CLINICAL PLACEMENTS IN UNDERGRADUATE MEDICAL EDUCATION: APPLYING AMC STANDARDS TO THE ASSESSMENT OF CLINICAL TEACHING PLACEMENTS

MEDICAL SCHOOL ACCREDITATION COMMITTEE

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1 BACKGROUND - ENSURING QUALITY CLINICAL PLACEMENTS FOR MEDICAL STUDENTS

1.1 The role of the Australian Medical Council

The Australian Medical Council (AMC) was established by the Australian Health Ministers in 1984 as a national standards body for primary medical training. The purpose of the Australian Medical Council is to ensure that standards of education, training and assessment of the medical profession promote and protect the health of the Australian community.

The functions of the AMC are:

- advising Health Ministers on matters pertaining to the registration of medical practitioners and the maintenance of professional standards in the medical profession
- advising and making recommendations to State and Territory medical boards on:
  - the accreditation of Australian and New Zealand medical schools and medical courses
  - the assessment for admission to practise of overseas trained medical practitioners
  - uniform approaches to the registration of medical practitioners
- advising the Commonwealth and the states on the recognition of medical specialties, and reviewing and accrediting vocational/specialist medical education and training programs.

The AMC has chosen accreditation as the preferred means of providing quality assurance of the primary and specialist/vocational phases of medical education and training.

Accreditation is perceived to have the following benefits:

- regular external review provides the organisation being reviewed with periodic stimulus to undertake a systematic process of self-examination and self-directed improvement
- the review allows the organisation to document and demonstrate the high quality of its programs to an external body, which makes examples of good practice public through the accreditation report
- the accreditation process encourages diversity and acknowledges that there is no single best way to produce a good doctor
- the accreditation process respects organisational autonomy by assessing each organisation against its goals and objectives, and by using the organisation's self-assessment as the basis for the review
- the peer review process, entailing assessment by a team of expert educationalists, teachers and members of the wider community, allows for the mutual exchange of ideas and solutions to common problems.

In its accreditation role, the AMC is concerned both to assure the quality of medical education and training programs, and to promote improvements in quality. The purpose of AMC accreditation of primary medical courses is the recognition of medical courses that produce graduates competent to practise safely and effectively under supervision as interns in Australia and New Zealand, and with appropriate foundations for lifelong learning and for further training in any branch of medicine.[1]

The Australian Medical Council's accreditation process aims to provide external independent assurance of the quality of basic medical education, by assessing medical schools against its standards for accreditation of basic medical education. The AMC respects the academic autonomy of

each university and encourages self-evaluation, innovation and diversity in medical education programs.

In assessing a medical school for accreditation, the AMC is concerned with both the pre-clinical and clinical stages of medical education. This paper will focus on the clinical stages of medical education, specifically the expectations that the AMC has of medical schools in developing, implementing and delivering high quality clinical placement experiences for students.

1.2 The aim of clinical training

The AMC views the development of clinical and scientific knowledge and skills and students' ability to apply these skills appropriately and sensitively as an essential component of any curriculum. Standard 8.3 of the AMC standards for accreditation of basic medical education,[1] sets out the AMC's requirements in relation to clinical placements and states that:

> *The medical school ensures there are sufficient clinical teaching and learning resources, including sufficient patient contact, to achieve the outcomes of the course.*
>
> *The school has sufficient clinical teaching facilities to provide a range of clinical experiences in all models of care (including primary care, general practice, private and public hospitals, rooms in rural, remote and metropolitan settings and Indigenous health settings).*
>
> *The school provides all students with experience of the provision of health care to Indigenous people in a range of settings and locations.*
>
> *The school actively engages with relevant institutions including other medical schools whose activities may impact on the delivery of the curriculum.*
>
> *The school ensures that the outcomes of the programs delivered in the clinical facilities match those defined in the curriculum.*[1]

The AMC believes that the most effective tool to enable students to develop the clinical competence and judgment described above is through participation in a variety of clinical clerkships. Clinical clerkships, or placements, have traditionally been undertaken in tertiary teaching hospitals. For a variety of reasons, however, it is now recognised that well supervised clinical placements can be and are offered in a broad range of primary and community settings and that training in diverse geographic locations is an essential component of medical training. These settings include general practice, community health centres, other ambulatory clinics, rural and remote health services, Indigenous clinics, nursing homes and centres for those with chronic intellectual or physical disability.

Furthermore, the AMC believes that there is a responsibility on universities to ensure that placements provide high quality, practical learning experiences for students. That is, clinical placements should not involve learning by observation or didactic teaching alone. Rather, placements must provide opportunities for genuine clinical interaction between students, patients and clinical teachers. This should be reflected by the school through defined learning outcomes to be achieved during each clinical placement.

In providing clinical education, medical schools need to ensure a supportive training environment for both students and teachers. This requires a commitment on the part of the school to provide appropriate support and training for teaching staff and a commitment on the part of the facility to allow clinicians time for such training.

1.3 The aim and of scope of the current paper

There has been remarkable growth in the last three years in the number of medical schools in Australia, which in time will have a great effect on the trained medical workforce and on Australian health services in general. Moreover, there have been, and continue to be, significant government-sponsored increases in student numbers in many of our established medical schools. One of the more challenging questions for the AMC has been the issue of matching increasing student numbers with appropriate clinical training places, and in deciding how medical schools might demonstrate that they have been able to arrange high quality clinical training in an increasingly crowded environment. Increasingly, medical schools are required to share teaching hospitals, as well as general and community practices. Changing models of service delivery mean that all medical schools are reconsidering the best locations for medical students to gain clinical experience.

The October 2006 meeting of the Medical School Accreditation Committee agreed to establish a working group to develop a policy on the Australian Medical Council's approach to assessing the increasingly complex challenges facing medical schools in providing clinical placements for students. The membership of the working group can be found at Appendix 1. The terms of reference, at Appendix 2, were approved by the Council's Executive in February 2007.

The working group met face-to-face in March and July 2007. Following these meetings, an executive was formed to draft the policy paper which was discussed by the full working group via a teleconference in August 2007, with the final draft distributed to members for comment in September.

This paper is concerned with the various aspects of ensuring high quality clinical placement opportunities in all health care settings. Some particular issues in relation to state health facilities, where the majority of placements are still occurring, received special emphasis. A brief overview of some of the issues surrounding the provision of placements in general practice settings and how universities may assist in addressing these is also provided.

The AMC recognises that the arrangements for negotiating clinical placements differ depending on the health setting in which students are placed. For instance, the governance structures and lines of reporting will differ between public and private hospitals, as they will in primary care and community settings. Nonetheless, as far as practicable, the AMC will expect medical schools negotiating placements in all healthcare settings to address the criteria for the arrangement and implementation of student placements, as set out in this document.

In summary, this paper aims to:

- provide background on significant policy and historical issues impacting on clinical placements in Australia and New Zealand
- articulate the information that medical schools need to provide in their accreditation submissions in relation to the planning, implementation and delivery of clinical placements for their students. Specifically, the paper will:
    - propose a requirement for medical schools to document their criteria and process for determining clinical teaching placement needs
    - set out the processes that medical schools need to consider when negotiating access to required clinical places
    - propose a requirement for medical schools to establish a working model of collaboration where multiple medical schools share common teaching facilities.

2 CLINICAL MEDICAL EDUCATION IN AUSTRALIA AND NEW ZEALAND

2.1 Establishment of medical schools

The first Australian medical school to be established was at the University of Melbourne in 1862. Between 1862 and 1975, a further nine medical schools were established,[2] including a second school in Sydney, Melbourne and Adelaide. Even with the establishment of a second school in these cities, there were sufficient inpatient beds in associated teaching hospitals to allow for essentially non-overlapping associations between individual university medical schools and particular public hospitals in relation to clinical placements. This situation has changed in at least four jurisdictions over the past ten years. As shown in Table 1, new medical schools have been established in Western Australia, New South Wales, Queensland and Victoria in response to the national move towards increasing Australian graduating doctor numbers.

Traditionally, medical education was provided largely via didactic lectures with clinical exposure obtained in large, metropolitan teaching hospitals.[3] This is no longer the case. As part of the development of comprehensive curricula there have been significant shifts, both internationally and within Australia, to move medical education into smaller hospital settings and into the community and general practice domains. (see The Edinburgh Declaration by the World Federation of Medical Education for further information).[4]

2.2 The policy background

In response to changing trends in the delivery of healthcare in Australia, in 1972 the Commonwealth Government established the Committee on Medical Schools to investigate future medical workforce needs. In relation to the teaching of medical students, the Committee recommended the expansion of clinical teaching sites from solely metropolitan teaching hospitals into general hospitals, community centres and general practice.[5]

A significant driver behind this change was the recognition that medical graduates required a greater understanding of the spectrum of health and disability prevalent in the community along with the skills and expertise to address these. The AMC has consistently endorsed these sentiments, articulating them in its standards for basic medical education.[1]

To facilitate the shift towards increased clinical education in the community, the Commonwealth Government has introduced a number of initiatives. These include the Rural Undergraduate Support Scheme, the introduction of University Departments of Rural Health (UDRH), the establishment of Rural Clinical Schools within medical schools, the introduction of a Practice Incentive Payment for general practices involved in undergraduate teaching, the development of rehabilitation/aged care/palliative care rotations in medical curricula, development of community-based paediatrics and psychiatry rotations within medical curricula, and the development of an Indigenous Health Curriculum Framework.[6]

Table 1: Medical Schools in Australia and New Zealand - Year of initial student intake by State or Territory

State/Territory	Medical School	Year of intake
Australian Capital Territory	**Australian National University** ANU Medical School	2004
New South Wales	**University of New South Wales** Faculty of Medicine	1961
	University of Newcastle School of Medicine and Public Health, Faculty of Health	1978
	University of Newcastle University of New England The Joint Medical Program, University of Newcastle University of New England	2008
	University of Sydney Faculty of Medicine	1883
	University of Western Sydney School of Medicine, Faculty of Health and Science	2007
	University of Notre Dame Australia School of Medicine Sydney	2008
	University of Wollongong Graduate School of Medicine, Faculty of Health and Behavioural Sciences	2007
Queensland	**Bond University** Faculty of Health Sciences and Medicine	2005
	Griffith University School of Medicine	2004
	James Cook University School of Medicine	2000
	University of Queensland School of Medicine, Faculty of Health Sciences	1936
South Australia	**University of Adelaide** School of Medicine, Faculty of Health Sciences	1885
	Flinders University School of Medicine, Faculty of Health Sciences	1974
Tasmania	**University of Tasmania** School of Medicine, Faculty of Health Science	1965
Victoria	**Deakin University** Faculty of Health, Medicine, Nursing and Behavioural Sciences	2008
	The University of Melbourne School of Medicine, Faculty of Medicine, Dentistry and Health Sciences	1862
	Monash University Faculty of Medicine, Nursing and Health Sciences	1961
	Monash Gippsland Medical School Faculty of Medicine, Nursing and Health Sciences	2008
Western Australia	**University of Notre Dame Australia** School of Medicine Fremantle	2005
	University of Western Australia Faculty of Medicine, Dentistry and Health Sciences	1957
New Zealand	**University of Auckland** Faculty of Medicine and Health Sciences	1968
	University of Otago Otago School of Medical Sciences	1875

In the 1990s the Commonwealth Department of Health developed the UDRH program. The aims of the program were to encourage students of medicine, nursing and other health professions to pursue a career in rural practice by providing them with opportunities to practise their clinical skills in a rural environment and to support health professionals currently practising in rural settings. Under the Government's Regional Health Strategy, further measures to attract medical staff to rural sites were introduced, including the establishment of the Rural Clinical Schools program in 1996. The aim of the strategy is to "*acculturate students into rural living with the intended long-term outcome of increasing the availability and viability of rural health services*".[7] Central to the Rural Clinical Schools program is the requirement for at least 25 per cent of each cohort of Commonwealth-funded medical students to receive at least 50 per cent of their clinical training in rural and remote areas.[8] In 2007, approximately 380 Australian medical students participated in the Rural Clinical School program. Fourteen rural clinical schools and 11 university departments of rural health have been established under these two programs.

In 2002, and in recognition of the increased role of General Practitioners in medical education, the Commonwealth Department of Health and Ageing introduced a Practice Incentive Program for teaching practices. The aim of the incentive was to encourage General Practitioners to become more involved in training and to remunerate them for a loss of consultation time due to their teaching activities.

2.3 The changing case-mix in Australian hospitals

Another factor affecting clinical placement opportunities is the change in the hospital case-mix models in Australian and New Zealand hospitals. These have led to:

- a greater division between generalists and sub-specialists. Super-specialised tertiary referral hospitals without general medicine are less able to deal with complex elderly patients with multiple co-morbidities and may be at a disadvantage when compared with regional and district counterparts with their complement of general physicians. This and other factors have led the NSW Director-General for Health to set as a priority for NSW Health improvement of assessment and the care of elderly patients with multiple medical problems.
- new models of sub-specialty practice e.g. rheumatology, endocrinology and gastroenterology, where patients are mainly cared for in ambulatory settings, and are infrequently admitted to hospital, for example, for acute intervention.
- increased patient acuity and complexity, which leads to episodic care as opposed to longer term clinical management.
- a move away from long-stay admissions towards short-stay, day only and day of surgery admissions, which reduce continuity of care and opportunities to follow patients through the care cycle.
- fewer hospital-based outpatient services.
- the loss of many less common, complex conditions to the private sector.
- the loss of many surgical conditions to the private sector.
- the loss of exposure to the long-term management of many common disorders, which are well managed in general practice.
- significant tensions between teaching and service provision, which forces specialists to choose between patient care and training and supervising students and recent graduates.
- a perception that some placements have less educational value, as students are encouraged to focus on the presenting complaint, as opposed to taking a holistic approach to care.

These issues are addressed comprehensively in a paper by Zajac (2003), *The public hospital of the future*.[9]

2.4 The challenges of undergraduate clinical teaching in general practice

There has been a growing increase in the use of general practice to provide clinical placement opportunities in the clinical training of medical students. Despite this growth, only about 20 per cent of Australian general practices currently participate in undergraduate medical training.[10] Many general practitioners report that they find training medical students to be personally and professionally rewarding.[11] However, a number of issues need to be addressed if general practice is to have an increasing role in clinical education at the undergraduate level. These include:

- a shortage of general practitioners, which is resulting in high demands for general practice clinical services and a contraction of time available for teaching[12]
- the predominantly private sector model of general practice. General practitioners are renumerated on a fee for service basis. Teaching reduces the amount of time that clinicians have for clinical work and is thus perceived, by some general practitioners, as costly.[12]
- a lack of general practice infrastructure to accommodate medical students, which is exacerbated by general practice being in the private business sector[9 12]
- the lack of strong links between general practice and universities, and the lack of academic recognition of general practice teachers by universities, which reduces the academic rewards available to general practitioners[12]
- a lack of formal training for general practitioners in teaching, mentoring, evaluation and assessment[11 12]
- a lack of private or public funds available for training of general practitioners in teaching, supervision and assessment
- the lack of a uniform accreditation system for general practices taking medical students. As yet there are no national standards for the teaching and supervision of medical students in general practice
- there is no formal and coherent system whereby general practices are formally linked to universities. There are ad hoc arrangements resulting in many general practices being in overlapping regions of universities. There is thus competition for clinical placements in general practices, both from general practice registrars and students from competing universities. This increases the risk of general practices being overloaded with teaching commitments from competing universities.

Undoubtedly, these same issues and difficulties will be experienced by specialists teaching in consulting rooms.

A number of the above factors were also raised by respondents to a survey conducted by the AMC to determine the capacity of the general practice sector to provide clinical learning opportunities.[13] It should be noted, however, that there was only a 12 per cent response rate to this survey. Thus, the findings need to be interpreted with caution. One possible interpretation by the survey authors for the low response rate is that perhaps a minority of general practices are actively involved in clinical placements. If this is the case, there is scope significantly to increase the number of medical student placements in general practice.

Before assuming that general practice can absorb the additional placement load, a number of measures would need to be implemented to address the above issues and to rationalise the current system of allocation and supervision. These include:

- universities establishing formal links with Australian Divisions of General Practice with the purpose of rationalising the allocation of medical students, monitoring work loads on general practices and coordinating the teaching support of practices. This particularly applies to regions where there are overlapping university areas of 'general practice influence'. Divisions or universities could be given formal Federal recognition and funding for coordinating roles in this area.
- the establishment of private and public partnerships between general practices, universities and Australian Divisions of General Practice, with the purpose of promoting teaching infrastructure of general practices.
- universities liaising with the Royal Australian College of General Practitioners and the Australian College of Rural and Remote Medicine to support the writing of national uniform standards for teaching and supervision of medical students in general practice.
- increased Commonwealth support for the recognition and financial support of general practices accredited for, and undertaking, medical student supervision and teaching.
- universities increasing their formal recognition of general practice accredited teachers by universities via formal academic recognition, titles, etc.[12]
- the provision of continued professional development, in teaching and supervision, for General Practitioners and General Practice registrars by universities[11] and Divisions of General Practice.
- increased communication and support for teaching General Practitioners from universities. This could include clear provision of information about the aims and objectives of general practice placements and greater access to course coordinators if problems arise.[11 12]

It is anticipated that many of these issues will be addressed under the criteria for medical schools negotiating clinical placements arrangements in this document.

2.5 Increase in medical student numbers

In response to perceived workforce shortages and the workforce maldistribution identified by Karmel,[5] the Commonwealth Government has introduced a number of measures to increase the number of Australian medical graduates. These include: doubling the number of medical schools between 2000 and 2008, introducing a capacity for domestic full-fee paying students in 2003 and increasing that potential number of domestic full-fee paying students from 10 per cent of a school's Commonwealth funded domestic quota to 25 per cent in 2007; and increasing the number of full-fee paying international students.[14] The plan further to increase student numbers was reinforced in July 2006, with all levels of government committing to fund an additional 400 medical student places.[15]

Using data from Medical Deans Australia and New Zealand, Joyce et al.[14] projects an overall increase of 81 per cent in the number of domestic medical graduates, from 1,348 in 2005 to 2,442 in 2012. Similarly, the Medical Specialist Training Steering Committee[5] projected an increase to 2,500 students by 2012. Both of these figures are more conservative than Australian Medical Association data,[16] which predict a rise to 3,400 domestic medical graduates by 2013. The apparent differences are no doubt due to sampling variability and assumptions concerning dropout rates and uptake of domestic full-fee paying places etc. Nonetheless, it is clear that there is going to be a significant increase in the number of medical students within the next five to ten years.

The increase in allied health student numbers is also impacting on the ability of medical schools to access clinical placements in large hospitals. The Productivity Commission Report cites DEST projections, that decisions to increase health-related higher education funding will see an increase of 4,800 nursing places and 3,600 dentistry and physiotherapy places by 2008.[17]

3 THE CLINICAL EDUCATION CONTEXT FROM 2007

3.1 Determining clinical teaching placement requirements

As discussed above, medical schools have traditionally been associated with one or more of the large teaching hospitals in providing the majority of their clinical experience for students. Curricula were not necessarily tightly structured under such arrangements. The medical school chose the discipline, blocks and placement modes but much of the actual teaching and learning was determined and implemented by hospital clinicians.

In recent years circumstances within both universities and health services have resulted in a re-examination of these traditional relationships. Universities have developed more detailed teaching and assessment programs based on curriculum outcomes and content. At the same time health facilities face greater service demands and are under pressure to provide placements for additional students from multiple universities and institutions teaching a broad range of health disciplines. Clinical staff have less time for teaching but are asked to take on increasing numbers of students.

Other factors that have impinged on the university-health service relationship include:

- the introduction of clinical experience earlier in medical courses
- the changing case-mix in large teaching hospitals
- a greater emphasis on patient rights and consumer interests leading to an increased need to negotiate student involvement with patients
- the need to provide a broader range of clinical placement experiences including rural, community, primary care and Indigenous health experiences.

Standard 8.3 of the AMC standards for basic medical education[1] includes five requirements for medical schools in establishing their clinical programs:

- identifying essential experiences and content for students in terms of presentations, conditions, skills and procedures that will underpin the clinical education components of the medical course
- translating the conditions, presentations, experiences, skills and procedures into a set of outcomes for the course which will meet the requirements for preparation for internship in Australia and New Zealand
- consulting with stakeholders, including state governments, local health authorities, hospitals and community practitioners about the outcomes of clinical placements and seeking input into the definition of essential experiences and content for students
- defining the required clinical settings in which students will gain the essential experiences and content
- dividing the essential experiences and content into blocks or units or disciplines and ensuring that all experiences are covered in the resulting approach.

Whilst AMC standards do not prescribe the specific length of placements, how disciplines are to be covered, or time allotted to them, they do provide broad guidelines. For example, Standard 3.2 requires that '*clinical sciences relevant to the care of adults and children*' and '*clinical skills*' are included in the curriculum and that there is '*a significant period*' of patient contact of '*at least two years*'. Similarly, the knowledge, understanding, skills and abilities to be gained during this time are stated in generic terms and include '*management of common conditions, history-taking and examination skills, communication skills, holistic patient care and patient-centred care, chronic self-management and role modelling of good practice*'.

In assessing a medical school for accreditation purposes, the AMC expects the medical school to describe its medical education processes, provide evidence of its success in meeting AMC standards, and identify challenges faced by the school and its response to those challenges. With the growing complexities faced by medical schools in providing clinical education, the AMC Medical School Accreditation Committee is giving greater attention to the evidence that medical schools provide of sustainable clinical training that provides experience in all modes of care and in an appropriate range of clinical disciplines.[1]

3.2 Matching placement needs with available resources

The process for determining the clinical placement needs requires medical schools to make clear both the underpinnings and the organisation of their clinical education programs. Matching placements to identified needs includes the following five steps:

- allocating student numbers to the various blocks, units or disciplines and demonstrating how they can be accommodated in the designated clinical settings
- identifying and providing educational resources to support students during these placements
- identifying the staff posts, including administrative staff, to be provided by the medical school to support the placements
- identifying student support mechanisms
- identifying how the school will support the clinicians who oversee and/or provide the teaching/clinical experience.

To assess the validity of a school's plans for clinical placements, the AMC could request quantitative information about the types of rotations offered in various facilities, the number of students undertaking rotations, the number of beds in the facility and the expected clinical population that students will have access to etc. This would be consistent with international accreditation processes like the Liaison Committee of Medical Education in the US.[18]

Medical schools need to consider each aspect of clinical placement arrangements when determining the number, nature and location of clinical placements required. Having mapped this, they will then need to examine available resources and commence the process of matching needs with suitable facilities.

3.3 The current role of state health departments

In response to the pressures on clinical placements described above, state health departments have established a variety of arrangements.

Whilst this discussion focuses on the Australian context, formal arrangements regarding resource sharing are also desirable in New Zealand.

The following arrangements are in place:

- The Victoria, Department of Human Services (DHS) has developed a Clinical Placement Strategy to assist in the development of a cohesive state-wide approach to the planning and resourcing of clinical training in the state. A Clinical Placements Joint Planning Group has been established, and a Relationship Agreement developed to govern the contractual arrangements between universities and the health service for undergraduate medical student clinical placements in hospitals. This includes a payment by the medical school to public hospitals for each student placement. DHS is also represented on a steering committee set up by three of the four Victorian medical schools which is mapping general practice placements and capacity. This data will be used to develop a state-wide plan for placements in general practice.

- In Western Australia, a Joint Consultative Committee for Medical Student Training has been established to oversee the clinical placement of medical students associated with the two universities operating in that state.
- In South Australia, a centralised information technology based clinical placement process is being developed. In addition, the Postgraduate Medical Council of South Australia is participating in the planning for a set of principles governing placement of final year students from both universities as apprentice interns in the public hospital system.
- The Queensland State Government requires a Student Placement Deed to be co-signed by Queensland Health and universities who wish to have students placed within a Queensland Health Facility. This is a standard state-wide deed between the Queensland Government and the university for placement of any student health professionals. The details of the clinical placements are negotiated locally between the university/school and the relevant Queensland Health facilities and these are appended as a Schedule of Placements. Currently, Queensland Health is not using this framework either to monitor placement loads or allocate placements centrally for student health professionals.
- In the Northern Territory, the of Health and Community Services (DHCS) and the Royal Darwin Hospital (RDH) have an agreement with Flinders University that all Northern Territory Clinical School staff must, as a condition of their employment, be involved in teaching. Currently students are only placed at the RDH and Alice Springs Hospital.

It seems very likely that other state and territory health departments will devise their own plans to manage clinical training in health facilities. There is a wide variety of intervention strategies and an obvious role for local stakeholders in this process. In general, some form of partnership arrangement of between the university or universities concerned and the relevant state or territory health department would be highly desirable.

4 LOOKING FORWARD

4.1 Negotiating collaborative arrangements

The AMC recognises that the provision of clinical education requires strong and supportive relationships between medical schools, hospitals, the community and private health providers and state and territory Departments of Health. Indeed, the Australian Medical Council notes that:

> *It is essential that the medical school has a constructive relationship with the state health department. The AMC considers it essential that there is a supportive state health authority, and that appropriate channels of communication are available to allow problems to be addressed and new initiatives to be developed.*[1]

Additionally, the AMC believes that there should be:

> *[E]ffective communication and liaison between the university, the school of medicine and the institutions associated or affiliated with the university. Clinical academic staff of the university working within teaching hospitals or other health care institutions must be integrated into the service and administrative activities of the institution so that they have appropriate access to patients for teaching and clinical research and to enable them to maintain their clinical skills. Staff employed by the affiliated institutions must recognise their role in teaching.*[1]

Given the additional pressures on clinical teaching resources, and the increasing need for universities to share clinical facilities and teaching resources, it will be important for medical schools to foster

and maintain relationships with clinical placement sites, state and territory health departments and other medical schools.

Having identified their clinical placement needs and matched these to existing resources, schools will need to negotiate access to clinical placement sites. The following factors will need to be considered:

- historical associations between medical schools and clinical teaching facilities
- geographic factors relating to the location of new and existing schools
- equity of learning opportunities for medical students of different universities
- innovations in clinical training, such as skills and simulation centres which may reduce requirements for patient contact
- variations in curricula between medical schools
- the availability of clinicians to act as clinical teachers in clinical facilities and their need for training, payment and support.

4.2 A model for collaboration

When clinical placements are determined and suitable facilities are identified, medical schools will need to secure ongoing access to these facilities and negotiate arrangements with other universities which share the facilities. The AMC believes that medical schools are best able to demonstrate the long-term sustainability of negotiated clinical placements in shared sites by demonstrating collaboration with other medical schools. This expectation will apply to all schools sharing facility resources, irrespective of whether it is a new medical school sharing with an existing school, two new schools establishing a clinical program or two existing schools sharing a particular facility because of increasing student numbers.

The AMC recognises that a requirement for identical clinical teaching programs at shared sites would impose unreasonable demands and restraints upon the curricula of the medical courses in the respective schools. However, there are some elements of training delivery in which a degree of consensus should be reached. These include:

- refining core learning objectives and essential clinical experiences to ensure that they are broadly similar. (Recognising that the common goal of medical education is to develop junior doctors who possess attributes that will ensure they are competent to practise safely and effectively as interns in Australia and New Zealand, and that they have an appropriate foundation for lifelong learning and for further training in any branch of medicine).[1]
- joint consultation with clinical stakeholders.
- ensuring sufficient places are available for the allotted number of students. Such allocation should include comprehensive mapping of available resources and clear timetabling of student access.
- resource provision. Student support may be specific to each medical school, for example online access to teaching materials, but a joint approach to other resource provision may prevent duplication and/or neglect of key areas. Wherever possible, this should include equivalent access to libraries, computer facilities, tutorial rooms, study rooms and car parking.
- staff appointments. Medical schools should negotiate the number and location of appointments, who should make them and how clinical teachers will be recognised. A range of models are available, including complementary appointments by each university, and appointments by one university with appropriate compensation by the other.

Collaboration will ensure that clinical teaching staff have input into each curriculum, that physical and human resources are provided in a rational manner and that similar learning and core experiences are provided for students from different schools.

In assessing medical courses and considering periodic reports from medical schools, the AMC will consider the evidence provided by each school to demonstrate that its arrangements for clinical teaching are based on enduring and supportive relationships.

5 AUSTRALIAN MEDICAL COUNCIL REQUIREMENTS FOR THE ACCREDITATION OF MEDICAL SCHOOLS

Rational allocation of scarce clinical placements can only be accomplished if medical schools with overlapping training domains work collaboratively with each other, the relevant state or territory health departments and private and community health providers to coordinate the placement of students from different medical schools in the available health facilities.

As discussed previously, there is a growing emergence of clinical placements in a variety of alternate clinical areas, including private, community, and rural settings. Arrangements for the adequate support of students in these settings will be essential. Noting the differences in governance structure, support for clinical placements will need to be equivalent to those that exist in public hospital settings. Medical schools will need to address areas including standards of clinical supervision, personal and administrative support, and arrangements for indemnification of staff and students.

During accreditation assessments, the AMC will evaluate the arrangements made by medical schools for clinical placements as follows:

1. Each medical school will be required to provide a copy of any written agreement or agreements or other evidence of affiliation, signed by a senior officer of the university, setting out the conditions reached with the relevant health facility for the placement of its students. Such agreements should detail:
    - the rights and duties of the specific health facility in agreeing to accommodate the students
    - the rights and duties of the students while attending the health facility
    - the rights and duties of the medical schools, including requirements to support and resource students on clinical placements
    - the rights and duties of the clinicians who teach in the medical curriculum
    - any other obligations of the two (or more) parties to the agreement.

    These agreements should cover indemnity, occupational health, security, administrative responsibilities, hours of access and the like.

2. If a clinical teaching facility is to be shared by two or more medical schools, the AMC will require:
    - a copy of any common documents signed by all parties involved describing agreed patterns of access and utilisation by the medical schools
    - a copy of any agreements governing any specific clinical areas or clinical staff that will not be shared within the facility
    - details of any arrangements for convergence of the curricula of the medical schools at the facility.

These requirements are consistent with the current AMC Standard 8.3:

> *The school actively engages with relevant institutions including other medical schools whose activities may impact on the delivery of the curriculum.*[1]

There may be cases where agreements do not cover all parties affected by the entry of another medical school into a specific hospital or teaching facility. Such parties may include:

- schools training other health professionals (nursing, allied health, etc)
- postgraduate training bodies
- clinical practices associated with the facility
- facility administrative staff.

In general, it is expected that the approach outlined above would enable the AMC to assess the extent to which a medical school has established sustainable and appropriate clinical training opportunities for its students, taking into account the interests of the teaching facilities, other schools and other parties involved. However, in cases where complete information is unavailable or doubt exists, the AMC may seek independent validation of information provided by making separate approaches to the other individuals or organisations involved in medical education at the facility concerned. This will be made explicit in the information given to the school under assessment.

6 CONCLUSIONS

The Australian Medical Council provides the following additional guidance to medical schools concerning accreditation requirements:

- Schools will be required to demonstrate that they can deliver sustainable clinical training that provides experience in a range of models of care and in an appropriate range of clinical disciplines.
- As far as practicable, the AMC will expect arrangements for all clinical placements to be equivalent, in terms of clinical supervision and administrative support, to those that exist in public hospital settings.
- To demonstrate a relationship between a medical school and health facilities used for clinical training, schools should provide a copy of any written agreement or agreements, or other evidence of affiliation, signed by a senior officer of the university, setting out the conditions reached with the particular health facility for the placement of its students, including acknowledgement of any other obligations to third parties.
- Where a clinical teaching facility is to be shared by two or more medical schools, the AMC will require a copy of documents signed by all parties, outlining agreements reached concerning negotiated patterns of access to, and utilisation of the facility, and any special arrangements relating to the involvement of clinical staff.
- Where schools are sharing common clinical facilities, details of any agreements reached regarding common learning goals, or curriculum convergence, must be provided.
- Where another party may be affected by the entry of an additional medical school into a specific teaching facility, the AMC may seek independent information from that party about any impacts on their program.

APPENDIX ONE: MEMBERSHIP OF THE WORKING GROUP

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APPENDIX TWO: TERMS OF REFERENCE

The Clinical Placements Working Group will recommend to the Medical School Accreditation Committee how AMC assessment teams will determine a medical school's capacity to provide clinical teaching that satisfies AMC requirements.

In doing so it will:

1. consider the stated requirements of the new revised AMC Accreditation Standards in respect of clinical training requirements
2. consider the clinical teaching opportunities open to medical schools and comment on how schools can demonstrate to an assessment team that the clinical teaching environment and teaching program for their students is adequate to meet the educational objectives of the program
3. consider what information supplied by schools might or should be validated by reference to other bodies, such as health departments, area health services, and other medical schools
4. consider what special or extra measures are to be considered, and what information is necessary for presentation, either singly or jointly, in the case of shared facilities in use by two or more schools.

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