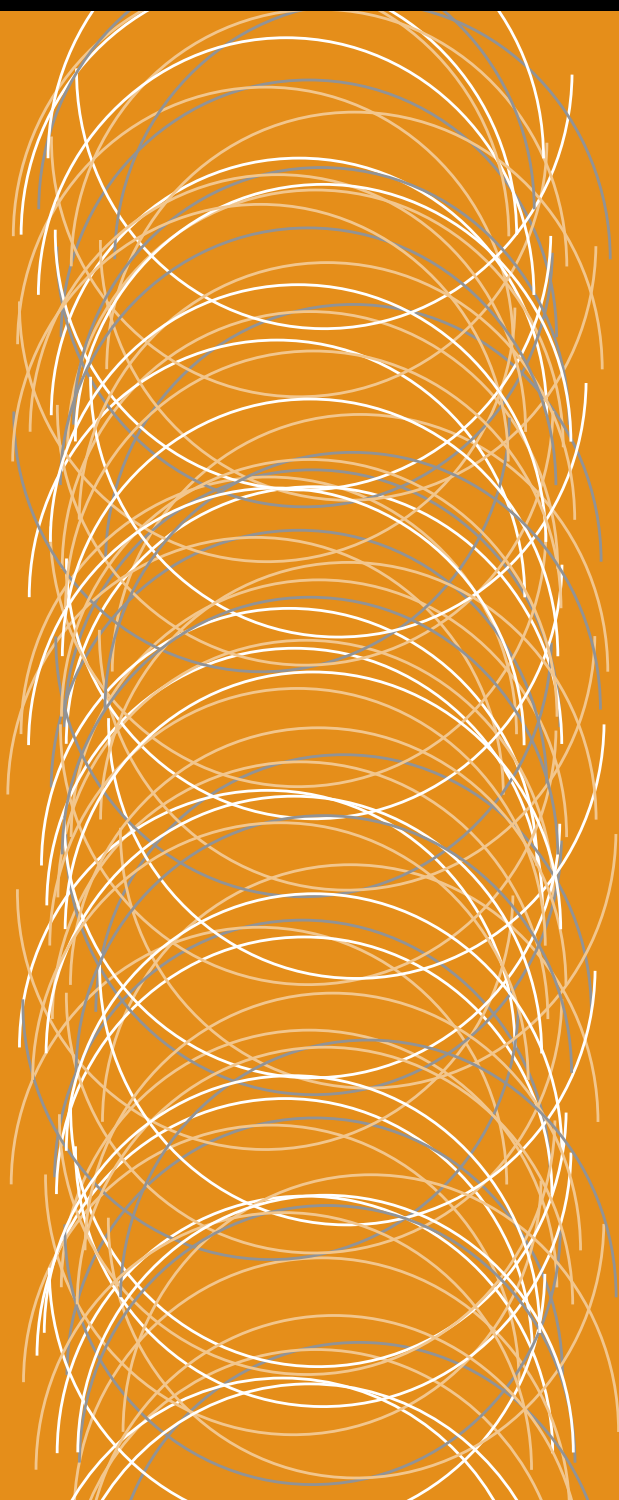


Australian Medical Council Limited

Accreditation of  
Bond University  
Faculty of Health  
Sciences and Medicine

AMC



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

The Bond University, Faculty of Health Sciences and Medicine is seeking reaccreditation of its medical program. The five-year undergraduate Bachelor of Medicine / Bachelor of Surgery program is accredited to 31 December 2015.

The medical program was originally granted AMC accreditation in 2004 until 31 December 2011. Accreditation was subject to a number of conditions, including follow-up visits.

In late 2010, the Faculty submitted a comprehensive report for extension of accreditation. The comprehensive report included an assessment visit due to earlier concerns in relation to the on-going viability of the medical program, academic staffing and preparation of teaching materials for the later clinical years.

AMC Directors extended the accreditation of the medical program to the maximum period possible, until 31 December 2015, subject to the submission of satisfactory annual progress reports.

In December 2014 Bond University submitted a Statement of Intent outlining the planned transition of the MBBS program to a Doctor of Medicine (MD) program.

In 2015 an AMC team reviewed the Faculty's reaccreditation submission, the Medical Students' Society of Bond University submission and visited the School and associated clinical teaching sites in the week of 25 May 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*.

### **Decision on accreditation**

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

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

## **Reaccreditation of established education providers and programs of study**

The accreditation options are:

- (i) Accreditation for a period of six years subject to satisfactory progress reports. In the year the accreditation ends, the education provider will submit a comprehensive report for extension of accreditation. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to a maximum of four years, before a new accreditation review.
- (ii) Accreditation for six years subject to certain conditions being addressed within a specified period and to satisfactory progress reports. In the year the accreditation ends, the education provider will submit a comprehensive report for extension of accreditation. Subject to a satisfactory report, the AMC may grant a further period of accreditation, up to a maximum of four years, before a new accreditation review.
- (iii) Accreditation for shorter periods of time. If significant deficiencies are identified or there is insufficient information to determine the program satisfies the accreditation standards, the AMC may award accreditation with conditions and for a period of less than six years. 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.

**The AMC is reasonably satisfied that the medical programs of Bond University, Faculty of Health Sciences and Medicine meet the approved accreditation standards.**

The 19 October meeting of the AMC Directors agreed:

- (i) That accreditation of the following medical programs of the **Bond University, Faculty of Health Sciences and Medicine be granted for a period of six years; that is until 31 March 2022**, subject to satisfactory progress reports:
  - o Doctor of Medicine (MD)
  - o Bachelor of Medicine / Bachelor of Surgery (MBBS) (accreditation of the MBBS will cease 31 December 2017 as the School will withdraw the MBBS by the end of 2016)
- (ii) That accreditation is subject to the following conditions:

**By July 2016:**

- To ensure separation of curriculum development and implementation, student assessment and program evaluation, undertake a review of the program's committee structure, and the relationship between the medical program, the Faculty Operations Group and other Faculty level committees (Standard 1.1.2)
- Establish a mechanism to ensure that relevant groups, including Indigenous groups, community organisations and health service consumers, are consulted on key issues relating to the curriculum, graduate outcomes and governance. (Standard 1.1.3)
- Provide evidence that the program's graduate outcomes review is finalised and the graduate outcomes are consistent with the AMC graduate outcome statements. (Standard 2.2.1)
- Provide evidence that the curriculum content is defined and objectives are set for the MD Project. (Standard 3.2)
- Develop and communicate learning outcomes for each stage of the MD program. (Standard 3.4)
- Develop and implement an assessment approach for tracking student progress of required portfolio elements. (Standard 5.1)
- Develop and implement a comprehensive evaluation and monitoring framework which addresses key elements of program delivery and provide evidence of a reporting schedule which prioritises key areas to be evaluated. (Standard 6.1)
- Formally evaluate program outcomes to refine the program in relation to selection, curriculum, assessment and student support, and in sharing results with key stakeholders. (Standard 6.2)
- Demonstrate a consistent reporting schedule to stakeholders, staff and students. (Standard 6.3)
- Demonstrate that the mechanism for appeals regarding selection is publicly available. (Standard 7.2.4)

## Key findings of Bond University, Faculty of Health Sciences and Medicine

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

Standard 1.1 is substantially met.

### *2016 conditions*

To ensure separation of curriculum development and implementation, student assessment and program evaluation, undertake a review of the program's committee structure, and the relationship between the medical program, the Faculty Operations Group and other Faculty level committees. (Standard 1.1.2)

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

### *2016 recommendations for improvement*

Provide an update on the recruitment to the position of Deputy Dean of the medical program. (Standard 1.1)

Expand on the Faculty's existing partnerships with relevant communities and organisations in the Indigenous health sector to promote the education and training of medical graduates. (Standard 1.6)

Provide an update on the recruitment of the proposed clinical academic chairs in Emergency Medicine, Mental Health and Evidence-Based Practice. (Standard 1.7)

|                                               |            |
|-----------------------------------------------|------------|
| <b>2. The outcomes of the medical program</b> | <b>Met</b> |
|-----------------------------------------------|------------|

Standard 2.2.1 is substantially met.

### *2016 Condition*

Provide evidence that the program's graduate outcomes review is finalised and the graduate outcomes are consistent with the AMC graduate outcome statements. (Standard 2.2.1)

### *Commendation*

The Indigenous Health curriculum, including the Cultural Immersion Program which provides an excellent platform for further Indigenous Health learning activities.



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

Standard 3.2 and 3.4 are substantially met.

*2016 conditions*

Provide evidence that the curriculum content is defined and objectives are set for the MD Project. (Standard 3.2)

Develop and communicate learning outcomes for each stage of the MD program. (Standard 3.4)

*Commendations*

The improvements in the delivery of the biomedical science curriculum, particularly with regard to the anatomy and pharmacology content.

The introduction of an Indigenous Health curriculum.

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

This standard is met.

*Commendations*

The impressively innovative range of teaching and learning methods aligned to the learning needs of students at different stages of the program.

The Bond Virtual Hospital, an outstanding example of innovation in teaching and learning, has achieved its intended goals of strengthening student engagement, and encouraging transition of problem based learning from exploration of biomedical principles to application in the clinical context.

The use of actors and volunteers in teaching basic clinical skills.

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

*2016 recommendations for improvement*

Provide updates on the development of Evidence Based Practice modules. (Standard 4.1)

Explore formal opportunities for interprofessional learning in Years 4-5. (Standard 4.7)

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

Standard 5.1 is substantially met.

*2016 Condition*

Develop and implement an assessment approach for tracking student progress of required portfolio elements. (Standard 5.1)

### *Commendation*

The management of assessment of student learning and detailed care taken to develop and document processes for blueprinting, implementation and review of assessment to ensure that students' progress through the program with the required knowledge and skills.

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

This standard is substantially met.

### *2016 Conditions*

Develop and implement a comprehensive evaluation and monitoring framework which addresses key elements of program delivery and provide evidence of a reporting schedule which prioritises key areas to be evaluated. (Standard 6.1)

Formally evaluate program outcomes to refine the program in relation to selection, curriculum, assessment and student support, and in sharing results with key stakeholders. (Standard 6.2)

Demonstrate a consistent reporting schedule to stakeholders, staff and students. (Standard 6.3)

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

Standard 7.2 is substantially met.

### *2016 Condition*

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

### *Commendations*

The well-developed processes to support and remediate students at risk of non-progression in the medical program. (Standard 7.3)

The policy and procedures to manage students with concerns regarding their fitness to practise. (Standard 7.4)

### *2016 recommendation for improvement*

Provide an update on the planned development of a pathway to recruit Aboriginal and Torres Strait Islander students.

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

This standard is met.

### *Commendations*

The high degree of enthusiasm and commitment of clinical supervisors.

The program's excellent physical facilities, which provide access to a wide variety of clinical teaching facilities and models of care.

## 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 the approved 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 program**

Bond University was established as Australia's first private university in 1989. The University is organised into four faculties: Business, Law, Health Sciences and Medicine, and Society and Design.

The Bond University medical program sits within the Faculty of Health Sciences and Medicine (the Faculty). In December 2014, the medical program has graduated its sixth cohort of students and there are over 450 alumni who are now part of the medical profession in Australia.

The medical program was originally granted AMC accreditation in 2004 until 31 December 2011 (consistent with accreditation of a new program - accreditation was granted until two years after the first graduates would complete the program). Accreditation was subject to a number of conditions, including follow-up visits.

Follow-up visits in 2006 and 2007 raised concerns in relation to academic staffing and preparation of teaching materials for the later clinical years. The follow-up visit in 2008 identified significant challenges facing the program and resulted in AMC Directors reducing the program's accreditation to 31 December 2009, subject to conditions including a follow-up assessment in 2009. Following the 2009 follow-up visit, accreditation was reinstated until 2011, subject to satisfactory updates throughout 2009 and satisfactory annual reports. The Faculty's reports were accepted by the Committee.

The Faculty submitted a comprehensive report for extension of accreditation in late 2010, which was also the submission for a follow-up visit in 2011. Following the visit, AMC Directors extended the program's accreditation to 31 December 2015, subject to satisfactory progress reports.

### **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 One**.

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

### **Appreciation**

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

# 1 The context of the medical program

---

## 1.1 Governance

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

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

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

Bond University was established as Australia's first private university in 1989. The University is organised into four faculties: Business, Law, Health Sciences and Medicine, and Society and Design.

Bond's medical program resides in the Faculty of Health Sciences and Medicine. The Faculty offers several undergraduate and postgraduate level programs including physiotherapy, exercise and sports science, nutrition and dietetic practice, biomedical sciences, and health sciences.

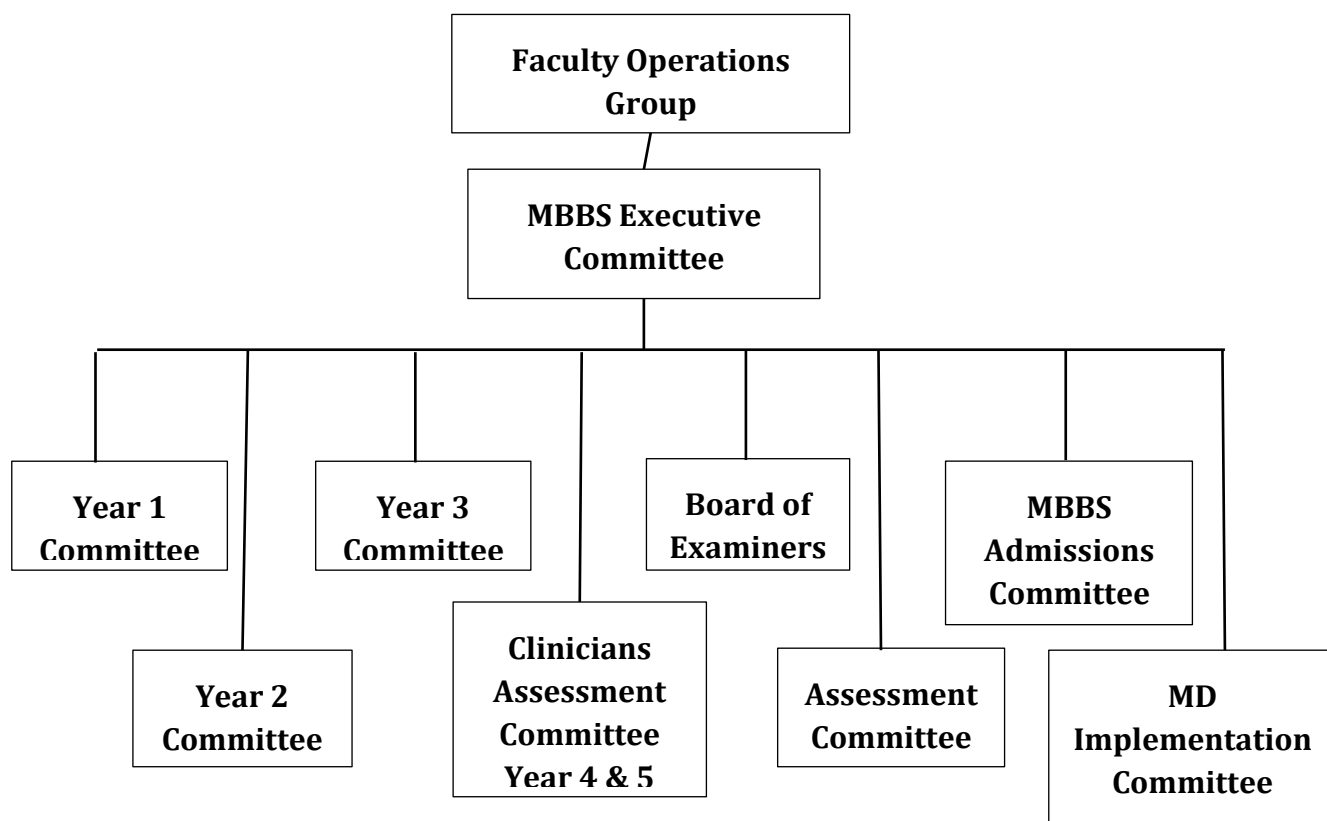
The University implemented a new organisational structure in January 2014. One outcome of the new structure is the university no longer uses the term "Schools" within faculties, and as a result there is no longer an organisational unit known as the School of Medicine. The restructure created four new Associate Dean roles within each Faculty (Research; External Engagement and Marketing; Learning and Teaching; and Student Affairs and Service Quality). The positions were filled by existing academic staff at .5 FTE for each appointment. While all faculties at Bond now have common administrative structures and a shared central service model, the Faculty of Health Sciences and Medicine retained extra professional support for the delivery of the medical program.

Leadership of the Faculty of Health Sciences and Medicine is provided by an Executive Dean who reports directly to the Vice-Chancellor and President of the University. The position of Executive Dean is a relatively new role, filled in September of 2014. The Faculty Executive includes the Faculty Business Director, Program Cluster Leads, Centre Directors, the Dean of Medicine, and the four Associate Deans.

The medical program is led by the Dean of Medicine. The Dean was appointed in 2014 following the resignation of the previous Dean who also held the role of Dean of the Faculty. The Dean of Medicine reports to the Executive Dean, and is responsible for the management of resources to deliver the medical program. The research outcomes of the Faculty are the responsibility of the Associate Dean Research. The other Associate Deans contribute to the medical program in roles including teaching within their areas of expertise.

The MBBS Executive Committee provides oversight of the medical program and reports to the Faculty Executive. The Chair is the Dean of Medicine and membership is drawn from a representative group responsible for the operational management of the medical program including year leads and theme leads.

### **Bond University MBBS Committee Structure**



In Years 1 – 3, a Year Coordination Committee manages curriculum delivery and assessment for that year of the program. The Year Lead chairs the committee and has responsibility for decision making with respect to each year of the curriculum. The membership of the Year Coordination Committees includes theme leads, and discipline staff are represented as required to ensure required expertise to teach and assess each year of the program.

Years 4 and 5 are guided by the Clinicians Assessment Committee rather than a Year Coordination Committee. This committee manages and assesses Year 4 and 5, which includes meeting at the end of each clinical rotation to discuss student performance in the clinical environment. The committee members are the Dean of Medicine, Year 4 and 5 leads, discipline clinical leads, and the clinical placement manager. They review student performance as assessed through In-Training Assessment results and make decisions on requirements for remediation or review of unprofessional behaviour.

The Board of Examiners coordinates assessment processes and rules of progression for the medical program, and is chaired by the Dean of Medicine. The Board of Examiners



meets at the end of each semester and after any significant periods of assessment to review and ratify de-identified examination results.

The MD Implementation Committee chaired by the Associate Professor (Medical Education), reports to the MBBS Executive and is responsible for supporting the transition to the proposed MD program. Until recently, this committee was referred to as the MD Working Party and reported to the Dean.

The Admissions Committee is chaired by the Dean of Medicine and provides oversight of admissions procedures and selection decisions. This committee reports to the MBBS Executive.

In addition to these major committees, an Indigenous Health Reference Group, responsible for developing the Indigenous curriculum in the medical program reports directly to the Dean. The terms of reference indicate the group holds responsibilities for developing, implementing and evaluating the Indigenous health curriculum, community engagement with the Indigenous community, and developing and implementing a recruitment and retention strategy for Indigenous medical students among other significant tasks.

The team notes the program has provided documentation concerning the program's governance structure with some discrepancies between different organisational charts, and between organisational charts and terms of reference for various committees. More significantly, due to the small size of the program, senior staff hold multiple positions of responsibility and have many committee appointments. This may produce real or perceived conflicts of interest.

In order to clarify program governance, there should be a review of the program's committee structure, and the relationship between the medical program, the Faculty Operations Group and other Faculty level committees.

The team notes the intention to recruit a Deputy Dean to assist with the management of the medical program. This new position would be an important additional resource to alleviate the multiple, potentially conflicting expectations placed on the Dean. The team would be interested in an update on the recruitment to this position.

The Faculty regards its major stakeholders as the University, the Gold Coast community and its health care providers, and the international medical community. While there is evidence of wide consultation with many of these groups, meaningful consultation and representation with Indigenous and consumer groups is not apparent. The Faculty is encouraged to establish a mechanism to ensure that relevant groups, including Indigenous groups, community organisations and health service consumers are consulted on key issues relating to the curriculum, graduate outcomes and governance. The team acknowledges that the program has not yet had an opportunity to consult widely regarding the proposed MD program and this planned consultation may offer an opportunity to engage with communities in South East Queensland outside the clinical community.

## **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 senior leadership of the University and Faculty are highly engaged in charting the strategic direction of the medical program. The Dean has autonomy and adequate resources to ensure program delivery.

The Dean's roles are clearly stated, and as indicated in the previous standard the team would support the additional resource of a Deputy Dean with adequate delegations to assist in the management of the medical program.

## **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 MBBS Executive Committee provides overall leadership in managing the medical program. The team was advised that the chair of the MD Implementation Committee will join the MBBS Executive Committee, and this should contribute to a seamless transition as the planned MD program progresses to implementation.

The Faculty has assessed the level of the proposed qualification against the Australian Qualifications Framework (AQF) and determined that it will meet the criteria for Level 9 (Extended Masters). The University has confirmed this assessment.

## **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 commends the motivation, enthusiasm and cohesiveness of academics and administrators within the medical program and the high level of interest and engagement around the educational process. The recent appointment of a discipline lead in Indigenous Health to lead further development of the Indigenous Health curriculum is a significant advance. The program has also appointed a Fellow in Medical Education to support clinical assessment and a full time Assistant Professor to support assessment across the program.

## **1.5 Educational budget and resource allocation**

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

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

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

The Faculty of Health Sciences and Medicine allocates the medical program's budget. Operational responsibility for the medical program's budget is vested in the Executive Dean of the Faculty, the Dean of Medicine and the Faculty's Business Director. The Dean of Medicine, advised by the MBBS Executive Committee, is able to approve the necessary expenditure to ensure that the medical program meets its objectives.

As a not-for-profit private institution the university receives no government funding or subsidy for its bachelor and coursework masters programs. The University operates as a company and its financial management is governed by the Australian Corporations Act.

The central costs of the University (including library, IT Services, building costs, etc.) are funded by contributions made by each faculty. The Faculty of Health Sciences and Medicine returns a contribution to University-wide expenses after it has acquitted its required program expenditure. The expected contribution for the financial year is determined during the budget process and between 2012 and 2014 the amount of the contribution to the central costs of the university held at a stable level.

The Faculty has clear responsibility for the program and adequate financial stability to sustain the program. It has sufficient resources and the autonomy to direct them as required and staff were positive, noting their requests for support were generally met. The Faculty has demonstrated it has the capacity to implement the program

## **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 Faculty has robust and functional partnerships with the Gold Coast University Hospital, smaller hospitals including public and private sites, and GP practices. In addition to these clinical sites there are a number of rural, overseas and Indigenous health services that provide rich training opportunities. The relationship with Griffith

University appears positive and seamless, which is particularly important at shared clinical training sites. This perspective is confirmed by the Dean of the Griffith University medical program.

Partnerships with local communities exist in particular through the simulated patient and volunteer program. The team commends the Faculty on the simulated patient program, and recognises the volunteers play a large role in teaching and assessment. The team will be interested in updates on the Faculty's partnerships with relevant communities and organisations, including in the Indigenous health sector, to promote the education and training of medical graduates.

## **1.7 Research and scholarship**

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

Research and scholarship within Bond University and the medical program are steadily expanding in the context of a relatively new and small university medical program and a University whose strength to date is education. There has been growth in the number of PhD students commencing and completing in the Faculty. Since 2012 there has been continued growth in the Faculty's research output.

There are particular areas of strength within the program (evidence based care with the Centre for Research in Evidence Based Practice) and within the Faculty (the Collaborative Research Network for Advancing Exercise and Sports Science). The University intends to build on these strengths, and scholarship in medical education is encouraged by the Faculty and University executive. Planned collaboration outside the university in this area may strengthen the depth of study and achievements.

New joint clinical chairs in Emergency Medicine, Mental Health and Evidence-Based Practice have been planned in partnership with Gold Coast Hospitals and Health Service. The University and the health service view the proposed clinical academic chairs as key to the promotion of research in the context of clinical care, and the team will be interested in an update on these positions.

Research capacity and research excellence is important for the transition to the MD program, with the planned incorporation of research projects as one way students will meet the requirements for a masters level program. Development of educational research excellence and increased research infrastructure, such as availability of statistical support for clinicians wishing to carry out research and supervise students, will help expand opportunities.

## **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 team commends the Faculty on the high calibre of its staff. A number of senior academic appointments have been made since the last AMC visit.

The clinical staff structure supports significant one on one supervision, assessment and remediation so students are ready for learning in the clinical setting.

The administrative staff ensures clinical sites are informed, well supported and that students are evenly distributed across sites and through the year. The program's success with clinical placements is in part due to these administrators.

The program has good community support for the simulated patient role, which plays a large role in teaching and assessment. Problem Based Learning facilitators are well trained and supported. There is also evidence of good support and training for the large numbers of academic staff with fractional appointments and simulated patients involved in delivering clinical skills training for students in Years 1 – 3.

## **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.*

Appointment and promotion policies recognise the multiple ways staff can contribute to scholarship within the program including education and research scholarship. The full time academic staff are appointed to standard academic contracts where they are expected to engage in teaching 40%, research 40% and service for 20% of their time.

Staff are well supported in provision of professional development opportunities as well as being given time to access professional development. The Faculty has developed a suite of graduate Clinical Education qualifications including a Graduate Certificate, Diploma and Masters. It has proved popular with staff and has been a tool for improving the education skills of seven staff to date who are key clinical teachers of the program.

Staff are encouraged to build educational scholarship based on the medical program's innovations, and the University recognises this area has great potential for demonstrating scholastic achievement.

## **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 Maori and their health.*

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

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

The Faculty has clearly articulated its purpose through vision and mission statements which were developed in 2011. The purpose of the medical program has been developed and refined through consultation with staff and students, partner clinicians and hospitals, and the university community.

### **Vision**

The Bond University medical program offers students opportunities to bring to life their ambitions to become outstanding practitioners, thinkers and leaders, well equipped to deliver evidenced-based, patient centred health care that meets the needs of a diverse community.

The mission of the program is as follows:

*The Bond University medical program prepares practitioners with the attributes required for guiding health care into the future. Students are exposed to the amazing opportunities and responsibilities that are part of medical careers. They are challenged to master and apply the biomedical, behavioural and social sciences that build the foundation for contemporary medical practice. Graduates are fully prepared to commence internship in Australia or New Zealand, with the critical thinking skills required to interpret and expand the evidence base for practice. The Bond University medical graduates demonstrate a commitment to care for themselves, their colleagues and all groups in the community. They demonstrate the clinical, interpersonal, teamwork and leadership skills to deliver high quality health care outcomes.*

The Faculty states that the Vision and Mission of the medical program is to address Aboriginal and Torres Strait Islander people through recognition of “the needs of a diverse community”. There is strong commitment in the first three years of the program to build understanding of the history and culture of Aboriginal and Torres Strait Islander peoples, and the determinants of health and wellbeing.

The Faculty defines its student and clinical communities and clearly relates its teaching, service and research activities to these communities. The team found that there was less

clarity of purpose with respect to the medical program's relationship with the broader Gold Coast community. The Faculty indicated to the team they planned to define the program's communities in the areas of research, disadvantaged community groups in Indigenous communities, aged care and the Pacific. The team was informed of the planned creation of an advisory board which may expand on the opportunities to consult with a wider stakeholder group. However, beyond this, the Faculty is encouraged to engage more widely with the Gold Coast community.

## **2.2 Medical program outcomes**

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

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

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

The medical program's graduate outcomes were developed in 2011 and 2012 and revised in early 2015. The outcomes are organised according to the program's three themes of Scientist and Scholar, Practitioner, and Health Advocate and Professional. These outcomes have been mapped to the AMC Graduate Outcome Statements at the level of program learning objectives and on a year by year basis. They are also consistent with the Bond University Graduate Attributes.

The outcomes of the program meet the AMC requirement for producing junior doctors, able to practise safely and effectively under supervision as interns in Australia or New Zealand, and with a foundation for lifelong learning and for further training in medicine.

The Faculty formed a working group to review the current graduate outcomes which served as a scaffold for developing the MD curriculum. Once approved by the University, the outcomes will be communicated through the learning management system. Following ratification of the graduate outcomes by the University, the team requests that the program provide evidence that the MD program's graduate outcomes are consistent with the AMC graduate outcome statements.

The program provides comparable educational experiences across most of its learning sites with common structures and tools for assessment across different sites. Regular meetings of the Clinicians Assessment Committee provide a forum for communication about student performance in Years 4 and 5, and allow comparison of clinical experiences across sites. Students in Year 5 may complete their rotations in many different hospital or community settings. Most non-elective hospital-based rotations are located at Gold Coast University, Tweed, Pindara, John Flynn, or Wesley hospitals. Each



site has specified supervisors and clinical coordinators with frequent communications between them and the program. Each supervisor is a member of the Clinicians Assessment Committee or is in close contact with the lead clinician.

The program reports that the General Practice placements generally have only one student at each placement, supervised by an accredited GP supervisor. Because of the diversity of these placements, academic GPs organise one day a week in standardised GP curriculum teaching and learning activities, which includes assessing all of the students to compensate for the potential differences in ITA standards between so many GPs. The Academic GP Lead maintains regular contact with the GP supervisors. GP teacher training events are held twice a year for all GP supervisors to attend.

The program has implemented several Year 5 outcome measures across all sites, including:

- Clinical Teachers ITA evaluations for all clinical rotations including general practice
- Student evaluation of each rotation
- Student diaries, or logbooks, used in many rotations
- Clinical placement coordinators feedback
- Performance in written and OSCE examinations
- Student Feedback (verbal, email, or phone).

The team is satisfied that the program provides comparable educational experiences across its learning sites.

### **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 program runs over four years and eight months and is organised into year-long subjects. Additional time is allocated for revision (Years 1-4), examinations (Years 1-5) or vacation breaks.

The courses within the medical program are:

- Year 1: Health & Well-being Across the Generations (2 semesters x 12 weeks)
- Year 2: Challenges to Health (3 semesters x 12 weeks)
- Year 3: The Understanding and Recognition of Illness (3 semesters x 12 weeks)
- Year 4: The Practice of Diagnosis, Delivery of Care & Therapeutics I (5 x 8 weeks)
- Year 5: The Practice of Diagnosis, Delivery of Care & Therapeutics II (5 x 7 weeks followed by 1 x 6 week).

Students, clinicians and hospital management with whom the team met were confident that the program has resulted in graduates with sound clinical skills, ready for supervised practice.

The proposed MD program will be of the same duration as the MBBS program. The program will offer an optional exit point at the end of Year 3 with the award of Bachelor of Medical Studies for those students unable to complete or wishing to exit. The MD Implementation Committee is confident that the revised program and rotations will provide equivalent, if not enhanced, clinical learning opportunities but specific outcomes have yet to be defined.

#### **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 first iteration of Bond's MBBS curriculum was based on the University of Sydney's graduate entry medical program, which Bond adapted for a school leaver entry program. By 2011, the program acknowledged the need to renew this curriculum. The MBBS was then altered from a four phase to a five year-long program with all points of progression assessments at the end of the calendar year.

The program now delivers a curriculum developed over the last four years. The first iteration of the new program for Year 1 occurred in 2013 with Years 2 and 3 of the new structure being implemented in 2014 and 2015, respectively. The curriculum development will continue until 2017 when the entire program will have been redeveloped from the initial MBBS program offering.

Years 4 and 5 of the current curriculum will be revised, adapted and renewed where necessary, to reflect the level of learning required at the AQF Level 9E. For example: Year 4 students are currently required to undertake 2 written cases per clinical rotation (a total of 10 cases), which is marked by their Clinical Supervisor. These cases contribute to their overall grade in the In Training Assessment (ITA) Report. In the MD program students would be required to submit a minimum of 3 of these cases, incorporating support by the literature, in their portfolio.

The teach out of the MBBS will be largely complete by 2016. In 2017 it is possible that there may be one or two students who have deferred/failed and will be completing the MBBS program rather than the MD. It is unlikely that there will be any students still enrolled in the MBBS in 2018.

A map of the medical program's current graduate outcomes to the AMC Graduate Outcomes Statements shows alignment. However, it will be important that the program continue ongoing monitoring of student performance to ensure the outcomes of the Health Advocate and Professional and the Practitioner themes in Years 4 and 5 are met following implementation of the proposed MD program.

The program is also in the process of developing the parameters of the MD project, and the team request that when this is complete, the Faculty provide evidence that the curriculum content is defined and objectives are set for the MD Project.

The Faculty introduced the new three theme structure for the 2012 student cohort. The curriculum is organised around three vertically integrated themes:

- 1 Scholar and Scientist
- 2 Practitioner
- 3 Health Advocate and Professional

The program's curriculum transitions from a focus on introducing the foundation biomedical sciences in Year 1 to Clinical Sciences across Years 2-5. The program has articulated how the themes and curriculum content, through Program and Year level outcomes, address the AMC graduate outcomes.

**Science and Scholarship:** The foundation biomedical sciences sit largely within the 'Scholar and Scientist' theme and constitute a large proportion of the early curriculum (i.e. 80% in Year 1 and 60% in Year 2). Other components are covered through the 'Health Advocate and Professional' theme with some learning activities involving team-teaching across the themes. The teaching of foundation biomedical sciences is well regarded by the students and has been successfully integrated throughout the curriculum. The integration of basic and clinical pharmacology has been a particular focus over recent years with 'therapeutics' now a key component of the Bond Virtual Hospital (Year 3). Staff with whom the team met stated that students were well prepared in the basic sciences. The key involvement of basic science academics in formal teaching and Problem Based Learning case construction in Years 1 and 2 of program provides evidence for this perception. The program has responded to earlier feedback about pharmacology knowledge by strengthening this in the Bond Virtual Hospital (BVH) cases, which are oriented towards learning about patient management.

**Clinical Practice:** The foundation communication, clinical, diagnostic, management and procedural skills are embedded in the 'Practitioner' theme. In Years 1 and 2 of the program, students are taught verbal and non-verbal communication skills in small group, facilitated sessions, which includes role-play with simulated patients and feedback from peers and clinical tutors. The challenges of communicating within a healthcare team also feature in Problem Based Learning cases in Years 1 and 2, as well as large group teaching sessions.

Year 3 includes an emphasis on integrating communication and patient assessment skills, as well as the development of skills to deal with more challenging patient groups. Communication with patients and healthcare teams is a central element of clinical placements in Years 4 and 5. Physical examination tutorials, using simulated patients, and small group practical sessions are scheduled in Year 2. These skills are further enhanced in Year 3 during integrated patient assessments and during clinical placements throughout Years 3-5. Both communication and physical examination skills are assessed through Objective Structured Clinical Examination (OSCE) stations across a number of years of the program.

The Practitioner Theme is well developed in Years 1-3 of the program. The team commends the well-articulated clinical skills program in these years, with opportunities for students to practice skills until a defined mastery level is attained. Moreover, students and clinical supervisors felt that students were well prepared for the transition to clinical learning in Year 4, with reinforcement of more advanced skills through scenario based simulation teaching in Year 4. It appears that simulation teaching is largely based at the Bond University Robina Hospital Clinical Education Research

Centre, with Wesley students receiving a different program. The team however did not receive any evidence that this was of concern to students.

In Years 4 and 5 there does not appear to be any formal teaching of clinical skills. This learning is overseen by each discipline and clinical placement, with the potential for uneven achievement of these skills. A 12 station clinical skills Objective Structured Clinical Examination (OSCE) will be implemented in Year 5 commencing in 2015, with students who do not reach a predefined standard to sit an additional OSCE at the end of the year before graduation.

In the final two years of the MBBS curriculum students are required to complete 58 weeks of core clinical rotations, 16 weeks of selective rotations and a 4 week elective rotation; as well as an 8 week selective in research in the final year. The clinical rotation time in the current MBBS program is 66 weeks.

In the proposed MD program students will complete a minimum of 72 weeks of clinical rotation experience comprising 61 weeks of core rotations, a 7 week clinical selective rotation, and a 4 week elective/pre-internship placement at the end of the medical program.

In the MD program students will also be required to complete a 7 week capstone rotation in which they will complete requirements for their individual MD project (research based, capstone-experience, or professional learning; this may include a further clinical placement if the capstone experience is chosen.)

The Faculty is confident graduates of the proposed MD program will have increased clinical exposure across the final three years of the program compared with the graduates of the MBBS program. Clinical supervisors and hospital management with whom the team met were uniform in their perception that Bond graduates were well prepared for supervised practice.

**Health and Society:** The curriculum to prepare students in this domain sits within the 'Health Advocate and Professional' theme. This includes health advocacy, medical ethics, lifestyle and health of individuals and populations. The theoretical and practical aspects of patient care are taught in Year 3 in sessions, which include role-play and case studies. These sessions are reinforced in the later years through simulation sessions. The Health Advocate and Professional Theme has a clearly defined, but smaller assessment weighting in Years 1-3 relative to the other themes. It is noted that evidence based medicine is considered part of the Scientist and Scholar Theme and teaching in this area has been significantly strengthened in Year 3. The Health Advocate and Professional Theme leaders have key roles on curriculum oversight committees in Years 1-3 but the continuation of this theme in Years 4-5 is less clear. Year 4 and Year 5 blueprint documents released to students on iLearn refer to PPD and H&S, rather than Health Advocate and Professional. Representation of this theme in the Clinical Years was through Year level learning outcomes and as a domain on the generic in-training assessment tool in the professionalism domain. Some Year 4 and 5 students indicated that the Health Advocate and Professional theme was not clearly visible or explicitly

covered, but rather was represented by email reminders to behave professionally and orientation talks on expectations.

**Professionalism and Leadership:** The curriculum to prepare students in this domain also sits primarily within the 'Health Advocate and Professional' theme.

### 3.3 Curriculum design

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

The Faculty have developed learning outcomes for all learning activities in the program. These are documented and used to ensure program integration, in blueprinting for assessment tasks and to guide student learning. Students are provided with student guides, accessed through the learning management system (iLearn), which include the high level learning outcomes for each year.

The Faculty have developed a curriculum based on 11 principles, which were developed in 2010/2011. The MBBS manages horizontal integration via the year leads who are responsible for the curriculum and assessment for each calendar year of the program. The theme leads and the pre-clinical and clinical assessment leads provide the vertical integration for the program. The theme leads ensure that there is a learning spiral where students are able to revisit topics multiple times throughout the program.

Vertical and horizontal integration of the three themes is maintained through representation of the theme and year leads on the MBBS Executive.

In Years 1-3 all Problem Based Learning cases have been rewritten according to learning outcomes. For example the Health Advocate and Professional theme is covered by specific learning objectives in Problem Based Learning cases.

The majority of students appear to be well prepared for clinical learning during the transition from Year 3 to Year 4. Some students suggested clearer communication of what was expected of them as members of the health care team would be useful for the first clinical placements. There are plans for a two week pre-internship shadowing experience at Gold Coast University Hospital for Year 5 students who have been allocated to internships there. This is part of the four week block that has been allocated for this purpose, which also incorporates presentation at a research symposium at the end of the year.

Horizontal integration between disciplines and rotations is less apparent in Year 4 and 5. Each discipline and rotation (e.g. Mental Health, Paediatrics) has discrete learning outcomes and sometimes, additional assessment activities during the rotation. The mechanism for integration and coordination of learning across the clinical disciplines is not yet clear.

### **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.*

Students are provided with handbooks, accessed through the learning management system (iLearn), which include the high level learning outcomes for each year. Learning outcomes related to specific activities or teaching blocks in Years 1-3 are provided to students in teaching sessions or are developed by students as part of the learning experience (e.g. Problem Based Learning). Students are able to compare their small group designed learning outcomes with those developed by the Faculty at the completion of the Problem Based Learning.

The Years 4-5 Rotation (subspecialty) level learning outcomes and core topics are articulated in the Student Guides, as well as in a “blueprint” of learning outcomes linked to written assessments. Students felt that the Student Guide outcomes were too high level to clearly guide learning, and they relied on the assessment blueprint for this. Concerns were raised at the perceived late release of the blueprint (in May 2015).

An explicit description of the learning outcomes for each stage of the proposed MD program is yet to be developed and the team requests an update on these when they are finalised.

### **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 program has developed an integrated curriculum to ensure awareness and experiential learning about Aboriginal and Torres Strait Islander peoples and their health. The team acknowledges the considerable amount of work which has occurred since the last AMC visit to develop and implement an integrated Indigenous Health curriculum. The Indigenous Health academic team, a small dedicated group, were confident about coverage of this domain.

The integrated Indigenous Health curriculum is delivered through Problem Based Learning cases and supplemented with other learning activities (e.g. Cultural Immersion Activity in Year 1). Nine cases across Years 1-3 include Indigenous content with assessment of the Indigenous Health curriculum including a ‘mind map’ following multi-choice questions (semesters 1-3), short answer questions (semesters 2 and 4) and a literature review (semester 8). The Indigenous Health curriculum in Years 4 and 5 is delivered via electives with some students undertaking a placement in an Aboriginal Medical Service or Aboriginal Community Controlled Organisations, or students being exposed to Indigenous Health issues through rural placements. The Faculty is making efforts to identify more elective Indigenous Health placement opportunities for students in Cape York, through the Apunipima Cape York Health Council, and other areas.

The team commends the Cultural Immersion Program, which provides an excellent platform for further Indigenous Health learning activities. The program is held off site as an overnight camp, and allows small groups of students to rotate through a range of cultural sessions. These sessions include a welcome to country, storytelling, and historical accounts given by Torres Strait Islander and Aboriginal community members, and culture and identity sessions. The program provides an excellent platform for further Indigenous Health learning activities. This is an impressive initiative, which has received Faculty and University awards, and has been showcased at a number of conferences.

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

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

The opportunity for students to pursue studies of choice exists primarily in Year 5 through selective and elective rotations. These rotations account for 18 weeks of the 39 weeks of clinical placements in the final year. Changes to the structure of Year 5 to be implemented in 2016 will enable students to complete a pre-internship placement or an additional elective (5 weeks). Clinical and research elective experiences are available to students in the current program, with up to 70 students across all cohorts having volunteered to conduct research in established projects.

The proposed MD program will use 100-120 hours of the formal elective rotation time for formalised structured group or individual projects. The extent to which student choice will be enhanced or restricted by the range of MD projects and selectives to be offered is not yet known. The team will be interested in updates regarding the introduction of MD projects, and encourages the program to maintain a broad range of learning opportunities.



## 4 Learning and teaching

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### 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 program employs a diverse range of educational methods appropriate to the level of study and setting. The pedagogical model for Problem Based Learning in Years 1-2 was clearly articulated and the team was impressed by the dedication to renewing Problem Based Learning (PBL) in Years 1 and 2. Consistency in the application of the Problem Based Learning model is ensured by regular facilitator briefings and peer teacher support. Engagement of more experienced Problem Based Learning facilitators in assessment and curriculum development assists in curriculum integration and alignment in Years 1 and 2, as well as providing professional development opportunities for teachers. Staff development is also important for ensuring that the curriculum continues to evolve and improve, given the reported low turnover rates for Problem Based Learning facilitators.

The rationale for expanding to a case based learning model in Year 3 through the Bond Virtual Hospital (BVH) modality was also clearly articulated. In the renewed Year 3 curriculum commencing in 2015, students are placed in the BVH and clinical simulation environment, with structured clinical placements. The students have the opportunity to complete blocks of learning in each of the core senior clinical rotations in the BVH clinical learning environment. In addition they continue to have weekly placements in a variety of clinical settings for 120 hours across Year 3 of the Medical Program.

The Bond Virtual Hospital has achieved its intended goals of strengthening student engagement, and encouraging transition of case based learning from exploration of biomedical principles to application in the clinical context.

Students were uniformly enthusiastic about the Bond Virtual Hospital and independently verified the purpose of renewing student engagement in case based learning. The suspense of not knowing which students were to present cases was effective in ensuring that all groups worked on preparing a case presentation and responding to the trigger questions in the electronic application, despite the absence of a facilitator.

Both un-facilitated and facilitated sessions take place each week linked with the virtual hospital. Within the facilitated sessions following virtual ward round, one person is chosen from each student group to be their 'spokesperson' in a larger facilitated group discussion. The students only become aware of this upon arrival at this session. This encourages students to take initiative in their learning, come prepared and develop communication skills such as clinical hand overs.

The Bond Virtual Hospital content is largely in the form of multimedia triggers such as brief snippets of clinical records, observations and investigations. Students appreciated

that the format of the case material and de-briefing session simulated clinical practice, focussed on developing their clinical knowledge. The team observed that advanced clinical decision making skills were covered, such as decision algorithms for discharging patients, which are often covered in the final years of medical programs. There was an apparent emphasis on acute presentations in the emergency context. A broad range of presentations in different clinical settings, covering core diagnostic and management skills, would be appropriate case material for students in the very early stages of clinical learning and link with the community based and low acuity placements that year 3 students experience.

While not equivalent to patient contact, students in later years felt that Bond Virtual Hospital had been helpful in achieving the secondary objective of preparing students for Year 4 by practising their case presentation skills.

It appears that Bond Virtual Hospital (BVH) has been developed independently of the Faculty IT group. Given its dependence on key individuals, the Faculty may wish to consider contingency plans for ongoing development and updating of BVH content, as well as technical back-ups in iLearn for revision and self-study.

Disseminating the BVH evaluation by publications is to be commended, and the team would be interested to hear of further scholarship on this innovation.

Small groups, extensive feedback and support of learning to mastery level are features across Years 1 to 3. This has been possible because of excellent and stable staffing, staff development and the use of tools in informal and formative assessment. Small class sizes were evidenced by no more than eight students per Problem Based Learning group, and five-six per clinical skills session.

A range of methods are used to develop clinical skills, including role plays, simulated patients, and part-task trainers, to build up to learning in clinical attachments. Emergency scenario based simulation sessions are also conducted in the later years of the program.

Large group teaching sessions have been renamed, and lecturers are encouraged to use more interactive modalities such as flipped lectures and multidisciplinary forums. Consistent access to recordings, in particular by visiting speakers, would be welcomed by students. While the program is consistent across clinical placement sites, access to core or recorded content in lectures and discipline led tutorial sessions could enhance the equivalence of learning opportunities in the clinical years of the program.

New or enhanced learning modalities planned for the MD program include core and elective research skills modules, and a portfolio. In 2014 the Faculty embarked on significant curriculum development in research methods teaching, resulting in a suite of evidence-based practice on-line modules that can provide research methods teaching for undergraduate, graduate and research higher degree programs in the Faculty. It is a highly flexible model that will enable academics to select and recommend appropriate components to suit student learning needs. While the core research modules in

Evidence Based Practice have already been developed, others are in planning stage. The team will be interested in updates on their development in the progress report.

The portfolio will compile evidence of achievement of existing elements in the program such as online research training modules and case reports. The portfolio uses a points based framework, accrued in a manner similar to continuing medical education points. Students will satisfactorily complete a range of research and clinically focused assessment tasks that demonstrate their capacity to understand and apply the scientific approaches of inquiry in medicine and related health care fields, and utilise research evidence in their clinical practice.

The MD project will be the major compulsory component of the MD Portfolio. Students in Year 4 will be offered the choice of:

- 1 Research based project
- 2 Capstone experience/rotation
- 3 Professionally focused project.

#### *Research*

This can be undertaken across the final two years. A list of suitable research projects identified by Faculty academics and associated clinicians will be offered to students to choose from. Students may undertake the whole project or participate with a small team and contribute to one or several parts of the project e.g. the survey, literature review, research ethics application etc., and write up their individual contribution, which contributes to the whole.

#### *Capstone Experience/Rotation*

A Capstone Experience is usually a final year experience, which provides opportunities for a student to apply the knowledge gained throughout their undergraduate degree. This project would be undertaken within a specific rotation in Year 5, with the required preparation and planning to achieve the learning outcomes undertaken prior to commencing the rotation.

Examples of a Capstone experience could include a specifically targeted project undertaken at the following existing sites:

- Kirakira Hospital in Solomon Islands
- An Indigenous health service in Tamworth, NSW or north Queensland
- A placement in a special area of clinical interest such as orthopaedic surgery.

During the placement, students would undertake and write up a number of activities that could include a clinical audit, or a targeted staff education session.

#### *Professionally focused project*

In the final two years students may choose the option to undertake a project in their special area of interest, for which they can demonstrate cognitive, leadership, technical

or creative skills. This could include educational development, a medical humanities project, writing a journal article, acting as a clinical tutor.

The MD implementation group are actively developing and confirming the range and type of projects to be offered to students. The Faculty is encouraged to define the learning outcomes for these projects to ensure clarity of purpose and equivalence of workload and achievement across the projects. Documenting agreed generic learning outcomes for these projects will assist in ensuring that the entire range of projects provides an equivalent and meaningful learning experience to the required standard.

As noted at Standard 3.2, the team requests updates on progress in the curriculum development for the MD Project.

## **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.*

Throughout the program, self-directed learning is formally encouraged as students move from facilitated to peer-led collaborative learning.

This is particularly evident in Years 1-3, where self-directed learning is formally encouraged through individual assessment of student engagement in Problem Based Learning sessions by the Problem Based Learning facilitators, graduating to student led collaborative learning in Bond Virtual Hospital (BVH) without facilitators. Despite initial misgivings, students were motivated to go through the BVH material in their groups, as they would be unpredictably selected to speak in the de-briefing sessions, which they found engaging and motivating.

In Years 4-5, students accepted that self-directed learning was to be expected during clinical placements. The high level learning outcomes in the year student guides did not always provide the specific guidance that some students desired. They were less confident about their learning, but most accepted that this uncertainty was part of learning about medicine.

The proposed MD program will introduce a student portfolio, which will consolidate and provide evidence of achievement in activities such as online modules and case reports which are already completed by students. The intention is to mirror the approach used in continuing professional development activities, and thus prepare students for graduate practice.

The MD implementation group is yet to develop a process for tracking student accumulation of the required portfolio elements, such as a portfolio plan, timeline and staged submission in Years 3 and 4. As noted in Standard 5.1, the team will be interested in updates on the implementation of this threshold assessment and how feedback or advice will be provided to students after their submissions to build lifelong learning.

### **4.3 Clinical skill development**

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

Development of clinical skills through role plays, simulated patients, and part-task trainers build up to learning in clinical attachments, the latter supported by simulation. The team was impressed with the consistency with which students and clinical supervisors reported that they were satisfied with the degree of preparation in clinical skills, in readiness for learning in clinical placements.

During the clinical years, structured teaching in clinical skills is less apparent. Mini-CEX and logbooks have been implemented in some, but not all, clinical rotations to assist the ongoing acquisition of clinical skills. Core skills will be tested in a new 12 station Objective Structured Clinical Examination (OSCE) in Year 5. It is anticipated that the majority of students will need to do both Part A and Part B of this OSCE. The extent to which remediation or extra teaching will be required or requested after Part A results are known will assist in determining whether more structured teaching in the Practitioner theme is needed after Year 3.

### **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 and clinical supervisors are consistently satisfied with student preparation in clinical skills, in readiness for learning in clinical placements. Clinical supervisors the team spoke with agreed the performance of Bond graduates as junior doctors was equivalent to graduates of other medical programs. Some clinical supervisors sought assurance there should be no reduction in clinical exposure, including with the introduction of the MD.

The MD implementation group acknowledged that a process of consultation and communication regarding the new program was yet to commence, and this may address supervisor concerns about the impact of the program.

Students who had experienced the transition from Year 4 to Year 5 noted that they were more ready to take on active roles following their first clinical year. At Gold Coast University Hospital for example, students are provided with their own electronic medical record logins, and are permitted to enter clinical notes, and order tests, provided they are signed off by clinicians. Instructions for doing so are provided in clinical site guides on iLearn, and confirmed by the Medical Student Placement Coordinator and students.

While the clinical rotation in the Solomon Islands is not available for all students, those who were placed at the KiraKira Hospital in the Solomon Islands were expected to assist with providing medical care, particularly at busy times, and after hours.

Students noted some variation in the type of clinical learning available across some rotations. Students endorsed placements such as Emergency Medicine (adult and paediatric) as being most effective for their learning because of the opportunities for hands on and participatory learning, supported by enthusiastic supervisors.

#### **4.5 Role modelling**

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

Informal role modelling occurs in the program, with students consistently naming particular clinician academics as role models, rather than clinicians or researchers. More formal opportunities for clinical and research leaders to teach in the program may strengthen this approach to motivating learners.

While only one third of the proposed MD projects will be focused on research, the majority of students, teachers and senior staff cited the opportunity to do research as a rationale for the MD and when discussing MD projects. The active involvement of the planned academic chairs at Gold Coast University Hospital and of key research active staff in the program may help students to see clinical research as a career path and to be more engaged in research during their degree.

#### **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.*

Patient centred care and collaborative engagement encompass an approach to interacting with patients and others; providing case based learning materials with names may signal that “cases” are people but patient-centredness and collaboration need to be reinforced with active learning in the clinical years.

Patient centred care and collaborative engagement concepts are promoted in Years 1-3 through the Health Advocate and Professional theme, Indigenous Health and a Shared Decision Making session in Year 3. However, these concepts are less evident in Years 4-5. A Year 5 learning outcome which is reflected in an in-training-assessment domain is the main evidence for formal curriculum in patient centred care in the clinical environment. Formal teaching and assessment explicitly covering and testing for patient centred approaches would strengthen students’ ability to apply these concepts to clinical practice prior to graduation.

#### **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 are frequent examples in the program of learning from health professionals other than doctors. Largely informal learning from other health professionals, such as in

multidisciplinary forums, psychologists in communication skills teaching, midwives in obstetrics and nurse educators in Emergency Department placements were cited by students and staff. It appears that students undertake formal interprofessional learning predominantly by learning from, rather than about, or working with, other health professionals.

While students receive an introduction to interprofessional learning during Years 1-3 with formal program content such as Problem Based Learning objectives, forums and resource sessions with other health professionals, this is less apparent in Years 4-5. The formal curriculum in interprofessional learning is represented by a high level generic Year 5 learning outcome which is reflected in an In-training Assessment (ITA) domain *Teamwork - Contributes effectively to peer-group learning and to the clinical team* but it is not clear how strongly this is promoted and achieved.

There may be opportunities to strengthen informal and formal learning by medical students with health professional students in physiotherapy, nutrition and dietetics and exercise science already within the Faculty, and during rural and overseas rotations. The team recommends that the Faculty further explore formal opportunities for interprofessional learning in Years 4-5.

## 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.*

Following the departure of the Clinical Lead for Assessment in late 2013, the leadership of the medical program made a conscious decision that assessment would be a shared responsibility across year and theme leads. In the intervening period, considerable efforts appear to have been made to review assessment policies and procedures, with the assistance of external reviews and Faculty development activities.

The team commends the efforts of the medical education group, and the designated assessment academics, in clarifying and developing the program's assessment processes and practices. Assessment principles and rules are clearly stated in the program's "Assessment Overview" (February 2015). A process for aligning assessment with stated learning outcomes for each stage of the program is documented in flowcharts, with key responsibilities being held by the Year Lead for the development, implementation and review of assessment.

The team notes the activities of the Examination Coordination Committee, including in coordinating exam development, and the program of Faculty development, particularly in Years 1-3 of the program. Staff who spoke to the team indicated these efforts could be sustained with current resources.

The team noted minor inconsistencies of committee nomenclature and functions from document to document, as previously noted in Standard 1. The team does not believe this impedes the function of the program's assessment, and is confident the documentation will be updated in the short term to reflect current governance arrangements.

An "Assessment Overview" document is provided to all staff. The program has also provided this document to students through iLearn, the main repository for student information. Assessment and progression rules together with semester by semester documents containing information about learning outcomes, assessment tasks, blueprints and student guides are available on iLearn. The team notes the multiplicity of documents on iLearn may be confusing to students and recommends the program consider creating simple overview documents outlining type of assessment, timing and weighting over the course of a year.



Students appear satisfied that assessments aligned with what they were taught, particularly in Years 1-2, and increasingly, with what they were expected to know, in Years 3-5. The progression to a more mature style of self-directed learning is commendable.

As discussed at Standard 4.2 the MD program will introduce a student portfolio, which will consolidate and provide evidence of achievement in activities such as online modules and case reports which are already completed by students. The Faculty should as a matter of priority develop and implement an assessment approach for tracking student progress of the required portfolio elements, such as a portfolio plan, timeline and staged submission in Years 3 and 4.

In response to an external review, the program has mapped all formative and summative assessment across all years of the program and the balance appears to be appropriate.

The Clinicians Assessment Committee is leading Faculty development to improve feedback on performance to both students and clinical supervisors and this should continue.

The team observed many staff with key responsibilities for assessment also held key roles in curriculum delivery and improvement, and in student support and progression. While this is not surprising in a new and smaller medical program, the implications for workload management and perceived conflicts of interest should be borne in mind to ensure the sustainability and integrity of the assessment program. While the assessment team were able to clearly articulate their roles and functions the team recommends a review and clarification of the committee structure and individual roles to ensure there is little potential for real or perceived conflicts. This review of assessment governance should be addressed by the larger review of committee structures and functions noted at Standard 1.

## **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.*

A range of written, practical and clinical assessment methods are used across the program, and are aligned with the level of learning required, demonstrated through various blueprinting processes.

Processes for blueprinting have been documented and are available to staff. As well as a high level blueprint for weightings, a more detailed blueprint of learning outcomes is available to students in Years 4-5, which is used by students as a learning tool. Students

were concerned that this blueprint had not been released until May 2015, and clarification of student expectations, in terms of the purpose and content of the blueprint, may be useful in allaying their concerns.

The Clinicians Assessment Committee has carriage for reviewing all workplace based assessments and review of professional behaviour by individual students at the end of each rotation. This group also has carriage of curriculum review, development and implementation in Years 4-5, as well as written assessment. It is not clear to the team how these different activities are operationalised. The original aim of the group, which is still evident, was to engage clinicians with the program, and assist supervisors who were reluctant to document concerns about students, to communicate those concerns to a group which could then take responsibility for following up with the student. While this approach has strengthened the validity of workplace based assessments and facilitated the identification of under-performing students, it could result in conflicted roles and/or insufficient time being available for curriculum development, and improvement.

The curriculum in Years 4-5 appears more discipline driven, and this is reflected in the different assessment tools for different disciplines.

Formal standard setting by modified Angoff and borderline regression are used. The appointment of assessment academic leads and examination coordination groups has facilitated the sustainability of these processes.

The team commends the release of information about assessment processes to students. Some students expressed concerns about the use of borderline regression in determining which students will sit Part B of the 5<sup>th</sup> year Objective Structured Clinical Examination (OSCE). Further explanation about this method and its purpose may improve understanding and allay student concerns.

### **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 University's regulations define the criteria for identification of underperformance, and the program has a clear process for managing underperformance. The Board of Examiners identify which students are academically "at risk" and they are referred to the Health and Professional Conduct Committee.

In the early years of the program efforts focus on remediation with a view to progression. If students do not improve, counselling is provided and students are directed to repeat the failed subject/year. Only one year may be repeated under normal

circumstances. Resit examinations are available for point of progression examinations. Underperforming students are identified through a range of processes including a short summative assessment held around week 6 of each semester in Year 1, and Problem Based Learning facilitator assessments. Staff indicated they were familiar with criteria for referring students to the Year lead on the basis of performance in Years 1-3.

Clinical supervisors were clear on whom they speak to if they had concerns about students. Several supervisors noted that the small cohort of students enabled identification of underperformers as they moved through the program, as well as the identification of students exhibiting unprofessional behaviour. The Clinicians Assessment Committee reviews student performance to enable hand over of those students with marginal performance to the next discipline, so there is a term to term handover process for students at risk.

Assessment feedback to students is generally well received. Formal feedback sessions are provided after written and Objective Structured Clinical Examination (OSCE) assessments. Most students feel the appropriate amount of information is conveyed by markers, explaining where the student can improve. However, some students who the team spoke with were less satisfied that this was sufficient feedback, as examiners' comments on papers varied in quality and quantity. Similar variability in satisfaction with feedback was noted by students regarding the Year 2 Integrated Multi-Domain Assessment.

For all assessments students are able to follow up with relevant assessment coordinators for more feedback if required.

During clinical skills training, time is allocated for each student to receive feedback from the supervising tutor of the session. Along with this, some sessions involve simulated patients who also give feedback. Students report this provides excellent first hand feedback and appraisal on certain clinical aspects and skills.

Students indicate feedback on summative assessments has improved in recent years, with assignments in Scientist and Scholar, Health Advocate and Professional and Practitioner given a breakdown of marks through a rubric and additional written and recorded comments. A statistical breakdown of examination marks is provided to students including a pass mark and median score for each section which allows students to identify areas for improvement. Students are provided access to their non-point of progression exam papers for review with a complete answer booklet, which is well received by students.

While there is a process for providing exam question writers with psychometrics on their questions, clinical supervisors frequently stated that they did not receive feedback on student performance (which can encourage benchmarking and reflection on the effectiveness of their teaching) or their teaching. The program should ensure that meaningful feedback occurs for both students and clinical supervisors.

Students were unsure of the utility of In-Training Assessments, stating that they were sometimes completed by supervisors with whom they had had little contact. While they appreciated that supervisors were meant to gather information about student performance from health care colleagues for the assessment, students were not sure that this happened, with some feeling that this compromised the authenticity of feedback. Other students regarded In Training Assessments as a *de facto* attendance sign off, to assure the program that the student had participated in the clinical placement, rather than an opportunity for obtaining meaningful feedback on their learning or performance.

#### **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 team commends the program for the quality assurance of its assessment program. The program provided evidence of robust processes to blueprint, develop Faculty members, conduct psychometrics, and ensure administrative support is adequate to make these processes sustainable. The program has provided an overview of the outcomes from assessment reviews and the planned actions.

Year leads have identified priority areas for improvement, including the quality of items, establishing an exam bank, ensuring consistency of workplace based assessment across sites and the introduction of mini-CEX and case commentaries for all rotations.

A paper based portfolio is a planned component of the MD program. Processes for monitoring and ensuring timely achievement of portfolio requirements are to be developed and the team encourages the program to confirm these assessments and learning outcomes as soon as practicable, given the planned commencement of a modified Year 3 curriculum in 2016 .

Markers of summative assessments use agreed marking rubrics and often practise double marking so samples are assessed by two academics. The Faculty uses clinical teachers and assessors for clinical exams, and examiners meet to standardise marking before exams.

## 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 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 University has a quality assurance framework which clearly defines the organisation's strategic priorities, accountabilities, responsibilities and documents a cycle of continuous improvement. As part of the quality assurance and improvement process, the Bond University Council leads a strategic review of each Faculty every five years.

A four person panel completed the first review of the Faculty of Health Sciences and Medicine in early 2012. The review panel was largely positive in their document which was presented to the University Council.

At the medical program level, the team noted several external reviews which have and will inform curriculum changes.

The Faculty provided the team with an evaluation calendar for 2015, which lists a range of formal and informal evaluation activities within the program.

Although an evaluation group was established several years ago, it has not met for at least a year. While Year 1-3 Coordination Committees and the Clinicians Assessment Committee provide formal opportunities for discussion and debate about change and major proposals regarding curriculum and program delivery, the team could not identify a currently convened committee responsible for curriculum evaluation renewal and development.

The team recognises the challenges in allocating resources to monitor and evaluate the curriculum and were pleased to be advised that the Faculty would look to implementing a review of evaluation governance structures and activities, bringing in independent experts where appropriate. It will be important for the program to develop and implement a comprehensive evaluation framework that identifies priority areas. The plans for evaluation and monitoring in the MD program do not appear to be fully developed.

The team suggests adequate resources should be allocated to guide ongoing monitoring and evaluation within the Faculty. The Faculty should develop a comprehensive evaluation framework which addresses key elements of program delivery and evidence of a reporting schedule which prioritises key areas to be evaluated.

Many of the processes to gather feedback within the medical program are consistent with University and Faculty processes. Students are able to provide feedback on both educators and subjects through the university wide e-TEVALS (electronic teaching evaluations) which are completed at the end of each semester in Years 1 – 3. The e-TEVAL is two parts, one an educator survey for student feedback on lecturers and tutors, and the second part a subject survey to evaluate the subject design and structure. These evaluations have very high response rates (approximately 80% and higher) since the evaluations were changed from paper based delivery to electronic format commencing 2012. Educators with low satisfaction scores are provided support to improve teaching strategies, and those with high satisfaction are acknowledged at each semester's Dean's Awards.

A new university-wide Quality in Learning and Teaching – Student Feedback (QILT-SF) system is being trialled. The system is designed to close the loop between student evaluations and subject coordinators to respond to key issues raised by students in the subject evaluations, with responses made available on iLearn.

The program solicits online feedback from Problem Based Learning groups each week in Years 1 – 3 on each case and its associated learning activities. This feedback is distributed to relevant staff and reviewed at Year Coordination Committees as required. Deficiencies in the cases and/or useful additional material can be identified through student feedback, thus enriching the curriculum and the medical program in general. Problem Based Learning facilitators are evaluated separately from the eTEVAL system. Those facilitators with low satisfaction scores are supported by the Problem Based Learning Lead to improve performance.

The team observed that informal feedback is communicated between the Faculty and supervising clinicians in hospitals. Hospital based clinical leads spoke highly of Faculty's willingness to receive and act upon feedback. However, the team were unable to readily identify formal program evaluation mechanisms for supervising clinicians, although the clinicians were keen to receive such feedback regarding their performance as supervisors. Acknowledging the challenges relating to evaluation where supervisors are geographically dispersed across many clinical specialities, the team encourages the program to establish formal evaluation and reporting processes regarding their experiences with the program.

Focused evaluation within the Year 3 curriculum includes evaluation of the Bond Virtual Hospital in 2014 within a research framework. An evaluation strategy for the renewed curriculum in Year 3 was provided to the team. The stated aims of the strategy are critical review of learning content and processes with a view to quality improvement; engagement of learners and Faculty in program development and improvement; and

encouraging habits of reflection as part of lifelong learning. The team looks forward to updates on Year 3 evaluation in the context of an overall evaluation for the program.

The Student Staff Liaison Committee (SSLC) plays an important role in evaluation and student feedback and is one mechanism for communication between the students and the curriculum/program management group. The SSLC meets twice per semester and is a forum for students via their year representatives to meet and raise concerns with senior staff of the medical program. The team noted while membership of the SSLC enables feedback to be directed to the Years 1-3 and Clinicians Assessment Committees, there is no formal mechanism to communicate key decisions made at these Committees back to the SSLC.

Students cited examples such as insufficient availability of lecture podcasts and lack of constructive feedback regarding Objective Structured Clinical Examination performance, and inconsistent experiences with the In-training Assessment processes, where improvements had been suggested to Faculty but not formally acknowledged or acted upon.

The Faculty plans more robust consultation with students and Faculty members regarding the planned MD program.

Students were supportive of the way in which the program responded to student concerns in implementing program changes. Examples provided to the team included requests for the earlier release of timetable information to enable planning for work/family responsibilities; and Year 3 student requests for more learning regarding clinical documentation which is now contained in the formal curriculum and recognised as a mastery skill.

The program collaborates with a range of different educational providers nationally and internationally. Collaboration with Griffith University is across curriculum, learning and teaching strategies and assessment. The collaborative approach is most explicitly demonstrated through the sharing of supervisory staff, a common rotation structure in Years 4 -5 and shared approaches to clinician feedback on student performance during rotations i.e. the In-Training Assessment. In 2015 the two medical programs will be running different Objective Structured Clinical Examination (OSCE) assessments, with shared stations and shared examiners as a means of benchmarking and collaborating with one another.

Additionally, the Faculty benchmark with visiting experts and reviewers. The medical program is involved with a range of assessment consortia including International Database for Enhanced Assessments (IDEAL) and Australian Collaboration for Clinical Assessment in Medicine (ACCLAIM) which act to provide a benchmark for student performance.

Staff of the medical program have been involved with a 2013-2014 initiative to provide a Graduate Certificate of Medical Education to staff of the Fiji National University. This

initiative is in collaboration with the medical programs at Flinders University, University of Otago and James Cook University.

## **6.2 Outcome evaluation**

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

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

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

The program participates in the Medical Students Outcomes Database which provides benchmarking opportunities against other programs. It was not clear to the team that the results of this data are used to inform program policies.

During 2012-2014, the program assessed program outcomes by surveying a small sample of graduates and their employers. Survey outcomes demonstrated a high level of employer satisfaction with Bond graduates' preparedness for the intern year and the program must be commended for these results. However, those locations employing small numbers of graduates have not been involved because they consistently expressed concern for the anonymity of those graduates. The team acknowledges the challenges of maintaining contact with graduates and the program reports they have a valid contact for approximately 79% of the 2012 graduating cohort at the end of their PGY1. The equivalent figure for 2013 is 73%.

A Faculty-wide project for longitudinal tracking of graduates from health professional programs commenced in 2013. This project has ethics approval to enable dissemination of findings relevant to program development or workforce issues and commenced with the graduating cohort from the medical program in 2013.

The Faculty has undertaken performance evaluation of student cohorts in relation to yearly progression rates for undergraduate and postgraduate entry status and gender. Evidence for more detailed analysis of subjects, placements and student characteristics was limited.

Ongoing formal evaluation of graduates and employers should continue, in particular with the changes to Year 3 and the introduction of the MD program.

Formal evaluation of program outcomes should be used to refine the program in relation to selection, curriculum, assessment and student support and in sharing results with key stakeholders.

## **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 evaluations are communicated to the relevant Year Coordination Committees, Clinicians Assessment Committee and MBBS Executive.

Electronic Teaching Evaluations (eTEVAL) results are released to all students and the Quality in Learning and Teaching – Student Feedback system will further add to mechanisms for ensuring students are aware of the results of their eTEVAL evaluations. Year 4 and 5 students receive summaries of their evaluation comments midyear and/or at the beginning of the subsequent year.

The program should demonstrate a consistent reporting schedule to stakeholders, staff and students.

## **7 Implementing the curriculum – students**

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### **7.1 Student intake**

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

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

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

The medical program has defined the size of the student intake in order to maintain a high quality of teaching and clinical exposure, achieve financial sustainability and align the number of graduating students with Queensland Health's capacity to provide intern places. Since 2012, the program's intake has been 95 students annually. The business case for the MD is predicated on a small increase in student numbers to an intake of 100 students per annum.

The ratio of school leaver to graduate entry admission is approximately 80:20. There are no Commonwealth Supported Places in the program.

While there are a small number of international students completing the program, the Faculty indicates there are no plans to admit further international students. This is consistent with Queensland Health's commitment to providing clinical placements and intern places to domestic students as a matter of priority.

The attrition rate in the medical program is comparable to other medical programs. Across the first six graduating cohorts the attrition rate of the medical program has averaged 8% between 2005 and 2010. On average 2-4 students each year are successful in obtaining a position in another medical school during their first year of enrolment in the medical program. There are a further 1-2 students from each cohort that are academically unable to progress past the third year of the program and 2-3 students who have left the program because of financial difficulties.

To reduce attrition, the Bachelor of Biomedical Science Pathway will allow eligible graduates of the Bond Biomedical Science program to enter into Year 2 of the medical program. In 2015, the first year of this pathway, 3 students were successful in meeting the course entry requirements and entered Year 2 of the medical program. The Faculty has also attempted to address the attrition rate through financial counselling offered to students entering the program with a special focus on ensuring that students understand that FEE-HELP is only able to fund the first two years of the program and that students will require substantial additional financial resources to complete the program.

The medical program does not have access pathways or targets for Aboriginal and Torres Strait Islander peoples, rural origin students and students from under-represented groups. The team would welcome signs that specific efforts are made to include students from rural, disadvantaged and particularly Indigenous communities.

The team acknowledges the University's establishment of the Nyombil Indigenous Support Centre. The program has made significant and largely successful efforts and success to establish Indigenous awareness and involvement in the curriculum. The Faculty considers that the next stage of work in advancing the Indigenous Health is recruiting Aboriginal and Torres Strait Islander students to the medical program. The medical program anticipates having a clear pathway developed for achieving the recruitment and retention of Aboriginal students in 2016 and the team would welcome an update on this important initiative.

The Faculty is working to establish scholarships for Indigenous students in the medical program, and the team encourages ongoing efforts to ensure this comes to fruition. The team notes that providing these scholarships would require sufficient space within the teaching program and some personal financial support beyond the base level of medical program fees.

## **7.2 Admission policy and selection**

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

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

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

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

The program has clear, transparent, objective admissions procedures at University and Faculty levels. All applications to the medical program are lodged with the Queensland Tertiary Admissions Centre. In early 2014 the Faculty based office of Student Affairs and Service Quality assumed management for the admission and selection processes of the Faculty. Information about application, selection and admission is available on the Bond website.

Commencing in 2014, graduates from the Bond University Bachelor of Biomedical Science Pre-Health Professional major are eligible to apply for entry to Year 2 of the medical program, with the first intake into Year 2 achieved for 2015. The curricula of both programs have been aligned to facilitate this transition. Selection is structured along the same pathway as the graduate entry pathway to Year 1 and includes academic results (minimum Grade [Point Average (GPA) = 3.25/4), prerequisite secondary

subjects (Chemistry, Maths B, English) or equivalent, and an eight station Multiple Mini-Interview.

Bond University has clear policies on enrolment of students with disabilities and infectious diseases. The University's Disability Policy is available on the university website.

The University has an established student services division that includes a disabilities officer. Details about the services and support for students with disabilities are available from the University website.

The Faculty has a Vaccination Policy including procedures relating to blood borne viruses and exposure prone procedures. The medical program has specific compliance requirements with which students must demonstrate compliance before the end of Orientation week. In particular, evidence of blood borne viruses must be known prior to entry to the program. Should a student develop a disability or infection during the program, the Faculty has shown flexibility in allowing continuation subject to conditions. It is possible to complete the program with compliance to conditions which are defined by the MBBS Executive Committee.

There are no Indigenous students in the medical program. The team acknowledges the current efforts to establish scholarships for Indigenous students and looks forward to an update on the success of these scholarships. The team found no specific admission, recruitment and retention policies for Aboriginal and Torres Strait Islander peoples. However, there is a clear motivation to recruit and retain Indigenous students to the medical program. Bond University has shown success in recruiting Indigenous students, with the number of students identifying as Indigenous increasing from 12 in 2008 to 43 in 2013. In 2014 there were three Indigenous students enrolled in the Faculty. The University reports a graduation rate of 86% for Indigenous students.

Public information on the selection process for the program is comprehensive and readily accessible on the Bond University website. Information about mechanisms for appeals regarding selection processes is not readily available. Information found in the FAQ section implies that the Faculty will not enter into any discussions regarding individual applications and provides no further information regarding appeals. The team encourages the Faculty to make information regarding appeals 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*

- *students with mental health needs*
- *students at risk of not completing the medical program.*

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

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

There is good information and an appropriate emphasis on the supports available at entry to the medical program. Students are required to complete compliance procedures and to sign a Student Charter and Code of Conduct at the commencement to the program.

Students with declared disabilities are provided with support through the central University Student Services and Disability Officers who make recommendations about the type of adjustments that might need to be put in place to support these students to meet the assessment requirements of the medical program. The student's confidentiality is protected throughout this process.

The range and strength of student support arrangements are impressive. The team found that support services are well understood and well used by students. Staff are very familiar with services available and will refer students to appropriate pathways.

The team commends the Faculty on well-developed processes to support and remediate students at risk of non-progression in the medical program.

The University has well developed generalised student information and support facilities. The medical program supplements these with a range of academic and personal support structures. Frequent and usually structured academic feedback occurs with Problem Based Learning completion, twice a semester with In-training Assessment's and after the Objective Structured Clinical Examinations. The program is small enough that the first point of contact for personal support is normally stated by students to be the Year Lead for all five years.

The Faculty has recognised that academic staff have a potential for conflict of interest if they must provide personal support and apply academic rigour. A Faculty based Academic Lead for Students has a specific role outside the academic program. The Student Support Lead will arrange social and psychological referral locally beyond the Bond campus.

A student may be designated as "at risk" for either professionalism or academic issues. If this occurs the student is directed to make contact with the Academic Lead for Students and a program for remediation is defined and monitored. The Academic Lead for Students is able to report to the "Student at Risk" committee if the student has been compliant and taken steps to remediate their academic or professional performance.

If a student is unable to remediate the behaviour or has sustained poor academic performance they may be referred on to the Health and Professional Conduct Committee for further assessment. There is no direct relationship between the MBBS Student at Risk Committee and the Health and Professional Conduct Committee.

The Health and Professional Conduct Committee is chaired by the Dean. The Chair will meet with the student, with the Student Affairs Coordinator taking minutes to outline what the student is alleged to have done. The processes of the Health and Professional Conduct Committee are explained to the student who may bring a support person to the meeting. The Academic Lead for students is often that support person. The Academic Lead for Students is not a member of the Health and Professional Conduct Committee or the Board of Examiners.

The Committee is then convened and populated at the discretion of the Dean. This recognises the potential for conflict of interest when a student's non-academic condition or behaviour may inappropriately influence the deliberations of the academic staff.

The team commends these efforts to separate student support and academic progression decision making. However, the team recognises that due to the close nature and small size of the program, it may be difficult to separate student support from academic progression decisions. The team encourages the program to investigate where these areas should be clearly separated.

The Clinicians Assessment Committee provides a vehicle by which students encountering difficulty in meeting the expectations of the clinical placements can be appropriately handed over, and their learning needs addressed proactively. This committee also allows for communication across the various clinical sites where students are on rotation.

## **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 team commends the Faculty on well-developed and apparently well-functioning policy, and procedures to manage students with concerns regarding their fitness to practise. The Health and Professional Conduct Committee deals with students identified with behavioural or professional issues.

One of the three integrated themes of the program is 'Health Advocate and Professional', and students and staff are strongly aware of the expectation that unprofessional behaviour personally or in a colleague, student or clinical teacher, will be recognised and addressed. The program provided several documented examples where fitness to practise concerns were managed successfully through the Health and Professional

Conduct Committee and resulted in positive outcomes for the students involved. These were of varying seriousness but all appeared to be appropriately addressed (and known of or acknowledged by other staff members at the interviews). The team was impressed by a strong culture of early intervention and remediation within the medical program.

## **7.5 Student representation**

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

The team commends the program on strong student representation in the governance of the program.

An elected representative of the Bond University Medical Students Society has a position on the MBBS Executive committee.

The Student Staff Liaison Committee includes Academic year leads and student representatives who are elected to either a year student lead role or academic representative position on the Bond University Medical Student Society. Year representatives are elected in each cohort who meet with and discuss cohort concerns to the Faculty and senior staff through the Student-Staff Liaison Committee (SSLC) meetings. The SSLC meets twice each semester. Students take the lead in the committee by working with their cohort groups to identify areas for discussion with the Faculty. These are then presented to Faculty members in the form of an agenda for discussion in the next scheduled meeting. The Student Staff Liaison Committee is chaired by the Associate Dean, Student Affairs and Service Quality and secretariat support is provided by the Office of Student Affairs and Service Quality.

## **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 medical program is indemnified and insured for all education activities through Unimutual Limited. The cover provided includes Malpractice Protection, Professional Liability Protection, and General and Product Insurances. Bond University is fortunate to have strong clinical placements at a wide variety of private hospitals. Student indemnity in clinical placements is covered by Bond University policies, the private hospitals policies and the individual senior clinicians' personal medical indemnity insurance.

Clinicians should be encouraged to ensure that their medical indemnity includes medical student involvement in their active clinical practice.

## **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.*

Students and staff of the Faculty have access to impressive infrastructure at the Bond University Campus and across their network of clinical sites. The Bond University Campus, which is used as the main site for delivery of the program in Years 1 and 2, continues to be developed for use by the Faculty.

Since the AMC accreditation visit in March 2011 the Faculty now has a second campus in the Robina precinct that includes the Bond Institute of Health and Sport (BIHS), and the Bond University Centre for Clinical Education and Research (BUCERC). These are both located within or near Robina Hospital, a 364 bed public hospital of the Gold Coast Hospitals and Health Service (GCHHS).

The opening of the Bond Institute of Health and Sport and the relocation of some staff teaching into non MBBS programs have enabled the expansion of space available to the medical program and refurbishment of facilities on the main campus. This has included establishment of a new Collaborative Learning Space and new biomedical science laboratories within the Faculty precinct.

Changes to the curriculum, refurbishment and expansion of the anatomy facilities, as well as the purchase of additional equipment, has enabled the relocation of all anatomy teaching to Bond University. This is a very positive development as the Bond University students are no longer required to travel to Griffith University for periods of intensive dissection to meet the learning outcome of the anatomy curriculum. Further improvements to the Collaborative Learning Space to facilitate interactive student learning activities are planned (e.g. flipped classroom) and would be highly beneficial to assist the delivery of the program in Years 1 and 2.

The Gold Coast University Hospital (GCUH) Parklands Campus, which opened in 2013, provides the staff and students with a state-of-the-art clinical learning environment. In addition, Bond University have recently completed fit-out of dedicated office space within the facility, which will provide a base for Bond University staff located at the GCUH. The Pathology and Education building includes two lecture theatres, simulation laboratories and student facilities, which are shared with allied health students and medical students from other programs. In addition, Bond University have recently completed fit-out of dedicated office space within the facility, which will provide a base for Bond University staff located at the GCUH. Travel to this key clinical site is facilitated by a light-rail with a terminus adjacent to the hospital.

The Bond University Clinical Education Research Centre at Robina Hospital, which opened in 2011 and hosts all students in Year 3, has been well fitted out over recent



years with a lecture theatre, student common room, simulation facility and tutorial rooms. This infrastructure is important for the delivery of the Year 3 curriculum, which uses the Bond Virtual Hospital as the key learning platform and requires small group learning followed by a larger group debriefing session.

A clinical school has been established at the Wesley Hospital (Brisbane). Students from Bond University, Griffith University and the University of Queensland share a purpose built education precinct, which includes a small lecture theatre, common room and computer access.

The program plans to establish a clinical school in partnership with Ramsay Health in 2015, which will consolidate the clinical placement opportunities for medical students at Pindara Private and John Flynn Hospitals.

The Faculty has two major research centres, the Centre for Research in Evidence-Based Practice (CREBP) and the Centre for Health and Human Performance.

## **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 on the Bond University campus have access to an extensive collection of monographs and on-line resources through the Campus library. The Faculty is well served by a central librarian allocated to the Faculty who also attends Faculty Learning & Teaching committee meetings and is involved in the introduction to Problem Based Learning teaching sessions in Year 1.

Recording of lectures using Mediasite, which is a Blackboard based platform, has gained widespread acceptance from academic staff and provides an excellent and well-utilised resource for students. Some casual or guest academics, some of whom have appointments at other universities, have remained unwilling to allow their lectures to be recorded, potentially due to IP issues, and this continues to be an area of frustration to the students.

The availability of internet connectivity at Tweed Hospital remains an unresolved issue.

The Student Learning Management System iLearn site provides the backbone of the students learning experience particularly during Years 1 and 2 of the program. This site is the repository of learning activities, student guides and an avenue of communication

between academic staff and students. ILearn is well supported by the University and Faculty by a team of professional staff with central point of contact for staff to liaise with regarding uploading of lectures and other learning materials.

There is heavy reliance on the Bond Virtual Hospital for the delivery of Year 3 and an apparent reliance on a small, albeit well resourced, team of highly motivated and dedicated staff to ensure regular refreshment of the content and support to the students during this highly interactive learning experience.

The delivery of Year 3 using the Bond Virtual Hospital application requires students to have access to an iOS device. Students who do not possess an iPhone or iPad are provided with a device by the Faculty however the staff report the uptake on the loan iPads is minimal.

Although Bond University has sufficient information communication technology infrastructure and support systems to achieve the learning objectives of the medical program there is one area of risk that will require monitoring. There is heavy reliance on the BVH for the delivery of Year 3 and an apparent reliance on a small, albeit well resourced, team of highly motivated and dedicated staff to ensure regular refreshment of the content and support to the students during this highly interactive learning experience.

### **8.3 Clinical learning environment**

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

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

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

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

Patient contact, limited in Years 2-3 and extensive in Years 4-5, is graded in a way that ensures students are ready for clinical practice and that graduates are prepared for internship.

In Years 2 and 3, students attend a variety of clinical settings equivalent to approximately 40 hours and 160 hours per year, respectively. In Year 4, students complete five clinical placements (Medicine, Surgery, Children's Health, Mental Health, Women's Health), each of eight weeks duration. In Year 5, students complete three core placements (ED, Critical Care, and GP) as well as a selective and an elective, each of

seven weeks duration. The introduction of the MD program will result in the elective rotation being replaced with an activity, which does not include clinical exposure. The team encourages the Faculty to ensure sufficient patient contact occurs with the introduction of the MD program.

The main teaching sites are the CGUH Parklands Campus, Robina Hospital and Tweed Hospital. Placements also occur across a network of private hospitals i.e. John Flynn Hospital, Wesley Hospital, Allamanda Hospital, Pindara Private Hospital, and Buderim Hospital.

The Faculty continue to increase the opportunities for students to complete a period of training in a rural learning environment.

The team spoke to a number of rural practitioners who were very positive about the Bond University students placed with them. Approximately one third of the cohort has the opportunity to undertake a portion of their clinical training in a rural location.

This includes an eight week clinical placement in paediatrics in Lismore during Year 4, and seven week selective placements in Beaudesert, Roma, and Mt Isa. In 2014, some Bond University students joined the Darling Downs Longlook program for eight weeks. It should be noted that Bond University do not receive funding from the Rural Clinical Training Scheme (RCTS) and, therefore, support rural placements from core funding. The Faculty should continue to increase the opportunities for students to complete a period of training in a rural learning environment and encourage uptake by students.

Some Bond University students are also able to complete a selective in Kirakira, Solomon Islands.

Currently opportunities for clinical placements in Aboriginal and Torres Strait Islander communities are limited. The appointment of a new discipline lead in Indigenous health should result in enhanced identification and development of more learning opportunities in Indigenous communities. The Bond University Program shares clinical sites with Griffith University at the Gold Coast University Hospital, Robina Hospital, Tweed Hospital and Wesley Hospital. The team notes that while it is well out of the purview of the medical program to effect change in this regard, it would be helpful if Tweed Hospital were included in the Queensland Health intern allocations.

A major change, which commenced in 2015, was the alignment of final year placement schedules between Bond University and Griffith University. From 2015 clinical rotations in Year 5 are undertaken in conjunction with students from Griffith University medical program. The coordination of clinical activities at the Gold Coast University Hospital and Robina Hospital are overseen by the Gold Coast Hospital Student Placement Committee. This committee is an excellent example of the benefits of the close and collegial relationship between Bond University and Griffith University, underpinned by key staff, and they, together with the Gold Coast Hospital Health Service are commended for this initiative.

Uniting Care Health (Wesley Hospital and Buderim Hospital) has also developed a collaborative model through the Uniting Care Health Clinical School. The clinical experience of students from Bond University, Griffith University and the University of Queensland, based at these sites, is overseen by the Head of the Clinical School and two clinical Sub Deans.

#### **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.*

A central Faculty placement officer who oversees clinical placements liaises closely with administration and clinical staff at each of the clinical sites. Bond University and Griffith University also jointly fund a Medical Student Placement Coordinator for the Parkland and Robina campuses of the Gold Coast University Hospital. These positions are highly valued by students and clinicians and the team views these positions as critical to the success and ongoing good relations with partners and teachers. The process of placing students at the Gold Coast University Hospital has been markedly simplified by the recent alignment of the final year curriculum. This is further evidence of the excellent relationship between the two programs.

Student progress in Years 4 and 5 is monitored through the Year 4 and 5 and Clinicians Assessment Committee.

There are close links between the Faculty and each of the clinical sites, which ensures that Bond University clinical staff, adjunct appointments and hospital clinical staff have sufficient time to teach.

The team was impressed with the commitment and enthusiasm of the clinical staff at all sites they visited, and with the well-organised liaison and support provided to them by Bond University through Year leads, Discipline leads, Clinical leads and placement coordinators.

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

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**Professor Fiona Lake (Chair), MD, FRACP**

Eric Saint Professor of Medicine and Respiratory Physician, School of Medicine and Pharmacology, the University of Western Australia

**Professor Wayne Hodgson (Deputy Chair), BSc PhD, GradDipHighEd**

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

**Professor Annette Braunack-Mayer BMedSci, PhD**

Head of School, School of Population Health, University of Adelaide

**Dr Iain Dunlop MBBS (Hons), FRANZCO, FRACS**

Ophthalmologist, Canberra Eye Hospital

**Professor Wendy Hu MBBS, DipPaed, MHA, PhD, FRACGP**

Professor of Medical Education, Director of MBBS Academic Program, University of Western Sydney

**Dr Mark Lubliner BMedSci (Hons), MBBS, MBA, FRACMA**

Group Director, Medical Services and Risk, St John of God Health Care

**Ms Annette Wright**

Program Manager, Medical Education and Accreditation, 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**

Dean of Medicine

Executive Dean

Vice chancellor

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

Academic Lead, PBL

Academic Lead, Student Support

Associate Dean, External Engagement and Marketing

Associate Dean, Learning and Teaching

Associate Dean, Research

Associate Dean, Student Affairs & Service Quality

Biomedical Sciences Lead

Clinical Lead – Emergency

Clinical Lead – Surgery

Clinical Lead – Tweed Hospital

Clinical Lead – Women's Health

Clinical Lead – General Practice

Clinical Sub-Dean, Gold Coast University Hospital

Clinical Sub-Dean, John Flynn Hospital

Clinical Sub-Dean, Pindara Hospital

Clinical Sub-Dean, Tweed Hospital

Discipline Lead, Indigenous Health

Faculty Business Director

Head of Program, Biomedical Sciences

Head of Program, Nutrition and Dietetics

Health Advocate & Professional Theme Lead

Practitioner Theme Lead

Scholar & Scientist Theme Lead

Year 1 Lead

Year 2 Lead/Anatomy

Year 3 Lead

Year 4 Lead

Year 5 Lead

**Faculty of Health Sciences and Medicine committees and groups**

Clinical Sciences Staff

Clinical Skills teaching staff

Discipline and clinical leads group

Evaluation group

Faculty IT Committee

GP Teachers

Health Advocate & Professional Theme

Indigenous Health Group

MBBS admissions committee

MBBS Executive Group

MD Implementation Committee

Medical Program Assessment Group

Practitioner Theme

Problem Based Learning Facilitators

Research Group

Rural Clinical School staff

Scholar and Scientist Theme

Solomon Islands teaching staff

Student Affairs & Service Quality group

Year 1 Committee

Year 2 Committee

Year 3 Committee

Year 4 and 5 Clinical Assessment Committee

**Medical students**

Medical Students Society of Bond University

Representatives from 1<sup>st</sup> – 5<sup>th</sup> year students

## **Clinical sites**

### Gold Coast University Hospital

Clinical teachers

Faculty staff

Hospital management

Joint Medical Students Placement Committee – Gold Coast Hospital and Health services

Students

### John Flynn Private Hospital

Clinical Sub-dean

Clinical teachers

Hospital management

Students

### Pindara Private Hospital

Clinical teachers

Faculty staff

Hospital management

Students

### Robina Hospital

Clinical teachers

Faculty staff

Hospital management

Students

### Tweed Hospital

Clinical sub-dean

Clinical Teachers

Hospital management

Joint Placements Committee – Tweed Hospital

Students

### Wesley Hospital

Clinical teachers



Faculty staff

Hospital management

Students





