Accreditation of the medical program of School of Medicine, Sydney the University of Notre Dame Australia
**Contents**

Executive Summary 2011 ................................................................. 1  
Decision on accreditation .................................................................................. 2  
Overview of findings .......................................................................................... 3  

**Introduction: The AMC Accreditation Process** .............................................. 12  
The University of Notre Dame Australia and School of Medicine, Sydney .......... 13  
AMC assessment of School of Medicine, Sydney ............................................... 14  
This report ............................................................................................................. 15  
Appreciation .......................................................................................................... 16  

1  **The Context of the Medical School** .............................................................. 17  
1.1 Governance ....................................................................................................... 17  
1.2 Leadership and autonomy .................................................................................. 22  
1.3 Medical course management ............................................................................. 24  
1.4 Educational expertise ......................................................................................... 28  
1.5 Educational budget and resource allocation ..................................................... 31  
1.6 Interaction with health sector ............................................................................ 33  
1.7 The research context of the school ................................................................. 36  
1.8 Staff resources .................................................................................................. 38  
1.9 Staff appointment, promotion and development ............................................. 43  
1.10 Staff indemnification ....................................................................................... 44  

2  **The Outcomes of the Medical Course** .......................................................... 45  
2.1 Mission .............................................................................................................. 45  
2.2 Medical course outcomes ............................................................................... 47  

3  **The Medical Curriculum** .............................................................................. 49  
3.1 Curriculum framework ....................................................................................... 49  
3.2 Curriculum structure, composition and duration ............................................ 50  
3.3 Curriculum integration ....................................................................................... 60  
3.4 Research in the curriculum .............................................................................. 62  
3.5 Opportunities for students to pursue choices ................................................. 63  
3.6 The continuum of learning ............................................................................. 64  

4  **The Curriculum – Teaching and Learning** .................................................. 65  
4.1 Teaching and learning methods ....................................................................... 65  

5  **The Curriculum – Assessment of Student Learning** .................................... 69  
5.1 Assessment approach ....................................................................................... 69  
5.2 Assessment methods ......................................................................................... 73  
5.3 Assessment rules and progression ................................................................... 75  
5.4 Assessment quality .......................................................................................... 76
6 The Curriculum – Monitoring and Evaluation ................................................. 79
6.1 Monitoring................................................................................................. 79
6.2 Outcome evaluation.................................................................................. 79
6.3 Feedback and reporting ........................................................................... 83
6.4 Educational exchanges ............................................................................ 84

7 Implementing the Curriculum - Students......................................................... 86
7.1 Student intake............................................................................................. 86
7.2 Admission policy and selection................................................................. 87
7.3 Student support.......................................................................................... 90
7.4 Student representation................................................................................ 93
7.5 Student indemnification ............................................................................ 94

8 Implementing the Curriculum – Educational Resources ................................. 95
8.1 Physical facilities....................................................................................... 95
8.2 Information technology............................................................................. 99
8.3 Clinical teaching resources.......................................................................102

Appendix One Membership of the 2007, 2009, 2010 and 2011 AMC Assessment Teams .................................................................109
Appendix Two Executive Summaries: 2007, 2009, and 2010 .........................113
Appendix Three Groups Met by the 2007, 2009, 2010 and 2011 AMC Assessment Teams .................................................................132
Executive Summary 2011

The AMC’s Assessment and Accreditation of Medical Schools: Standards and Procedures describe the procedures by which an institution may seek assessment of a proposal to establish a new medical program. This involves an assessment of plans before the program is introduced, and subsequent follow-up assessment if required. In 2005, the AMC assessed and accredited plans for the introduction of a four-year, graduate-entry medical program at the University of Notre Dame Australia (UNDA), Fremantle. In 2007, the AMC then considered plans for the four-year, graduate-entry medical program to be offered by the University’s School of Medicine, Sydney. As students graduating from these two programs receive different qualifications, and the programs are managed and run as distinct academic programs, the AMC has assessed and accredited the two programs separately.

The AMC requires institutions establishing a new program to present the following for the first accreditation assessment: the outline of the full program with details for at least the first two years; details of the financial, physical and staff resources available to design and implement all years of the program, and to support the program when fully established; and an institutional assessment of strengths and weaknesses.

The 2007 AMC assessment resulted in accreditation of the medical program being established at School of Medicine, Sydney for the maximum possible period, which is until two cohorts have graduated (2013). At this time, the AMC considered the School had appropriate structures and clear plans to support the implementation of the medical program. Because the University chose to present the detailed curriculum plans for the medical program in stages, the AMC completed a follow-up assessment in 2009 to consider the development of plans for Years 3 and 4 of the medical program, which were to be implemented from 2010. This assessment noted the successes in establishing School of Medicine, Sydney and implementing the early years of the Sydney medical program. It also raised concerns regarding the pace of progress towards implementation of Years 3 and 4, and the organisation of the resources necessary to make this phase a success. The AMC decided to complete a further assessment in 2010.

An AMC Team visited the School and clinical teaching sites in April 2010. The AMC was unable to complete its assessment, because of changes in the School’s leadership shortly after the visit. It indicated that it would need to review the program implementation in the changed circumstances. An AMC Team completed this assessment in October 2010.

At its November 2010 meeting, the AMC Directors found that the medical program of the University of Notre Dame Australia, School of Medicine, Sydney substantially met the AMC accreditation standards. The AMC changed the School’s accreditation to December 2011, and imposed conditions on the accreditation. The School was required to report on these conditions in December 2010, February 2011, the start of the 2011 academic year, April 2011 and August 2011.

In May 2011, having received the School’s April 2011 report on accreditation conditions an AMC Team visited the School to discuss progress with students, staff and School committees.

The AMC Team reported to the October 2011 meeting of the Medical School Accreditation Committee. The Committee also considered advice from the Team Chair concerning the School’s August 2011 report on accreditation conditions and advice from the new Dean of School of Medicine, Sydney on developments since her appointment in May 2011. This
report presents the Committee’s recommendation on accreditation, as endorsed by the AMC Directors at its November 2011 meeting, and the detailed findings against the AMC accreditation standards.

**Decision on accreditation**

Under the *Health Practitioner Regulation National Law Act 2009*, the AMC may grant accreditation if it is reasonably satisfied that a program of study, and the education provider that provides it, meet an approved accreditation standard. It may also grant accreditation if it is reasonably satisfied the provider and program of study substantially meet an approved accreditation standard, and the imposition of conditions on the approval will ensure the program meets the standard within a reasonable time. Having made a decision, the AMC reports its accreditation decision to the Medical Board of Australia to enable the Board to make a decision on the approval of the program of study for registration purposes.

The AMC’s finding is that in 2011 the University of Notre Dame Australia, School of Medicine Sydney MBBS program substantially meets the accreditation standards.

The report describes significant progress in important areas, including leadership, staffing, curriculum governance and implementation. These should enhance the capacity of the School to deliver the curriculum. The implementation of the full four years of the program is a significant milestone. Now that the full program has been implemented, the AMC expects the School will focus on the review and evaluation necessary to improve the curriculum, and on developing medical education expertise to ensure high quality medical education is provided.

In making its accreditation decision in 2010, the AMC considered its unsatisfactory progress procedures. Under these procedures, the Medical School Accreditation Committee may recommend to the AMC Directors:

(i) that the concerns are being addressed. In this case, the AMC will grant ongoing accreditation for a defined period subject to satisfactory progress reports, or

(ii) that the concerns can be addressed by imposing conditions on the accreditation. In this case, the AMC will grant ongoing accreditation for a defined period subject to satisfactory progress reports and to the conditions being met within this period, or

(iii) that the concerns are not being addressed and/or are unlikely to be addressed within a reasonable timeframe and the education provider and its proposed program do not satisfy the accreditation standards. In this case the AMC will revoke the accreditation.

In 2011, the Medical School Accreditation Committee considers that a number of the conditions have been addressed. Others can be addressed by retaining or imposing conditions on the accreditation. At their November 2011 meeting AMC Directors agreed:

(i) that the expiry date on the period of accreditation of the Bachelor of Medicine, Bachelor of Surgery medical program of School of Medicine Sydney, The University of Notre Dame Australia return to 31 December 2013 subject to the following conditions:
A. By 30 April 2012, evidence to address the conditions detailed in the Key Findings Table relating to:
   - Standard 1.1 - Governance
   - Standard 1.2 - Leadership and autonomy
   - Standard 1.4 - Educational expertise
   - Standard 1.9 - Staff appointment, promotion and development.

B. By the 2012 progress report evidence to address the conditions detailed in the Key Findings Table relating to:
   - Standard 1.6 – Interaction with the health sector
   - Standard 3.3 - Curriculum integration
   - Standard 5.1 - Assessment approach
   - Standard 5.2 - Assessment methods
   - Standard 8.2 - Information technology.

C. By the 2013 comprehensive report to the AMC, evidence to address the conditions detailed in the Key Findings Table relating to:
   - Standard 3.2 - Curriculum structure
   - Standard 6.1 – Monitoring
   - Standard 8.3 - Clinical teaching resources.

(ii) that School of Medicine, Sydney provide a comprehensive report to the Medical School Accreditation Committee by September 2013. As well as reporting on the conditions listed above, the report should outline the School’s development plans for the next four to five years. The AMC will consider this report and, if it decides the School is satisfying the accreditation standards, the AMC Directors may extend the accreditation up to December 2017, taking accreditation to the full period which the AMC will grant between assessments, which is ten years.

Overview of findings

The following ‘Key Findings Table’ sets out the findings of the 2011 AMC assessment. The right column indicates whether the standard has been met, substantially met or not met. Whether the status of the standard has changed since the 2010 assessment is also indicated.

Where accreditation standards are noted as ‘substantially met’ the School must provide to the AMC evidence of actions to meet the specific standard, as specified in the right column of the Key Findings Table and in accordance with the timeframe as specified in part (i): A, B and C above.

The Table also lists recommendations for improvements in the medical program. These are listed in the left column of the Key Findings Table. While the AMC expects the School to consider and report on its response to these recommendations in progress reports, they are not conditions of accreditation.
Overview of Findings

Key Findings Table: The findings against the accreditation standards are summarised below.

<table>
<thead>
<tr>
<th>1. Context (governance, autonomy, course management, educational expertise, budget, health sector, research context, staff)</th>
<th>Overall this set of standards remains SUBSTANTIALLY MET.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Governance</td>
<td>Standard 1.1 remains substantially met</td>
</tr>
<tr>
<td>The AMC requires evidence that the new governance arrangements established to address issues of variation in curriculum delivery and student experience across the School’s dispersed clinical sites are effective and that the relevant School processes are being universally applied.</td>
<td></td>
</tr>
<tr>
<td>1.2 Leadership and autonomy</td>
<td>Standard 1.2 is now substantially met</td>
</tr>
<tr>
<td>Areas of strength</td>
<td>The AMC requires evidence that the Dean’s management review has resulted in effective leadership of the medical program with clear responsibility for the management of the medical program backed by appropriate medical education expertise.</td>
</tr>
<tr>
<td>• The appointment of the Dean will enhance stability and provides the School with an opportunity to formulate a strategic plan for its further development.</td>
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</tr>
<tr>
<td>1.3 Medical course management</td>
<td>Standard 1.3 is now met</td>
</tr>
<tr>
<td>Areas for improvement</td>
<td></td>
</tr>
<tr>
<td>• The Curriculum Management Committee to take responsibility for ensuring the curriculum is delivered in a consistent manner across all clinical sites. Although a challenge in all schools with multiple and dispersed sites, it is important that the curriculum continues to guide selection of clinical placements rather than learning being determined by clinical placement availability.</td>
<td></td>
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</tbody>
</table>
1.4 Educational expertise

**Areas of strength**
- The considerable work by staff of the Medical Education Unit to develop the program.

**Standard 1.4 remains substantially met**

The AMC continues to require evidence that the School has a plan enabling access to sufficient educational expertise for developing and managing the medical program at a level consistent with AMC standards.

1.5 Educational budget and resource allocation

**Standard 1.5 is now met**

1.6 Interaction with the health sector

**Areas of strength**
- Impressive clinical placement partnerships are developing, both in well-established teaching hospitals, and in growing hospitals that will offer increasingly significant teaching opportunities in the future.

**Standard 1.6 remains substantially met**

The AMC requires evidence that the agreements with health services are effective in managing specific teaching plans at each site, student placement numbers and the School’s expectations of clinicians.

1.7 The research context of the school

**Areas for improvement**
- Give greater priority to development of an active research program, including:
  - involve the School in other University of Notre Dame Australia research and collaboration with other research institutes and/or organisations.
  - consider the implications of the current staffing model, in which Heads of Discipline and discipline leaders have small fractional appointments, for the capacity of these leaders to be research active.

**Standard 1.7 remains met**
<table>
<thead>
<tr>
<th>1.8 Staff resources</th>
<th>Standard 1.8 is now met</th>
</tr>
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<tbody>
<tr>
<td><strong>Areas for improvement</strong></td>
<td></td>
</tr>
<tr>
<td>• Review the staffing model to ensure that it enables academic staff to engage in academic activities beyond curriculum implementation, and coordination. This may include fostering the development of their discipline, and contributing to the advancement of knowledge and scholarship.</td>
<td></td>
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<table>
<thead>
<tr>
<th>1.9 Staff appointment, promotion and development</th>
<th>Standard 1.9 remains substantially met</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Areas of strength</strong></td>
<td></td>
</tr>
<tr>
<td>• The appointment of a Clinical Years Education Support and Liaison Officer.</td>
<td></td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td></td>
</tr>
<tr>
<td>• In the performance appraisal process for academic staff, require evidence of development of educational skills.</td>
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<tr>
<th>1.10 Staff indemnification</th>
<th>Standard 1.10 remains met</th>
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<tr>
<th>2. Outcomes (mission, course outcomes)</th>
<th>Overall, this set of standards remains MET.</th>
</tr>
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<tr>
<th>3. Curriculum (framework, structure, content, duration, integration, research, choices, continuum)</th>
<th>Overall, this set of standards remains SUBSTANTIALLY MET.</th>
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<table>
<thead>
<tr>
<th>3.1 Curriculum framework</th>
<th>Standard 3.1 remains met</th>
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<tbody>
<tr>
<td>3.2 Curriculum structure, composition and duration</td>
<td>Standard 3.2 remains substantially met</td>
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<tr>
<td><strong>Areas of strength</strong></td>
<td>The AMC will require evidence that:</td>
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<tr>
<td>• Identification of specific learning goals</td>
<td>(i) the School has an effective mechanism to provide descriptions of the content, extent and sequencing of the curriculum that guide staff and students on the learning outcomes for each stage of the program. This would be addressed by enhancing the newly developed curriculum map.</td>
</tr>
<tr>
<td>for the diverse learning opportunities, and communication of these to students.</td>
<td>(ii) the lines of communication essential to the integration of the clinical rotations and to the achievement of uniform learning objectives and assessments across the various learning sites are working effectively.</td>
</tr>
<tr>
<td>• The positive feedback from students about their clinical rotations and the enthusiasm of their clinical teachers.</td>
<td></td>
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<tr>
<td>• The initiatives by clinical discipline heads to improve communication with respective disciplines leaders and teachers at each site are welcome.</td>
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<tr>
<th>3.3 Curriculum integration</th>
<th>Standard 3.3 remains substantially met</th>
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<tbody>
<tr>
<td><strong>Areas for improvement</strong></td>
<td>The AMC will require evidence that:</td>
</tr>
<tr>
<td>• Review and enhance the opportunities for formally revisiting the biomedical sciences in MED3000 and MED4000.</td>
<td>(i) the School has evaluated the effectiveness of the mechanisms to improve integration of the formal teaching program and clinical rotations.</td>
</tr>
<tr>
<td></td>
<td>(ii) the Rural Clinical School is continuing to develop in line with the plans (Standard 8.3) and that the School is assessing and monitoring the students’ achievement of adequate breadth and depth in the Rural Clinical School settings.</td>
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<tr>
<th>3.4 Research in the curriculum</th>
<th>Standard 3.4 remains met</th>
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<tr>
<th>3.5 Opportunities for students to pursue choices</th>
<th>Standard 3.5 is now met</th>
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<tr>
<th>3.6 The continuum of learning</th>
<th>Standard 3.6 remains met</th>
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<tr>
<td>4. Teaching and learning methods</td>
<td>Overall, this set of standards remains MET.</td>
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<tr>
<td>4.1 Teaching and learning methods</td>
<td>Standard 4.1 Remains met</td>
</tr>
<tr>
<td>Areas of strength</td>
<td></td>
</tr>
<tr>
<td>• The Team continues to be impressed by the commitment of teaching staff to working with students individually and in small groups.</td>
<td></td>
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<tr>
<td>Areas for improvement</td>
<td></td>
</tr>
<tr>
<td>• Continue to review the mechanisms by which students record and report on the range of clinical experiences available in different rotations.</td>
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<tr>
<td>5. Assessment (approach, methods, rules and progression, quality)</td>
<td>Overall, this set of standards remains SUBSTANTIALLY MET.</td>
</tr>
<tr>
<td>5.1 Assessment approach</td>
<td>Standard 5.1 remains substantially met</td>
</tr>
<tr>
<td>Areas of strength</td>
<td></td>
</tr>
<tr>
<td>• Since the last report the Medical Education Unit has engaged additional staff and has completed a number of assessor training courses at multiple sites in an effort to ensure consistency in assessment across campuses.</td>
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<td></td>
<td>The AMC requires evidence of further development of the assessment policy and practices, including:</td>
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<td></td>
<td>(i) reviewing the MED3000 and MED4000 assessment processes</td>
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<tr>
<td></td>
<td>(ii) improving formative assessment processes for the clinical rotations to better inform students and staff early of emergent learning difficulties and to ensure consistency of assessment standards and processes across teaching sites</td>
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<td>(iii) clearer and more detailed marking rubrics.</td>
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<tr>
<td>5.2 Assessment methods</td>
<td>Standard 5.2 is now substantially met</td>
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<tr>
<td></td>
<td>The AMC requires evidence that:</td>
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<tr>
<td></td>
<td>(i) the School has systems to ensure students are receiving feedback from formative and summative assessments on their clinical rotations</td>
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<tr>
<td></td>
<td>(ii) there is greater consistency in MED3000 and MED4000 in clinical teachers’ approaches across sites and disciplines to completing the clinical competency formative and summative assessments.</td>
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<tr>
<td>5.3 Assessment rules and progression</td>
<td>Standard 5.3 remains met</td>
</tr>
<tr>
<td>5.4 Assessment quality</td>
<td>Standard 5.4 remains met</td>
</tr>
<tr>
<td>Areas of strength</td>
<td></td>
</tr>
<tr>
<td>• The School benchmarks some assessment components against those of other medical institutions.</td>
<td></td>
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<tr>
<td>Areas for improvement</td>
<td></td>
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<tr>
<td>• Use external expertise in reviewing and benchmarking assessment practices, particularly the summative multi-station assessment tasks, short answer questions and the clinical rotation formative assessments.</td>
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<tr>
<td>• Ensure summative assessments provide adequate testing of students’ interpretation of signs and symptoms across a variety of service delivery settings.</td>
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<tr>
<td>6. Monitoring and evaluation (ongoing monitoring, evaluation, feedback and reporting, educational exchanges)</td>
<td>Overall this set of standards is now MET.</td>
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</table>
| **6.1 Monitoring**  
Areas of strength  
- Review of elements of MED1000 and MED2000 has resulted in positive changes to areas of the course such as the anatomy curriculum. | Standard 6.1 is now substantially met.  
The AMC requires evidence that:  
(i) The School has presented and discussed elements of MED1000 and MED2000 with all relevant discipline heads.  
(ii) teacher and student feedback from the clinical years is being sought systematically within a formal quality improvement framework that includes the discipline heads. |
| **6.2 Outcome evaluation** | Standard 6.2 remains met |
| **6.3 Feedback and reporting** | Standard 6.3 remains met |
| **6.4 Educational exchange** | Standard 6.4 remains met |
| **7. Students (intake, admission, support, representation)** | Overall this set of standards is now MET. |
| **7.1 Student intake** | Standard 7.1 remains met |
| **7.2 Admission process** | Standard 7.2 remains met |
| **7.3 Student support** | Standard 7.3 is now met |
| **7.4 Student representation**  
Areas of strength  
- The Team commends the positive relationship between the student representative body and the Dean. | Standard 7.4 remains met |
<table>
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<tr>
<th>7.5 Indemnification</th>
<th>Standard 7.5 remains met</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Resources (physical, IT, clinical teaching)</td>
<td>Overall, this set of standards remains SUBSTANTIALLY MET.</td>
</tr>
<tr>
<td>8.1 Physical facilities</td>
<td>Standard 8.1 is now met</td>
</tr>
<tr>
<td><strong>Areas of strength</strong></td>
<td></td>
</tr>
<tr>
<td>• The substantial building program to support the development of the clinical schools and its progress over the last six months.</td>
<td></td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td></td>
</tr>
<tr>
<td>• Review the pathology specimens used in the integrated anatomy, pathology and radiology workshops.</td>
<td></td>
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<tr>
<td>8.2 Information technology</td>
<td>Standard 8.2 remains substantially met</td>
</tr>
<tr>
<td></td>
<td>The AMC requires evidence that library facilities are of an equivalent standard at all clinical sites, and include core texts for all years.</td>
</tr>
<tr>
<td>8.3 Clinical teaching resources</td>
<td>Standard 8.3 remains substantially met</td>
</tr>
<tr>
<td></td>
<td>The AMC requires evidence:</td>
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<tr>
<td>(i) of formal and high level communication with all health services and relevant medical schools to support the access of students to the required clinical experience and clinical teaching.</td>
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</tr>
<tr>
<td>(ii) that the Rural Clinical School is continuing to develop in line with plans.</td>
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Introduction: The AMC Accreditation Process

The AMC is a national standards body for medical education and training. Its principal functions include assessing Australian and New Zealand medical schools and medical courses, and granting accreditation to those that meet the approved accreditation standards.

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

The standards and procedures for accreditation are published in the AMC’s Assessment and Accreditation of Medical Schools: Standards and Procedures. The AMC lists the knowledge, skills and professional attributes expected upon graduation, defines the curriculum in broad outline, and defines the educational framework, institutional processes, settings and resources necessary for successful medical education.

The AMC’s Medical School Accreditation Committee oversees the AMC process of assessment and accreditation of medical schools and reports to the AMC Directors. The Committee includes members of the Council itself and nominees of the Australian and New Zealand medical schools, the Medical Council of New Zealand, health consumers, medical students, the Confederation of Postgraduate Medical Education Councils, and the Committee of Presidents of Medical Colleges.

Accreditation of a new medical course is a two-stage process. The institution submits an initial Stage 1 submission describing the planned curriculum and resources to support delivery. The Medical School Accreditation Committee makes a recommendation to the AMC Directors on whether or not the planned curriculum is likely to comply with the AMC accreditation standards and if the institution has demonstrated that it is able to implement the course.

Once an institution has approval to proceed to a Stage 2 assessment, the accreditation process is as follows. The AMC appoints an assessment team comprising a balance of members from different states, medical schools, the basic and clinical sciences, hospital and community-based teachers, experienced academic managers, health service managers and community interests. Members with other expertise may be part of the team, as considered appropriate. The medical school submits to the team detailed documentation on the medical curriculum and the resources that underpin its delivery.

The school’s accreditation submission forms the basis of the assessment. After reviewing the submission, the Team conducts a visit to the school and its clinical teaching sites, which normally takes a week. Following the visit, the Team prepares a detailed report for the Medical School Accreditation Committee, providing opportunities for the medical school to comment on successive drafts. The Committee considers the Team’s report and then submits the report, amended as necessary, to the AMC Directors. The Directors make the final accreditation decision. In the case of new medical courses, accreditation may be granted for a period up to two years after the full course has been implemented, subject to satisfactory annual reports. Granting accreditation may also be subject to other conditions, such as follow-up assessments.

Once accredited by the AMC, all medical schools are required to report periodically to the Medical School Accreditation Committee on the ongoing evolution of the medical course,
emerging issues that may affect the medical school’s ability to deliver the medical curriculum, and issues raised in the AMC accreditation report. The AMC requires new medical schools to report annually.

The University of Notre Dame Australia and School of Medicine, Sydney

The University of Notre Dame Australia (UNDA) is a private university recognised under the Higher Education Funding Act. Its main campus is situated in Fremantle, Western Australia. The University was founded in 1989 through an act of the Western Australian Parliament and a canonical statute from the Archdiocese of Perth. The University formulated its main organisational structure of national colleges and constituent schools across the three campuses in Fremantle, Sydney and Broome. The College of Medicine, comprising Schools of Medicine in Fremantle and Sydney, forms part of this structure.

By 2010, UNDA had over 7,000 students enrolled on its three campuses studying in eight academic disciplines:

- Arts and Sciences
- Business
- Education
- Health Sciences
- Law
- Medicine
- Nursing
- Philosophy and Theology.

Plans to establish the Notre Dame School of Medicine, Sydney were announced by the Prime Minister, the Hon John Howard, and the Archbishop of Sydney, Cardinal George Pell, on 1 August 2004. School of Medicine, Sydney was to form part of the planned UNDA Sydney Campus. This campus opened in February 2006 with foundation Schools of Arts and Sciences, Business, Education, Law, Nursing, and Philosophy and Theology. By 2008, enrolments at the Sydney campus had grown to 1,700, mainly school leaver undergraduate students, with plans to increase enrolments to 5,000 by 2018.

The Australian Government and the New South Wales and Victorian governments provided support to the University in planning the proposed School. The University has also received support from public and private health care providers, particularly in the Catholic health care system.

The medical program was proposed as a four-year, graduate-entry program with an initial intake of 104 students, leading to a degree of Bachelor of Medicine and Bachelor of Surgery (MBBS). The curriculum was to be based on the curriculum adopted and developed by the Notre Dame School of Medicine, Fremantle, which was acquired and developed from the MBBS curriculum at The University of Queensland. School of Medicine, Sydney adopted the learning objectives, curriculum, teaching methods, and School management structures of the Fremantle School. School of Medicine, Sydney, however, was to remain directly responsible for its own curriculum, assessment and quality assurance.

The University planned School of Medicine, Sydney location in historic parish buildings associated with the Sacred Heart Parish in Darlinghurst. Students would study biomedical science units at the University of Technology Sydney. The School planned to establish three
clinical schools, two based in metropolitan Sydney and Melbourne, and one in rural New South Wales.

**AMC assessment of School of Medicine, Sydney**

In June 2005, the Medical School Accreditation Committee considered a submission from the University of Notre Dame Australia for a first-stage assessment of its proposed Sydney medical program. The AMC determined that the submission did not satisfy AMC requirements for a Stage 1 submission and the University was so advised. The Committee considered a resubmitted Stage 1 submission at its August 2006 meeting which still did not satisfy AMC requirements, and AMC representatives met with senior University staff in September 2006 to assist them elaborate on the additional information required.

The AMC subsequently accepted a resubmitted Stage 1 submission with supplementary information. The School submitted its Stage 2 accreditation submission in March 2007. The AMC Team reviewed the submission and completed the formal accreditation assessment during the week beginning 14 May 2007. The Team presented its preliminary findings to the University on 18 May 2007.

The Medical School Accreditation Committee considered the Team’s report and the response from the School at their July 2007 meeting. The AMC granted accreditation the UNDA School of Medicine, Sydney medical program until December 2013. The accreditation was subject to conditions including:

- a visit by an AMC team in 2009 to review the implementation of the first year of the course and the detailed plans for later years; and
- the University provide satisfactory annual reports.

Following the 2007 report recommendations, an AMC Team visited the School from 4 to 7 May 2009. The visit included the School’s Darlinghurst campus, the clinical schools based in metropolitan Sydney and the Werribee Mercy site in outer Melbourne, and the Rural Clinical Sub-School based at St John of God in Ballarat.

The Team congratulated the School for successfully implementing Years 1 and 2 of the program. The Team noted strong student support for the Sydney program. The Team noted the development of Years 3 and 4 was underway. However, for the detailed planning and smooth rollout of Year 3 in 2010, the Team reported to the AMC that early appointment of the proposed discipline leaders was essential, both in School of Medicine Sydney itself and in the various clinical schools. The Team had considerable concerns about the limited progress on both learning objectives and a coherent framework across clinical sites to ensure successful outcomes for students during their clinical attachments. There were additional concerns about student placements in the Rural Clinical School.

After considering the 2009 report as endorsed by the Medical School Accreditation Committee, AMC Directors confirmed the original accreditation period. The Directors also set additional conditions on the accreditation, requiring progress reports addressing concerns raised in the report, and a further visit in 2010 to review the progress of clinical placements in New South Wales and Victoria, and the development of the Rural Clinical School. AMC Directors also informed the University of the AMC’s continuing concerns regarding progress in relation to implementation of the clinical years of the program, and the implications, under AMC policy, of unsatisfactory progress.
The 2010 AMC Team visited the School and clinical teaching sites in April. Shortly after the visit, the University advised that the Dean of the School had resigned. Due to the importance of School leadership in this busy implementation phase, particularly in a School that had made a limited number of appointments to leadership positions, the AMC concluded that it was not able to complete its assessment of the program and would need to review the program implementation in the changed circumstances. An AMC Team completed this assessment in October 2010 and reported to the AMC Medical School Accreditation Committee at meetings on 26 October and 4 November 2010. The Committee considered the draft report of the 2010 assessments and made recommendations on accreditation within the options described in the AMC accreditation procedures.

In July 2010, the *Health Practitioner Regulation National Law Act 2009*, was implemented. Under the 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 program of study substantially meet an approved accreditation standard, and the imposition of conditions will ensure the program meets the standard within a reasonable time.

The AMC found that the University of Notre Dame Australia, School of Medicine Sydney medical program substantially met the accreditation standards. It set conditions on the School’s accreditation and required reports from the School on progress against the conditions. It also required a visit by an AMC team, following submission of a progress report in April 2011.

The 2011 Assessment Team visited the School from 16 to 19 May 2011.

This report

This report details the findings of the 2007, 2009, April and October 2010, and 2011 assessments of the University of Notre Dame Australia, School of Medicine Sydney Medical Program.

Each section of the accreditation report begins with the relevant AMC accreditation standards. The comments of the four AMC teams are then recorded under the standards in chronological order.

The AMC made some minor changes to the accreditation standards in 2007 and 2010. This report includes the current version of the standards and the 2011 commentary is based on these. The 2007, 2009 and 2010 commentary were written to the version of the standards current in that year.

The memberships of the assessment teams are given at Appendix One.

The Executive Summaries and recommendations from 2007, 2009 and 2010 assessments are included as Appendix Two.
Appreciation

The AMC thanks the University and staff of School of Medicine, Sydney for the detailed information provided in the School’s accreditation submissions, and acknowledges the planning and hard work in preparation for the assessment visits. The AMC is grateful to the staff, clinicians, students, and others who met one or more of the AMC teams and thanks them for their hospitality, cooperation and assistance during the assessment processes.

The groups met by the AMC during each visit are given at Appendix Three.
1 The Context of the Medical School

1.1 Governance

The medical school’s governance structures and functions are defined, including the school’s relationships with its campuses and clinical schools and within the university.

The governance structures set out, for each committee, the composition, terms of reference, powers and reporting relationships, and ensure representation from all relevant groups in decision-making.

The school consults on key issues relating to its mission, the curriculum, graduate outcomes and governance with those groups that have a legitimate interest in the course.

2007 Team Commentary

The governance structures and functions of School of Medicine, Sydney are clearly defined. The structure provided in the submission and further clarified at the visit describes the current School of Medicine, Sydney position within the broader University of Notre Dame Australia structure. The School’s relationships with the School of Medicine, Fremantle, the Executive Dean of the College of Medicine, the Deputy Vice-Chancellor (Sydney) and the Vice-Chancellor are well documented.

With the growth of the University’s Sydney campus, and the development of School of Medicine, Sydney, the University is in the process of altering its governance structures to provide more autonomy to the Sydney campus and School of Medicine, Sydney. This will involve creating a Provost (or Associate Provost) position for the Sydney campus, to be responsible for academic matters related to the Sydney campus, and separating the current single Academic Council into two academic councils, one for Sydney and one for Fremantle. There will be a separate research committee and ethics committee but one core curriculum committee. This committee will deal with the core topics of philosophy, ethics and theology, which are compulsory for all students enrolled in the University. Each School of Medicine has its own Curriculum Management Committee. The Executive Dean’s role will change from one of representation of constituent schools on a centralised Academic Council to that of ensuring appropriate commonality of curriculum and standards, and efficient sharing of resources across the schools in Sydney and Fremantle.

There will be an overall Executive Committee comprising the Vice-Chancellor, two Deputy Vice-Chancellors and two Provosts. Over time, the University’s centralised finance and other corporate services will be partly duplicated in Sydney. This will be an appropriate progression reflecting the growing maturity of the Sydney campus.

The School is directed by the Dean, with appropriate advice and support from a School Executive Committee. The School’s committee structure is well considered and functional, ensuring effective operation of the committees and the School. The Dean is advised by five committees, including the Executive, Research, Evaluation, Selection and Curriculum Management, and an External Advisory Board. The documentation of the committee structure, including membership, terms of reference, and minutes of meetings, is extensive and adequate. All committees have suitable representation, and will have student representatives where appropriate. The School does not have a departmental structure.

There is evidence of appropriate consultation processes and engagement of many stakeholders, including the External Advisory Board involving a wide range of key, senior stakeholders. The Dean of the School and several senior school staff have met on several
occasions with the Deans and senior staff of other medical schools with an interest in the clinical placements of School of Medicine, Sydney. However, the Deans of other medical schools reported to the Team that they did not regard the level of consultation at the time of the visit to have been optimal.

The School has considered matters related to the small numbers of staff engaged in the management of the School and the planning, development and early implementation of the curriculum. Members of the School Executive Committee have been identified who would be capable of acting in executive roles within the School at short notice, if this were required.

2009 Team Commentary

The University of Notre Dame Australia has formulated its main organisational structure of national colleges and constituent schools across the three campuses in Fremantle, Sydney and Broome. The College of Medicine, comprising Schools of Medicine in Fremantle and Sydney, forms part of this structure. Each School of Medicine is headed by a Dean who reports to the Executive Dean of the College of Medicine. At present, the Dean of School of Medicine, Sydney is also the Executive Dean of Medicine and Pro-Vice Chancellor (Medicine).

The University believes the College structure is best suited to achieving its principal goals, which are clearly articulated in its mission statement. The strategy to achieve these goals demands a final enrolment position of 10,000 EFTs by 2018, shared equally between Fremantle and Sydney. The University believes that by remaining relatively small, it is better able to achieve its goals and this is reflected in its ‘institutional smallness’ policy.

The organisational structure of School of Medicine, Sydney is clearly defined but appears unnecessarily complex, given its small size. The structure is relatively ‘flat’ thereby offering the Dean a high level of control over operational matters including finance and administration, course development and delivery, and personnel. Many individuals in areas of responsibility appeared uncertain of their exact role and their direct reporting lines. The School needs to eliminate these uncertainties by providing well-defined position description and ensuring that individuals are aware of their job content.

The organisational structure embraces a large number of committees, most with well-defined terms of reference and membership. The top-level committees serve executive, research, evaluation, selection, curriculum management and Indigenous-consultative functions. School of Medicine, Sydney Curriculum Management Committee has several subcommittees covering the various domains, assessment and Indigenous/rural components of the course. The committees’ membership ensures representation from all relevant groups in decision-making.

Through the Dean, there has been continuing and further consultation and engagement with stakeholders. This has ensured a good level of understanding of the School’s mission and goals and a high level of support.

2010 Team Commentary

Since the 2009 assessment, significant changes have occurred in the School’s leadership. The School’s Foundation Dean, Professor Julie Quinlivan, took up a more senior position in Notre Dame Fremantle between the 2009 and 2010 visits. Professor Victor Nossar acted as Dean from 10 May 2009 to August 2010. A new Dean, Professor Gerald Carroll, took up the position from 16 November 2009.
The University’s governance structure has been further developed since the 2009 AMC assessment visit. The Dean of School of Medicine, Sydney is responsible for the School’s academic leadership and management including financial and human resource management. The Dean reports directly to the Deputy Vice-Chancellor and Provost in Sydney, and then to the Vice-Chancellor. The Dean also has a functional relationship with the Pro-Vice Chancellor Medicine, based in Fremantle. The Dean has direct reporting lines from the Associate Deans.

The course’s preclinical phase is delivered at the School’s Darlinghurst headquarters but with input to teaching from the University of Technology Sydney (UTS). Three clinical schools include the Sydney Clinical School, the Melbourne Clinical School and the Rural Clinical School. An Associate Dean manages each of clinical school. Within each clinical school are specific campuses, known as sub-schools. The Sydney Clinical School has three sub-schools (St Vincent’s and Mater, Auburn and Hawkesbury). The Melbourne Clinical School has one sub-school at Werribee and the Rural Clinical School has three sub-schools (Ballarat, Lithgow and Wagga Wagga).

Each of the seven sub-schools has a head, who reports directly to the relevant associate dean.

Within clinical disciplines is an overall Head of Discipline position, and clinical discipline leaders at each clinical sub-school.

Since 2009, the School has made appointments to more key positions, although some of these are relatively recent. On paper, the School has coherent governance structures within each of its three clinical schools and their sub-schools, and an overarching structure in Sydney appropriate to manage both academic and administrative functions across a distributed program. Further development of this governance structure and, in particular, the delineation of the Associate Dean roles is welcome. The Associate Dean is responsible for delivery of teaching, but content is separately determined, in theory by the Heads of Disciplines and in practice by the Medical Education Unit, interacting with helpful discipline leaders.

At the time of the April 2010 assessment visit, the University had announced that it would reorganise its Rural Clinical School, giving much greater prominence to Wagga Wagga as its head office, and redefining the relative contributions of the three sites delivering the rural program. The School argued clearly for the merits of this proposal, based on the relative strengths of the sites. The Team’s visit to Wagga Wagga and its meetings with clinicians showed the enthusiasm for teaching and strong local support for an expanded number of medical students. Implementing these plans will affect priorities for resourcing, teacher support and capital development, as well as student allocation.
2010 Supplementary Comments

Figure 1 shows School of Medicine Sydney structure.

Figure 1

Immediately following the Team’s April 2010 assessment visit, the University Vice-Chancellor advised that the Dean had resigned and would finish in his role on 5 May 2010. Professor Gavin Frost, Dean of the Fremantle School of Medicine was appointed as Acting Dean. Professor Frost will continue in this post until January 2011.

Following the School’s change in leadership, the University notified stakeholders that School of Medicine, Sydney had reverted to the original plan for the Rural Clinical School, with Lithgow as the School headquarters. This has inevitably caused disappointment in Wagga Wagga, and raised significant logistic issues for the School’s leadership.

The resignation of the Dean, when the School’s planning and curriculum roll-out needed to accelerate, highlighted the Team’s concerns about the small and stretched senior management team and the School’s vulnerability to such losses. The subsequent resignation of other long-term School staff further weakened its capacity in the short term.

Under Professor Frost’s leadership, additional academic and general appointments have been made and all the Associate Dean positions are filled. The Associate Dean Rural, who began in July 2010, has worked quickly with the Dean to review the capacity and requirements of the School’s dispersed rural teaching sites. This position has been filled on a short contract basis to 31 January 2011. Selecting a new Associate Dean able to continue to develop good relationships and to facilitate site development will be critical.
The University is in the process of making appointments to most discipline leader positions. Heads of Discipline have now been appointed in all clinical disciplines, except paediatrics. At the time of the Team’s visit, some positions had been established for some time, but several had been confirmed only in recent weeks.

The School’s relationship with its sub-schools is defined. The roles and responsibilities of the Associate Deans and Heads of Sub-Schools are well described, as are those of the Heads of Discipline and Discipline Leaders. As is appropriate, all the clinical academic staff are focused on writing and preparing to implement the Year 4 (MED4000) curriculum and on the continuing delivery of Year 3 (MED3000). The Team was unable to clearly establish plans for further developing their roles in curriculum review and discipline leadership beyond this intensive current phase. Although this is understandable, as some of the positions had so recently been filled, early clarification of these plans is needed. An important priority must be to establish relationships between Heads of Disciplines and the Discipline Leaders at all sites, enabling the MED4000 program to be implemented and assuring ongoing, broad equivalence of clinical experience and course implementation in their given disciplines.

On curriculum matters, Heads of Discipline also have an educational reporting relationship to the Associate Dean, Teaching and Learning. The Team was unclear where responsibility would lie for addressing any substantial variation in students’ experience across the dispersed sites, as either a curriculum matter or through the Heads of Sub-Schools. The School is aware of the need to be clear on this important matter, but has deferred this until after implementation of MED4000.

The Team noted that sub-school heads had commenced regular teleconferences and found these of considerable value. The Team encourages the School to consider similar regular teleconferences between Discipline Heads and Discipline Leaders in each discipline across the School.

2011 Team Commentary

The School’s governance structures have continued to evolve and greater stability was apparent as senior leaders had become more familiar with their roles and the School’s requirements. A new Dean, Professor Christine Bennett, commenced early May 2011. Professor Gavin Frost, who had been the Acting Dean, had continued to provide support for the School. The Team noted that the Associate Dean Rural, had continued her role with the School.

Until the appointment of the new Dean, Professor Frost spent one week in four at the Sydney School. The Executive continued to meet monthly in the week that Professor Frost was in Sydney. The Sydney School Executive is now supported by a full-time Executive Officer.

In 2010, the AMC found this standard was substantially met, and sought evidence of processes to address issues of variation in curriculum delivery and student experience across the School’s dispersed clinical sites.

The School has improved the processes to support curriculum delivery, especially by improving and clarifying the processes for communication between Heads of Discipline, the Curriculum Management Committee and Heads of Sub-Schools.

The Heads of Discipline and Domain Committee is a new Sub-Committee of the Curriculum Management Committee, which is intended to provide a forum for discussion of curriculum implementation issues and possible strategies and solutions. This Committee will report to
the Curriculum Management Committee, which is responsible for the implementation of changes to the curriculum.

While these developments are acknowledged, at the time of the Team’s visit there was only limited evidence that the School’s clarified communication processes were being universally applied and it was too early to assess their effectiveness (for example, the first Heads of Discipline and Domain meeting had recently been held).

The Team observed that curriculum delivery and the students’ clinical experience still varied across the clinical sites. The Team acknowledges that this is a challenge in a School with multiple and dispersed sites. Nevertheless, this is the model chosen by the School, and while some variability is inevitable and welcome, this must be within the parameters of the curriculum. Until there is a clear and effective curriculum map covering the whole course, the content of which is well-understood across the School, implementation of a consistent program will remain a challenge.

The Team was pleased to learn that a curriculum map for MED3000 and MED4000 was developed in July 2011. This document, which was subsequently reviewed by the Team, is a promising start, but will require further development if it is to be an effective curriculum management tool.

The Team understands that in the early stages of developing the School, and because of uncertainty about access to places, the availability of clinical placements was a major focus. As access to places becomes more secure, the School will need to demonstrate in progress reports that the new processes and structures are effective tools to align clinical placements with curriculum requirements.

The Team noted that the disciplines of pathology and radiology did not seem to be included in the School structure in the same way as other disciplines are, with the Chairs in pathology and radiology reporting directly to the Dean, rather than through the Associate Dean, Teaching and Learning. The Team was pleased to note that the School addressed this anomaly following the visit, so that these two disciplines are integrated into curriculum development, review and related resource discussions.

1.2 Leadership and autonomy

_The medical school has sufficient autonomy to design and develop the medical course._

_The responsibilities of the academic head of the medical school for the educational program are clearly stated._

**2007 Team Commentary**

The School is composed geographically of a central School, which will be located in Darlinghurst from December 2007 in a purpose-designed building, and three clinical schools, which will be situated in Sydney, Melbourne and Ballarat (the Rural Clinical School). The delegation of authority for the function of the School from the University to the Dean, as the academic head who is responsible for the leadership and management of the School, is well documented.

The educational program is the responsibility of the Dean, assisted by advice from the Curriculum Management Committee and its subcommittees, in the broader context of the core curriculum requirements of the University. The School has considerable autonomy to develop the medical course without intervention from the University, with the exception of
the requirement for students to undertake the core units (theology, ethics and philosophy) which are compulsory for all students graduating from the University.

The Dean has led the development of a School Strategic Plan 2007 to 2017, which is well documented. An annual review of the Dean’s performance is undertaken by the University Provost. The University has now developed an Academic Freedom Policy Statement for staff that reflects the context of a Catholic University environment. The Team considered that the statement provided reasonable assurances for staff acting in the context of a comprehensive medical curriculum.

**2009 Team Commentary**

The Dean of School of Medicine, Sydney continues to have a high level of autonomy and support from the University to ensure the successful development and deployment of the medical course within the parameters set by the mission and goals of the University. This includes delivery of the medical course at Melbourne and the rural clinical school. The responsibilities of the Dean, as academic head, are clearly stated.

The Dean has demonstrated strength of leadership that has been pivotal to the successful implementation of Years 1 and 2. The University must ensure that, with the completion of the current Dean’s term, there is continuity in leadership for succession planning into the future, particularly with the very important implementation of the clinical years from 2010.

**2010 Team Commentary**

A new Dean commenced in November 2009. The Team noted that he has moved rapidly to address some of the gaps listed in the previous AMC report. While acknowledging the adequacy of the School’s governance structure, the Team remained concerned that the central leadership and development team is relatively small, and that the team members are carrying numerous concurrent roles and functions. The Team therefore remained unconvinced about the long-term sustainability of this structure and considered the program remained extremely vulnerable to loss of critical staff. The Team strongly encourages the School to move immediately to the appointment of a Deputy Dean, permanent Associate Deans and the remaining Heads of Disciplines. The School should also consider making additional senior appointments to support the teaching and learning portfolio in School of Medicine, Sydney.

**2010 Supplementary Comments**

Before the Dean’s resignation, the Team’s view was that the School should be able to deliver its full clinical years’ curriculum, but that many issues relating to clinical teaching placements and objectives still needed clarification. For this to occur, the Team considered effective leadership and concerted effort for the remainder of 2010 would be essential.

The circumstances of the Dean’s resignation raised questions about the autonomy of the position in making decisions about the academic resources needed to design and develop the medical program.

In the October 2010 discussions with the Team, senior School staff and the Acting Dean indicated there had been positive changes in School and University relationship, and that they felt assured of appropriate autonomy to design and develop the program. The Team noted the current Acting Dean has a well-established relationship with the University’s senior staff and there is clear evidence currently that the Dean has the authority to administer the educational program to meet the objectives of the medical course. The AMC will need to be assured that
an appropriate level of autonomy will be available to the new Dean (anticipated to be appointed from January 2011).

The secondment of the Dean from Fremantle to the position of Acting Dean has given some much-needed stability to the School. The Acting Dean’s familiarity with the School and the staff in Sydney has facilitated management of the transition period and refocussed planning and implementation for MED4000.

The University hoped to make an appointment to the position of Dean in the near future. The University re-advertised the position nationally and internationally in September 2010 and received some significant interest in the position. However, the Team remained concerned that the School may still not have a new Dean by the beginning of the 2011 academic year. If this were the situation, the AMC would need assurance that an appropriate School academic would be appointed as Acting Dean.

2011 Team Commentary

In 2010, the AMC found this standard was not met, but could be addressed by evidence of academic leadership with sufficient autonomy and capacity to deliver the medical program, either a new Dean in post by 1 February 2011 or alternative effective leadership, supported by effective senior clinical leaders.

Professor Christine Bennett took up the post of Dean of School of Medicine, Sydney on 2 May 2011. As noted above, the Acting Dean continued in position until this appointment was confirmed.

The Team welcomed the appointment of the new Dean, noting that she had only just taken up her appointment at the time of the visit and as such, any judgments about the effectiveness of the new leadership structure would be premature. The Dean outlined her vision for the School and her intent to conduct a management review in the first few months. The Team supported this approach and noted information on changes made as a result of this review. The AMC will wish to be informed of the effects of the changes made through annual progress reports.

1.3 Medical course management

The school has established 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 course.

2007 Team Commentary

The School’s curriculum is determined by the Dean, on the advice of the Curriculum Management Committee, chaired by the Medical Education Unit Director. This committee plans, implements and reviews the curriculum on behalf of the Dean, who may accept or reject the Committee’s recommendations. It has appropriate membership, including staff with expertise in medical education and with a variety of disciplinary backgrounds in both basic and clinical sciences.

The Curriculum Management Committee has six subcommittees including the Assessment Committee, Basic and Clinical Sciences Domain Committee (BCS), Communication and Clinical Skills Domain Committee (CCS), Population and Public Health Domain Committee (PPH), Personal and Professional Development Domain Committee (PPD) and the Indigenous Health Curriculum Consultative Committee (IHCCC).
The Curriculum Management Committee has met regularly since July 2006. The Team was impressed with the rapid progress achieved in curriculum development over this period. Although the University of Queensland curriculum and teaching resources have been used as a base, significant effort has been expended in adapting these to local conditions. There is a high level of internal organisation and timetabling, and a clearly defined program for the activities of the Curriculum Management Committee and its subcommittees over the next several years. The activities of curriculum development have been keeping to schedule throughout the planning phase.

2009 Team Commentary

School of Medicine, Sydney Curriculum Management Committee is part of the Medical Education Unit (MEU) and has the responsibility to plan, implement and review the curriculum in order to achieve the objectives of the medical course. The School has developed an appropriate subcommittee structure with broad representation, and there is academic and clinical educational expertise among the University staff centrally. The Curriculum Management Committee reports through the committee chairperson (who is also the MEU director) to the Associate Dean, Teaching and Learning. The ultimate authority rests with the Dean who may accept, modify or reject the committee’s recommendations.

While the committee structure appears to be fulfilling the requirements of the first two years of the curriculum, its appropriateness for the development of Years 3 and 4, with the additional complexities associated with implementation at a large number of clinical sites, requires review.

2010 Team Commentary

The Associate Dean, Teaching and Learning has a pivotal role overseeing assessment and curriculum development (including Aboriginal and Torres Strait Islander health and rural health). The establishment a Clinical Years Committee is a welcome and essential addition to the Curriculum Management Committee subcommittees. This addition secures input from all key contributors to the Years 3 and 4 curriculum. As Chair of the Curriculum Management Committee and Clinical Years Committee, the role of the Associate Dean, Teaching and Learning, entails obtaining and integrating input from the heads of all key curriculum domain committees, Heads of Disciplines and Head of Assessment. This is a major role.

The Associate Deans of the three clinical schools oversee coordinating and implementing the medical curricula at their component clinical sub-schools. See Table 2 for committee structure.

As mentioned earlier, within each clinical school are specific campuses or sub-schools. The appointment of Head of Clinical Sub-School for each of these has significantly strengthened the sub-schools’ operational capacity. The subsequent appointment of Year 3 discipline leaders at the Sydney and Melbourne Clinical Schools has been critical in preparing these sites for the first groups of Year 3 clinical students.

The Team remained concern that these appointments were only finalised a short time before the MED3000 clinical program commenced. These concerns are reinforced by similar delays in the appointment of Heads of Disciplines and Year 4 discipline leaders, and in preparing the Sydney, Melbourne and Wagga Wagga schools for the Year 4 clinical program in 2011. The appointment of Heads of Clinical Sub-Schools has filled key operational roles in implementing MED3000. However, these have not fully compensated for the absence of
discipline heads, and there is a real risk of curriculum drift and inconsistent educational experience if this is not rapidly redressed.

**2010 Supplementary Comments**

The committee structure at October 2010 is shown in Figure 2 below.

**Figure 2**

The Curriculum Management Committee, and particularly its Chair, continue to have a large workload as implementation of MED4000 approaches, and are focused on achieving this task.

The Team considered the School’s increased capacity and the current focus on planning for MED4000 was likely to allow this program to commence on time. However, the capacity to review and adapt plans in the face of unforeseen problems is very limited by time and resources. The Team was concerned that the lack of depth of educational expertise (see also 1.4) continues to limit the School’s capacity to plan and review in a timely manner.

The role of the Curriculum Management Committee will need to evolve and expand once all years of the program are implemented to include oversight of the curriculum and content review. The Team considered that the Committee’s role should evolve to include:

- authority to implement its curriculum decisions rather than its present advisory function;
- formal processes for curriculum evaluation, review and development;
- inclusive processes for considering and deciding on the contributions of specific disciplines to the course;
formal mechanisms to ensure broad similarity of learning opportunities across all learning environments, and equity of access to quality medical education for all students.

In June 2010, the Vice Chancellor wrote to the AMC President undertaking that the University would ensure all current third year students were advised of their fourth year placements at least three months before the end of the year (mid–end August).

In addition, on the assumption the next AMC visit was October 2010, it would, by this time:

a. complete the fourth year curriculum including assessment standards and formats;

b. appoint all discipline leaders and take all steps to ensure that the discipline leaders understood their role, responsibilities and lines of communication.

By the October visit, the School had recently informed Sydney students of their MED4000 placement details. Students in Melbourne knew the clinical sites they would attend. There had been significant change in the plans for rural students due to the decision not to develop Wagga Wagga into a major hub. This led to uncertainty for ten students who were expecting to be placed there, which the School had moved to address.

The MED4000 curriculum plans were substantially developed by October 2010, although the back-to-base teaching resources for 28 days were awaiting final review, and five more were still to be developed. This is discussed further in Section 3 of the report. The MED4000 assessment plan was not developed.

The School is in the process of recruiting and appointing 50 additional academic and general staff for the introduction of MED4000. In the October 2010, the School had appointments recommended for more than 30 positions, including most of the discipline leaders for Year 4. The Team understood the majority of appointments would begin on 1 January 2011.

Since the April 2010 visit, the University has established a small External Accreditation Advisory Committee. The group’s role is to advise the University and School on the steps required to ensure all AMC accreditation standards are met. The group held its first meeting on 30 September 2010 and an ongoing role over approximately 12 months is envisaged.

2011 Team Commentary

In 2010, the AMC found this standard was substantially met. To meet the standard, the School was asked to provide evidence that the Curriculum Management Committee had the responsibility, authority and capacity to review and develop the curriculum.

In 2011, the School had revised the terms of reference so that the Committee has clear responsibility for curriculum evaluation, review and development, and for developing strategies to address curriculum issues.

The External Accreditation Advisory Committee established by the University in September 2010 has held monthly teleconferences with the School’s Executive Team. It visited Werribee, Ballarat, Lithgow and Sydney in early April 2011.
1.4 Educational expertise

The school ensures appropriate use of educational expertise, including the educational expertise of Indigenous people, in the development and management of the medical course.

2007 Team Commentary

The School has educational staff, including senior clinicians, with appropriate educational experience and expertise. In addition, the School is utilising academic staff at the University of Technology Sydney (UTS) to provide a significant part of the biomedical science education curriculum to students in Years 1 and 2. The staff from UTS have considerable teaching and research experience, including experience in teaching postgraduate students, albeit non-medical students.

The domain approach to the curriculum, utilising focused expertise in the four curriculum domains (Basic and Clinical Sciences, Personal and Professional Development, Population and Public Health and Communication and Clinical Skills) is an appropriate approach and likely to result in the delivery of a high-quality curriculum aimed at producing balanced, well-equipped medical graduates.

As with many new medical schools, the School is highly dependent on a small number of dedicated, experienced and committed staff to drive the new School’s efforts. This represents a significant risk and warrants a risk management/succession planning strategy. The School is aware of this risk, and appropriate steps to manage it are being undertaken.

In terms of Indigenous health, the School has taken a strategic approach in establishing an Indigenous Health Curriculum Consultative Committee. The Committee is composed of both Indigenous and non-Indigenous members who have expertise in the provision of health services to Indigenous people, and who have relevant knowledge of Indigenous communities and their health issues. The aim of this group is to advise on the role, skills and experience required for appropriate Indigenous health educators, and to advise on the integration of Indigenous health issues into the curriculum. The Team supported this approach, which had developed on a background of the extensive experience of two of the School’s senior staff with Indigenous health and Indigenous health services.

While the Indigenous committee was yet to meet, its membership appears exemplary. The planned approach is likely to provide a positive long-term Indigenous health approach to the curriculum and graduate skills and qualities. Advice has already been sought from Indigenous communities in relation to the most appropriate approach to the incorporation of Indigenous health within the curriculum.

The School will also benefit from the experience and skills available in the Notre Dame Broome campus in Western Australia, which has a strong Indigenous health focus.

The School has demonstrated support for academic staff to engage in medical education meetings and workshops relevant to curriculum development and contemporary practice in medical education.

2009 Team Commentary

Teaching staff are collectively expected to provide the skills and expertise for curriculum delivery. It is vital that the School makes appointments of Discipline Heads in a timely manner to ensure effective leadership. The Team suggests that this should be around July 2009 to ensure that the clinical placements for MED3000 have a consistent overall approach,
and that student experiences at the various sites are equally likely to meet the learning objectives of Years 3 and 4. At present, many clinical staff remain uncertain about their responsibilities and reporting lines. This must be corrected by ensuring that these staff, as well as any new appointments, have job descriptions that are specific and leave no ambiguity as to the role and responsibilities of the staff member.

The Team recognises the educational expertise of the teaching staff associated with the Darlinghurst School, including senior clinicians, but this appears much less robust in the peripheral locations. The School must ensure that all staff, irrespective of location, have the opportunity to develop the skills expected of them.

In relation to the Indigenous health component of the curriculum, it was reassuring to note that the consultative committee is utilising the Medical Deans’ Indigenous Health Curriculum Framework. The proposed inclusion of one three-hour visit to the Mt Druitt Western Sydney Aboriginal Medical Service, spent predominantly with an administrative person, is commendable as an introduction to the background circumstances of Indigenous persons. However, it would be beneficial for students to observe and participate in clinical interactions with Indigenous patients to promote understanding of the difficulties and differences in history taking and physical examination in this context. School of Medicine, Sydney might consider incorporating a clinical session for direct student/Indigenous patient interaction by utilising the ‘Health Assessment’ Medicare framework. Other medical schools are utilising this opportunity at the Western Sydney Aboriginal Medical Service at Mt Druitt, and there are already protocols in place for this to occur. An agreed timeline for further three-hour sessions, as suggested by the head of the consultative committee, would further enhance integration of Indigenous health in the School’s medical course. The Team encourages the development of broader experiences outside an urban Aboriginal medical service setting.

2010 Team Commentary

School of Medicine, Sydney has a small team with medical education expertise in its central Sydney office. This team has made substantial progress in developing learning objectives, mapping content for Year 3 disciplines and developing educational materials to support back-to-base days for the first clinical year.

The small Indigenous Health Curriculum Development Team continues to prepare sites for specific learning experiences in Indigenous communities. The AMC Team acknowledged the efforts of this group in conducting cultural safety training at the Sydney school.

As noted previously, the School is highly dependent on a small number of staff to drive the School’s efforts. This represents a significant risk and warrants a risk management/succession planning strategy. Specific educational expertise to support teaching and learning for both staff and students at all clinical sub-schools remains lacking, particularly within the Melbourne and Rural Clinical Schools.

The Team encourages the School to consider increasing the educational expertise at each clinical school, to maintain links with the Medical Education Unit and ensure that curriculum needs are met. There are specific needs for training clinical teachers and supervisors, and for local curriculum and assessment planning.
2010 Supplementary Comments

The October 2010 assessment confirmed the need for additional educational expertise. The School has made a number of excellent appointments to senior academic positions, but the strengths are more in management than in education.

The School needs leadership in medical education at each sub-school to ensure the Sydney-developed curriculum, programs and assessment are uniformly delivered. This is most urgent in the Melbourne Sub-School to support skills development in clinical supervision, formal program delivery and assessment. As the Rural Clinical School’s role increases, so will its need for educational support.

The Team encouraged the School to formalise how it maintains awareness of international developments in medical education.

2011 Team Commentary

In 2010, the AMC found this standard was substantially met. To meet the standard, it sought evidence that the School had a plan enabling access to sufficient educational expertise for developing and managing the medical program at a level consistent with AMC standards.

During the 2011 assessment visit, the Team met staff of the School’s Medical Education Unit as well as the School’s curriculum committees. The School’s accreditation submission listed 13.9 Full-Time Equivalents (FTE) in the Medical Education Unit with 8.9 academic FTEs including the Heads of Disciplines. The Team considered these figures substantially overstated the FTE commitment specific to medical educational expertise. It also listed 5.0 general FTEs, which included a new full-time position of Clinical Years Education Support and Liaison Officer.

The Team remained concerned about the extent of the medical education expertise in the School to support the implementation and development of the curriculum. The Team was concerned that a number of important developments, identified for attention in earlier reports, were not completed. These included a robust curriculum map to support delivery of a coherent and consistent curriculum, delivery of high quality and contemporary assessment processes and examiner training.

The effect of limited medical education expertise is also demonstrated in the limited training and support for clinicians. While there is evidence of good clinical experience for students, with often very dedicated clinicians providing the supervision and teaching, the clinicians who supervise and assess the medical students had variable, and in some cases quite limited, teacher training and support. In addition, the uptake of these courses remained low, in part because the timing and location of the sessions did not suit the clinicians.

Following the Team’s visit, the School advised that a new Head of the Medical Education Unit had been appointed, with restructuring expected in the medium term to develop the Unit and clinical leadership. The Dean reported that she and the new Unit Head had initiated a review of a number of aspects of the curriculum including, the structure of Back to Base days, consistency of teaching and assessment across clinical schools, external benchmarking and professional development of clinical teachers. Specific disciplines and domains reviews are also underway.
The AMC will expect reports on the School’s progress of the review of the medical education expertise available to support the medical program and the outcomes of the reviews of the curriculum elements.

1.5 Educational budget and resource allocation

The medical school has a clear line of responsibility and authority for the curriculum and its resourcing, including a dedicated educational budget. There is sufficient autonomy to direct resources in order to achieve the mission of the school and the objectives of the medical course.

2007 Team Commentary

The Dean negotiates a global budget with the University and has autonomy and accountability in budget expenditure within the University’s policy framework. The Dean is responsible for managing this budget, including a dedicated educational budget. Staffing plans are negotiated with the University and are the responsibility of the Dean. The Vice-Chancellor has committed the University to providing all resources required to achieve a successful educational outcome for the School.

Within the budget, the Dean has authority to redirect resources to achieve the School’s educational outcomes, within University guidelines. The School is not included in a broader Faculty of Health Sciences, and is becoming more independent from School of Medicine, Fremantle. The Sydney School retains clear control over its own staff, programs and budget.

2009 Team Commentary

The Dean is responsible for the School’s budget, including capital expenditure and operations. The financial reporting lines appear appropriate and authorities are well described. Income appears sufficient to meet the operational needs of the School including the development of the new curriculum. The School is financially well supported by the University, which has guaranteed sufficient funding to ensure the successful development and implementation of the new MBBS program to the standards required by the AMC. In addition, the Dean has negotiated $4.5 million in both 2010 and 2011 for capital development. Other funding applications are currently under review. If successful, the proposed funding should ensure the provision of the badly needed physical resources required for Years 3 and 4 of the course at the Melbourne Clinical School, the Auburn Sub-School and the Rural Clinical School at Lithgow. The Team considered these developments essential to the successful functioning of these clinical sites.

2010 Supplementary Comments

The University’s budget is based on the calendar year. Schools and departments prepare and submit a draft budget proposal by the end of June in the year preceding the financial year. Budgets cover salaries and wages, operating expenses and capital budget.

The University has not adopted a completely school-based budgeting process where each school contributes an overhead to general university operations. The annual budget allocation for School of Medicine, Sydney is not predetermined by income generated from student fees, commonwealth funding, or grant funding, although these factors are taken into account when determining the final budget allocation.

The Chief Financial Officer, Staffing Office and Vice-Chancellor work with School and department heads to set the budget based on the School-submitted budget requests. Final
budgets must be submitted for the University’s committees by September in the year preceding the financial year and then become set. The budget is revised in March each year when student numbers across the University become fixed.

The University has indicated that, for 2011, budget centres will be established for each of School of Medicine, Sydney Sub-Schools.

The School also receives funding from the Department of Health and Ageing for capital development of metropolitan and rural sites, and the operation of the Rural Clinical School and other initiatives including the Rural Undergraduate Support and Coordination (RUSC) Program.

Past AMC reports had all indicated concern about the School’s lean resources, and particularly how this affected the staffing profile and the timing of appointments. The AMC expects a model that provides sufficient resources, including staff, to enable ongoing delivery of the program, and the necessary delegations to direct resources to allow program objectives to be achieved.

Senior University officers indicated resourcing issues were reviewed after the resignation of the Dean in May 2010. In October 2010, the School senior staff expressed confidence in the budget processes that had developed. There was evidence the University was approving a considerable number of new appointments.

The Team had the opportunity to review the School’s financial statements and was assured the model and the amount of funding available for 2011 were appropriate. The AMC will, however, need assurance about ongoing autonomy for budget and resource allocation processes to ensure that the program can continue to be implemented, particularly in view of the University’s annual budgeting process and the appointment of a new Dean in 2011, who will need the capacity to review the plans to date and may need additional support. The Team was provided with a statement from the University’s Chief Financial Officer indicating that all funding received from the Australian Government for Medicine will be passed on to the School.

2011 Team Commentary

In 2010, the AMC found this standard was substantially met. To demonstrate that the standard was met, it sought evidence of ongoing autonomy for budget and resource allocation to allow the objectives of the medical program to be achieved.

The University’s financial policies and the method for allocation of the School’s educational budget and resources had not changed since the AMC’s last assessment in October 2010. The discussions with University staff and School Executive reinforced the view that there was a clear line of responsibility and authority for the curriculum and its resourcing, and that the Dean of the School was able to exercise autonomy to direct resources in order to achieve the School’s mission and the medical program objectives.

The School has been in a growth phase but this will slow now all years of the medical program have been implemented. The University indicated that it would continue to fund the School with a generous percentage of the medical student income.
1.6 Interaction with health sector

The medical school has constructive partnerships with relevant health departments and government, non-government and community health agencies to promote mutual interests in the education and training of medical graduates skilled in clinical care and professional practice.

The medical school recognises the unique challenges faced by the Indigenous health sector and has effective partnerships with relevant local communities, organisations and individuals.

The medical school works with its partners to ensure university staff in affiliated institutions are integrated into the service and administrative activities of the institution. In the same way, the university works with its partners to ensure that staff employed by the affiliated institutions can meet their teaching obligations and that peer review and professional development are a regular part of this interaction.

2007 Team Commentary

The School has developed relationships with the Australian government, state governments, divisions of general practice and a number of hospitals. School officers have also met hospital clinical groups involved or potentially involved in student placements. As noted in Standard 1.1, however, feedback from interested Deans of other medical schools indicated that the level of engagement with them over the past 12 months was insufficient for them to understand fully the model of clinical training that was being proposed, and the implications for sites where more than one university places medical students.

It is recognised that the clinical years are still some time away and that there is adequate scope to communicate effectively, and negotiate and agree arrangements with other medical schools for access to the practices, hospitals and other care settings proposed for clinical placements. This may include arrangements where one university fills the role of lead university for a hospital or site. This arrangement is intended for Auburn and Hawkesbury hospitals, St. Joseph’s Hospital, Lithgow Hospital, Calvary Hospital, Mercy Werribee Hospital, St John of God, Ballarat, and Bendigo and Berwick hospitals. It is likely that most, if not all, students at these hospitals will be from Notre Dame.

A view expressed to the Team on several occasions was that at the health service level it is desirable for students to be indistinguishable, regardless of their university of origin, with respect to curriculum content and teaching and assessment requirements. However, this may cause some tension, given the current ‘clinical mentor’ model proposed by the School. The School has acknowledged this concern and has agreed that it will not implement the mentor model at the three shared hospital sites where it is not the lead university. At these sites it will adopt the block rotation model, and has planned accordingly for this. It may be possible to take a standard approach to core teaching and curriculum across different universities, whilst maintaining the capacity to retain some features unique to one university such as Notre Dame’s back to base teaching days.

Concern was expressed to the Team about the broader impacts of the School’s proposal to employ and pay clinical mentors, whose role will include clinical teaching, at 0.1FTE. This was seen as a concern by other universities and by health services, in terms of possible disengagement of teachers from teaching for other universities and discontent on the part of clinicians not eligible for such payments. The Deans of potentially co-located medical schools expressed a concern that this approach could lead to a large increase in the cost of clinical training for all schools. The Team recognised that the establishment of an
employment relationship with clinical teachers also had advantages in terms of requiring specific inputs and quality of service from those employees. In many cases, the clinical teachers in the private and public sectors are the same. Some of the concerns expressed to the Team may be the result of the health system beginning to feel the effects of an increasing pool of medical students requiring training in a health system with limited capacity and a finite pool of clinician teachers.

The School has indicated a willingness to modify both the payment arrangements and the mentoring model to ensure effective and amicable collaboration between universities. This willingness needs to be communicated more effectively to other interested medical schools. The School is encouraged to reflect on its educational model and proposed clinical teaching arrangements, to consider if the model is optimal and whether further compromise is required to achieve successful clinical placement outcomes. The School is encouraged to redouble its efforts to effectively communicate with and engage with other interested parties, including co-located universities, hospitals and clinical groups.

The School recognises the unique challenges faced by the Indigenous health sector and is working to ensure it has effective partnerships with relevant local communities, organisations and individuals. As mentioned, advice has been sought from Indigenous communities in relation to the most appropriate approach to incorporation of Indigenous issues within the curriculum. The curriculum is designed to incorporate Indigenous health into core educational resources rather than treating it as an additional curriculum component. The Team regarded this approach as positive and innovative but was concerned that few detailed plans are yet available, despite the proposed starting date of January 2008.

2009 Team Commentary

The Team noted that constructive partnerships have been developed with many government and non-government organisations and community health agencies. This is particularly apparent with the area health services in New South Wales (NSW), the Department of Human Services in Victoria and the NSW Institute of Medical Education and Training (IMET).

Since the previous visit, discussion with key stakeholders has been wide-ranging and effective. It is noteworthy that the previously noted tensions with other medical schools have been addressed. The University has reached general agreement on clinical access issues with the University of New South Wales, The University of Melbourne and Deakin University. The three universities now appear to have a better understanding of the teaching and learning plan at School of Medicine, Sydney. While the relationships appear to be working smoothly at an operational level, there is a need for more formal agreements between the partners that clearly define the relationships and the specific details of lines of demarcation, clinical access for students, and sharing of resources. In particular, a tripartite agreement could be developed between the University of Notre Dame Australia, Deakin and Melbourne universities.

2010 Team Commentary

School of Medicine, Sydney enjoys good support from hospital administrations and area health authorities for implementing its hospital-based medical programs at Auburn, Hawkesbury and Werribee Mercy Hospitals. This support was also evident at the private and public hospitals in Wagga Wagga. Werribee Mercy Hospital is a rapidly growing health service and, since it is not shared with any other universities, is expected to provide a good teaching base for the Melbourne Clinical School in the future.
The Team noted the capacity in both the private and public hospitals in Wagga Wagga to accommodate a larger number of students. All health service staff held the view that, with proper coordination and placement planning, students from both the University of Notre Dame and the University of New South Wales would likely meet their learning objectives. There are good opportunities at Auburn, Hawkesbury and Mercy Werribee to expose medical students to multicultural perspectives on health and illness.

2010 Supplementary Comments

The Team continued to have significant concerns about the relationships of UNDA with other universities at sites where clinical placements are shared, particularly in Melbourne. These are addressed in Section 8 of this report.

In Victoria, health services whose clinicians would contribute to the teaching and supervision of Notre Dame students expressed goodwill for the School but also considerable uncertainty about the actual requirements. The School needs to address these issues as a matter of priority to retain and build on this goodwill and to ensure delivery of the MED4000 program.

The proposed changes in plans for the use of the Rural Clinical School sites caused a period of uncertainty for at least two of the sites. The School is now working collaboratively with all the rural sites to build strong and sustainable relationships. Nevertheless, there has been an unfortunate delay in developing the potential of the Wagga Wagga site and at the time of the visit, development plans were still under negotiation, if rather more hopeful than some months ago.

The School has acknowledged the unique challenges faced by the Indigenous health sector and is building effective partnerships with relevant local communities, organisations and individuals to support teaching.

2011 Team Commentary

In 2010, the AMC found this standard was substantially met. As evidence that the standard had been met, it requested written agreements showing that the uncertainties of some health services about Notre Dame teaching requirements have been addressed, and that the School had consolidated relationships with key rural sites.

The School’s accreditation submission indicated that formal Memoranda of Understanding have been either developed or renewed with all local health networks, health departments, hospital groups and individual hospitals. These include Western Health, Calvary Health Care Bethlehem Limited, Ramsay Health, St John of God Healthcare, Healthscope, Mercy Health, Little Company of Mary Health Care, the Victorian Aboriginal Health Service, St Vincent’s and Mater Health, and a number of public hospitals. These memoranda address general principles of collaboration, the legal and financial dimensions of the agreement and indemnification, consultation and conjoint appointments. More specific agreements may be needed over time.

The Melbourne Clinical School has recently developed separate Services Agreements for each discipline replacing the MOU Heads of Agreements with the University of Melbourne for MED3000 and MED4000 year placements at St Vincent’s and Sunshine (Western Health) Hospitals.

The Team acknowledges progress in formalising arrangements to support continued teaching of Notre Dame medical students in this network of sites, including local level service
agreements for several disciplines and services. However these service agreements were unsigned at the time of the Team’s visit. The School also had further work to do in terms of relationships with the Head of School of Medicine, the University of Melbourne, and securing clinical placements at Ballarat.

The School is continuing negotiations for the planned opening of the Rural Clinical School site in Wagga Wagga. As was noted in the 2010 AMC report, a small number of students funded by the Rural Undergraduate Support and Coordination Program were undertaking their four-week rural placements in Wagga in 2011.

The Team was impressed by the clinical placement partnerships that are being established in both well-established teaching hospitals and in newer and private hospitals. With ongoing collaboration, these will offer rich opportunities for students as they grow and develop.

1.7 The research context of the school

The medical course is set in the context of an active research program within the school.

2007 Team Commentary

In the self-evaluation presented by the School in its accreditation submission, the School identified research as a weakness. This is not unexpected in a new school. The key issue at this stage is realistic planning for an active research program in the future. Currently, the University has centralised research and ethics committees that are constituted according to National Health and Medical Research Council guidelines. In the near future, separate research and ethics committees will be established for the Sydney campus. The University Research Foundation makes approaches to major donors although the School is permitted to approach appropriate potential local donors.

University resources to support research are centrally allocated on a competitive basis. Set-up grants and seed funding for new academic appointments are not differentiated and are very modest. The Dean retains a small research budget to facilitate research and there will be some research facilities, including limited laboratory space, provided for staff at the Darlinghurst campus. Biostatistical resources are provided from the Office of the Provost.

The School Research Committee, which is appropriately constituted and has clearly stated aims and role, has met three times. There is a School Research Plan for the period 2007 to 2017. The research goals, which are consistent with those of the University, are to foster collaborative relationships; encourage the development of a research culture; maintain, develop and train staff in research knowledge and skills; ensure that selection processes include recruitment of research-active staff; encourage competition for external research funds; and encourage recruitment of honours and PhD students. There is a strong emphasis on building the capacity to compete effectively for external, competitive research grants.

The School has a 10-year goal of doubling the number of staff with a higher research degree and for 30 per cent of staff who are 0.4EFT or more to achieve a new research grant each year. Currently only a small number of senior staff holds NH&MRC grants. In addition, only a very limited number of senior academics hold higher research degrees. Future appointments will include requirements for both research and teaching. There will be time protection for research and full-time staff will have their teaching hours capped. However, there is a risk that the capped teaching time for senior staff will be eroded due to the pressure to provide administration and teaching, and help for more junior members of staff attempting to increase their research knowledge and skills.
The plan to enhance the School’s research capacity is sensible. However, if the School is to deliver on its strategic research goals, the Team encourages it to develop additional strategies to promote a stronger research focus and performance by the School’s senior academic staff.

2009 Team Commentary

The ongoing development and pending implementation of Years 3 and 4 of the course has seen a continuation of the pattern in which most of the attention of staff is directed at teaching and learning with little opportunity or incentive to engage in research. In addition, the organisational structure of the School is discipline based and curriculum focused. While this is understandable in the context of the demands of the new course, the School is strongly encouraged to develop a research culture that is embraced by all academic staff. Most staff are not aware of the content of the School research plan. The plans, policies and guidelines to foster research must be developed with broader staff input and ownership. This is lacking at present.

Notwithstanding this, the School is to be congratulated on the successful establishment of the Cunningham Centre for Palliative Care research, the Cerebral Palsy Institute, and the Notre Dame Centre for Health and Rehabilitation research.

2010 Team Commentary

The School’s research program has developed over the past year. The number of staff involved in research has increased. Collaborations between the School and UTS will predominantly be in basic biomedical research areas. At UTS, the main research groups in biomedical sciences are in the Institute for Biotechnology of Infectious Diseases (IBID). In the past, the research at IBID has focused primarily on biology and control of infectious diseases in animals. In recent years, IBID has broadened its scope to include human diseases, and, in this area, IBID and School of Medicine, Sydney have identified strategic opportunities.

The School’s publications and professional activities from 2007 to 2009 reflect the majority of School staff’s commitment to research. In 2009, 24 School academic and clinical staff were involved in research. Currently, two tutors are studying for higher research degrees by research. Group tutors have recently identified areas of interest in general practice that have potential for research. Individual discussions are underway with the interested tutors to facilitate implementing research projects.

While the UNDA research program remains nascent, the Team acknowledged the challenges in developing an active research program during the medical education program’s rapid growth and establishment. The Team nevertheless encourages the School to continue with these developments as actively as possible, and to consider developing an educational research focus related to its medical education program.

2010 Supplementary Comments

The Team hopes the Acting Dean’s plans to encourage a research program at the Lithgow Rural Clinical School eventuate.

2011 Team Commentary

The School’s plans to establish active research groups are still at an early stage, since the focus has been on the implementation of the curriculum.
As all years of the medical program are now in place, the AMC would expect the School to give greater priority to development of an active research program, which will in turn enhance the medical program.

In future reports, the AMC will expect the School to demonstrate its involvement with the rest of the University in research and developments in collaborating with other research institutes and/or organisations.

The Team encourages the School to consider the implications of the current staffing model, in which Heads of Discipline and Discipline Leaders have small fractional appointments, for the capacity of these leaders to be research active.

1.8 Staff resources

The medical school has a detailed staff plan that outlines the type, responsibilities and balance of academic staff required to deliver the curriculum adequately, including the balance between medical and non-medical academic staff, and between full-time and part-time staff.

The medical school has an appropriate profile of administrative and technical staff to support the implementation of the school’s educational program and other activities, and to manage and deploy its resources.

Staff recruitment includes active recruitment by Australian schools of Aboriginal and Torres Strait Islander people and by New Zealand schools of Māori, together with appropriate training and support.

The school has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the medical course and the responsibilities of the school to these practitioners.

The medical school communicates its goals and objectives for basic medical education to these practitioners and facilitates training for them in their teaching and assessing roles.

The medical school routinely evaluates clinical teacher effectiveness using feedback from students and other sources. It offers these teachers guidance in their professional development in their teaching and assessing roles.

2007 Team Commentary

The School has a detailed staffing plan for both academic and administrative staff up to 2015. This reflects the progressive growth in student numbers from 2008 to 2011. Year 1 and 2 teaching resources are supplemented by the employment by UTS of additional non-medical academics to support the biomedical sciences educational component. Domain chairs have been engaged, as have relevant medical academic staff for Years 1 and 2. The current and planned academic staffing profile appears to be the minimum required to achieve the School’s educational outcomes, particularly given the need to allow protected time for research. This profile should be reviewed now and annually over the next four years, recognising the lead time from approval of a position to the commencement of the appointee.

The School is looking ahead to identify people for key leadership roles in Melbourne. This will be important to ensure delivery of the curriculum in 2010. The School recognises that the identification of appropriate hospital coordinators in Victoria, and to a lesser extent in New South Wales, is a critical step in achieving the graduate outcomes. Hospital coordinator numbers have been identified in the staffing plan. The School has already appointed four
hospital coordinators and will employ an additional eight in the next 12 months. The School has plans to identify, appoint and develop people in these positions in 2007 and 2008.

As arrangements in hospitals where two or more universities have medical students become clear, the School may need to review the numbers of coordinators and hospital-based academic staff. If the result of negotiations is that each university manages its own students independently, then additional resources may be required. Draft job descriptions of the hospital coordinator and clinical mentor roles have been prepared. Two crucial appointments in radiology and pathology need to be progressed as soon as possible, particularly given the intention to use imaging as an adjunct to anatomy teaching in the early years.

The current and planned academic staffing profile appears to be the minimum required to achieve the School’s educational outcomes. It should be reviewed now and annually over the next four years, recognising the time from approval of a position to the commencement of the appointee. In addition, the School is encouraged to develop succession planning outside the main Sydney School, particularly in relation to senior staffing to safeguard future leadership and key academic positions.

Administrative staffing is currently very limited. Administrative staffing requirements are being analysed through a review and allocation of the tasks that will need to be undertaken each year. However, the Team remained concerned that the administrative staffing plan will not be adequate to support the School’s activities effectively. The School is encouraged to consider at least an additional two full-time equivalent administrative staff in ongoing roles to support the Sydney Clinical School (Darlinghurst campus) when it opens at the end of 2007.

Indigenous educator requirements have yet to be identified, awaiting the input of the Indigenous Health Curriculum Consultative Committee. Although it is commendable that a Professor of Indigenous Health has been appointed, his location, in the Northern Territory, may limit his contribution to direct teaching. While the approach to Indigenous health teaching is commendable, progress needs to occur soon if the practical outcomes are to be available for students in 2008.

There are memoranda of understanding with a number of divisions of general practice, public and private hospitals. Negotiations are progressing on memoranda with public hospitals and co-located universities.

The Team remained unconvinced that there is enough FTE staff. It suggests the AMC require a report on the revised staffing plan and progress with appointments by June 2008.

2009 Team Commentary

School of Medicine, Sydney has had significant changes in senior staff since its inception, and the Team was informed of the recent departure of the Associate Dean, Teaching and Learning, and the impending departure of the Foundation Dean. The School has been proactive in seeking replacements for the Dean and other senior positions. The engagement with very senior clinicians in some of the new clinical sub-schools is strategic but requires early consideration of succession strategies.

The School staffing plan includes a recruitment program designed to meet the requirements of increasing student numbers through to 2011. Teaching resources for Years 1 and 2 continue to be supported by the University of Technology Sydney employing additional non-medical academics to support the biomedical sciences educational component. While the staffing plan supports adequate staff numbers for Years 1 and 2 of the program, there is an
urgent requirement to appoint discipline leaders in clinical disciplines to oversee the detailed planning of the MED3000 clinical placements.

The administrative staffing plan still requires adjustment to reflect the inevitably increasing workload created by increasing student numbers, ongoing curriculum development and the expected increase in academic staff numbers. With the appointment of the proposed, and urgently needed, additional clinical teaching staff in specific clinical disciplines, and those employed in assessment and evaluation roles, it is essential that these staff have adequate administrative support to enable them to focus on academic issues.

The School has an affirmative action plan to recruit Indigenous academic staff and has now successfully appointed an active Head of the Indigenous curriculum.

2010 Team Commentary

It was pleasing to see the appointment of Heads of Schools and Discipline Leaders at the Sydney and Melbourne Clinical Schools. These appointments have allowed the MED3000 program to commence successfully at both schools. The availability of staff specialists and career medical officers at some of the hospitals, such as Werribee Mercy and Auburn, has enhanced the overall capacity to supervise clinical placements at these sites.

The Team met general practitioners (GPs) at the Sydney and Melbourne Clinical Schools and observed the GPs’ commitment and enthusiasm for the UNDA program at both clinical schools. The Team was impressed by the Melbourne Clinical School’s proactive leadership in general practice. This re-emphasises the importance of selecting good discipline leadership early, its role in establishing this program and enhancing program uptake members of the GP community.

While the MED3000 program has made a very good start at the Sydney and Melbourne Clinical Schools, the Team remained very concerned about the delay in appointing discipline leaders, even at small fractions, to progress planning on the clinical sites for the MED4000 program. This is true for all clinical schools, and particularly for the Melbourne and Rural Clinical Schools. Appointing discipline leaders, staff with educational expertise and administrative staff is urgently needed in the Rural Clinical School to progress detailed planning of its programs, both separately and, at shared sites, in relation to other universities’ existing programs.
2010 Supplementary Comments
The School provided the following information on staff numbers.

Staff Growth of Headcount

Of the current vacancies: 31 were in the process of offer, six were being advertised and one was being interviewed.

The School forecasts that it will have 72.1 FTE academic and general staff in 2011. The Team was pleased to see continued expansion in the number of academic and general staff, although there are still gaps, notably in paediatrics.
Many of the academic appointments remain small fractional appointment (many at 0.1 or 0.2 FTE) and this could limit capacity to undertake major academic activities while implementing the curriculum. The Team met the Heads of Discipline and clinical Discipline Leaders at a range of sites and all expressed great enthusiasm for their role. However, most are active clinicians and for some, expanding commitment to the medical program and to a leadership role in their discipline would be difficult. The School will need to continue to monitor the adequacy of its resources.

The Team acknowledges the School is undergoing a period of intense recruitment. The AMC will need to see evidence that the School meets AMC standards concerning staff resources once the full program is implemented.

The School’s model, which gives very large curriculum roles to the teaching and learning portfolio and has small fractional appointments of academic staff in the clinical disciplines, means that the School’s curriculum development and review capacity remains stretched. The School must consider making additional senior appointments to support the Teaching and Learning portfolio in School of Medicine, Sydney.

2011 Team Commentary

In 2010, the AMC found this standard was not met. The AMC indicated it needed assurance that the governance structure would provide sufficient academic staff and senior leaders to support the School’s dispersed teaching model during the AMC accreditation period. It asked the School to develop a senior staffing risk management plan following a review of the appropriateness of the governance structure.

In 2011, the Team found that the Heads of Discipline positions had been filled, apart from Paediatrics, which was also unfilled at the time of the 2010 assessment. The Team noted that in October 2011 the School had appointed co-chairs to this position.

The Team was impressed by the enthusiasm of the Heads of Discipline and their commitment to providing good clinical experience for Notre Dame students. The Heads of Disciplines agreed that their main focus was on the implementation of the program. Given their small fractional appointments, it would be challenging to extend their role as academic leaders.

For the School to continue to meet its mission, it must be able to develop and renew the medical program so that it takes account of changes in medical practice, the health needs of the community and advances in medical science. This requires academic staff able to foster the development of their discipline, and contribute to the advancement of knowledge and scholarship. For the academic disciplines to develop at this School, the academic staff will need time for activities beyond curriculum implementation and coordination.

There are also challenges meeting the need for regular communication between clinical leads and Heads of Discipline across the large number of teaching sites within the sub-schools and Clinical Schools.

In October 2011, the School provided a risk management plan related to the senior staffing.

The School has continued to expand its staffing numbers, with 70 FTE appointed (46.3 FTE academic staff and 23.7 FTE general staff) at the time of the Team’s visit. There were also 3.6 FTE pending and 4 vacant FTE as at 21 April 2011. In its response to the Team’s draft report in October 2011, the School indicated that this had increased to 75.8 FTE (49.6 FTE
academic and 26.2 FTE general staff). There were also 1.5 FTE pending and 1.1 vacant FTE as of 28 October 2011.

1.9 Staff appointment, promotion and development

The university and the medical school have appointment and promotion policies for academic staff that address a balance of capacity for teaching, research and service functions, and recognise meritorious academic activities with appropriate emphasis on research and teaching.

The medical school has processes for development and appraisal of administrative, technical and academic staff, including clinical title holders and those who hold joint appointments between the university and other bodies.

The medical school’s employment practices are gender balanced and culturally inclusive.

2007 Team Commentary

The School has appropriate policies for the appointment, promotion, appraisal and development of academic and administrative staff. The policies include externally funded health professionals. Clinician appointments are for three years and hospital registrars have the possibility of appointment at Associate Lecturer level.

The School’s employment practices are gender balanced. While the Catholic nature of the University is reflected in the University’s general approach, including cultural sensitivity, there is no evidence that religious beliefs factor in employment or promotion opportunities.

2009 Team Commentary

The University has appropriate procedures for staff appointment and promotion. A program for academic staff development is provided which includes the opportunity to undertake the University’s Graduate Certificate of University Teaching. The employment practices continue to be gender-balanced and culturally inclusive, with recognition of equal employment opportunity. Facilitating teaching development of clinical tutors is discussed in section 4.1.

2010 Team Commentary

A process for evaluating teaching skills has been developed and will be implemented in 2010 at the completion of the first MED3000 clinical rotation. In collaboration with the School of Medicine, Fremantle and the School of Health Sciences, School of Medicine, Sydney will be participating during 2010 in ‘train the trainer’ workshops developed and delivered by the authors of Teaching on the Run.

In 2009, 11 staff successfully completed the first unit ‘Introduction to Tertiary Teaching and Learning’, which is part of the four-unit Graduate Certificate in University Teaching. New staff members took part in an induction program in January 2010, and ongoing staff participated in curriculum workshops. These workshops are held during pupil-free periods.

The Team had particular concerns that School of Medicine, Sydney should ensure onsite availability of teaching development for both sessional academic staff and other clinical teachers at the Melbourne and Rural Clinical Schools.
2011 Team Commentary

In 2010, the AMC found this standard was substantially met. To meet the standard, the School was asked to provide evidence of processes for development of clinical teachers at all the clinical schools.

In 2011, the School had appointed a Clinical Years Education Support and Liaison Officer, and had provided some workshop-based training, particularly to support student assessment. However, substantial further progress was required.

There continued to be some imbalance between the availability of training opportunities in Sydney and Melbourne. While the School has a plan for clinical teacher evaluation, there did not appear to have been any formal reporting of results.

There should be a clearly documented plan for the professional development of clinical academic staff (including how to teach and assess students) and this will be an important way to promulgate the content of the curriculum widely throughout the School.

In addition to a formal plan, the AMC would expect to see evidence that workshops and other teaching and training sessions are occurring.

The Team noted that the performance appraisal process for academic staff did not appear to require evidence of development of educational skills and recommends that the School add a requirement for such evidence.

1.10 Staff indemnification

*The university has arrangements for indemnification of teaching staff, with regard to their involvement in clinical research and the delivery of the teaching program.*

Staff employed within, or appointed to, the School are covered by the University’s insurance policies while teaching or involved in research approved by an appropriately constituted ethics committee. All student activities within hospitals with which the School has formal agreements, and within the private consulting rooms of mentors, are indemnified. Students will not be permitted to undertake clinical activities in other settings.

2009 Team Commentary

Staff employed by the School are covered by the University’s insurance policies.

2010 and 2011 Team Commentary

The School continues to meet this standard.
The Outcomes of the Medical Course

2.1 Mission

The medical school has defined its mission, which includes teaching, research and social and community responsibilities.

The school’s mission addresses Indigenous peoples and their health.

The school’s mission has been defined in consultation with academic staff and students, the university, government agencies, the medical profession, health service providers, relevant Indigenous organisations, bodies involved with postgraduate medical training, health consumer organisations and the community.

2007 Team Commentary

The stated mission of School of Medicine, Sydney is clear and meaningful. It places emphasis on teaching, social and community responsibilities through the production of graduates with appropriate attributes in these areas. In addition, the mission seeks to graduate practitioners likely to practice medicine in areas of unmet need (professional and geographic).

Within the mission statement, the School addresses Indigenous peoples and their health through implied inclusion as an area of unmet need but does not refer specifically to an Indigenous health strategy as noted in this standard. The Team encourages the School to consider making this a more identifiable goal within its mission statement.

Distinctively, the mission seeks to graduate practitioners who will assist in meeting the health needs of people living in cities and country regions of eastern Australia, and to make a special contribution to the advancement of Catholic health care provision in these areas. The goals of the School to be presented to students in the 2008 information handbook, Foundations of a Medical Vocation MED 1000, include the objective to ‘be of special service, through...its graduates…to the Church and to Catholic health care institutions and systems in eastern Australia’.

The vision for the role of research is not clearly articulated and its inclusion within the mission of the School is lacking. Underpinning goals and objectives of the School, as related to the mission, are presented slightly differently within various publications, including the information handbook, Foundations of a Medical Vocation MED 1000, for students commencing in 2008 and the Research Plan. The School is encouraged to articulate clearly and consistently the role of research within the mission of the School.

The School has identified and defined its mission and objectives in consultation with government agencies, health service providers, professional medical bodies, hospital specialists, university leaders from Notre Dame, other institutions involved in delivering the course and Catholic Church leaders.

As this is a new medical school, consultation with students is yet to be undertaken.
2009 Team Commentary

The core mission statement has been amended to include a number of points related to research and Indigenous health, as recommended in the 2007 AMC report. The mission of School of Medicine, Sydney is to ‘develop and train excellent medical graduates for the public and private sectors, who will assist in meeting the health needs of the people in cities and country regions of eastern Australia, and to make a special contribution to the advancement of the Catholic health care providers in these areas’.

Specifically this includes:

- excellence in training in communication and clinical skills to produce highly technically skilled graduates;
- excellence in training in anatomy and the biomedical and clinical sciences to produce graduates with excellent basic and clinical science knowledge
- excellence in training in ethics, philosophy and the medical humanities to produce graduates who appreciate the social and ethical obligations of doctors to the wider community
- excellence in training in research with the aim to produce evidence based practitioners who will aspire to advance medical knowledge
- excellence in training in Indigenous and rural health with the aim to improve Indigenous and rural healthcare outcomes for Australia.

2010 Team Commentary

Although the mission of School of Medicine, seeks to graduate practitioners likely to practice medicine in areas of professional and geographic unmet need, the School’s relative emphasis on sub-specialist rotations, especially in MED4000, and limited experience in general practice outside the Rural Clinical School setting appears at some variance with the mission. The most prominent area of unmet professional need in Australia is in general practice. General practitioners are also the predominant providers of Indigenous medical care.

There are a number of well-supported rotations in general practice. However, these need more prominence in the curriculum to counter the prevailing hidden curriculum message that hospital rotations provide the best learning experiences for medical students. General practitioners who were interviewed, and students who had completed GP rotations, gave a very positive impression of the little amount of general practice available to students. Efforts to increase the prominence of general practice should be considered.

2011 Team Commentary

In 2011, the Team’s discussions with general practitioners and students confirmed the impressions of the 2010 AMC Team. Several students who met the Team commented that they had completed rotations in general practices which had a very specific and limited scope. While such placements can provide excellent experience, it is recommended that they be combined with more generalist experience. The School acknowledges the need to monitor these experiences, and indicated that the Head of General Practice was working with general practitioners to define broad learning objectives for student placements and would review student feedback on this experience.
2.2 Medical course outcomes

The medical school has defined graduate outcomes and has related them to its mission.

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

The outcomes are consistent with development of the specific attributes incorporating knowledge, skills and professional attitudes of medical graduates endorsed by the Australian Medical Council.

2007 Team Commentary

The mission statement links closely with the 33 course-enabling objectives of The University of Notre Dame School of Medicine, Sydney. Graduates satisfying these will demonstrate ethical, knowledgeable, skilful and dutiful attributes. These objectives are derived from those of the American Association of Medical Colleges. They have been refined following broad consultation in Western Australia for adoption by the School of Medicine, Fremantle and subsequently by School of Medicine, Sydney. Formal consultation, particularly with the public, has not been as extensive in NSW as it was in WA. School of Medicine, Sydney intends the term ‘dutiful’ to include knowledge and skills related to the epidemiological aspects of disease and associated concepts of social justice. The Team considered that this may lead to some confusion in the Australian context, where ‘duty’ is generally interpreted differently. It considered that understanding of the School’s objectives would be promoted by the inclusion of a brief explanation of the intended meaning and context of the four areas of course-enabling objectives (ethical, knowledgeable, skilful and dutiful).

The defined objectives and values are mapped to each of the AMC attributes for medical graduates. However, the School’s objectives relating to the ‘ability to interpret medical evidence in a critical and scientific manner’ (AMC attribute 24) do not appear to link clearly with acquisition of knowledge of evidence-based medicine or with skills in interpreting research outcomes to inform clinically relevant evidence. School of Medicine, Sydney objectives (5 and 27) that are stated to achieve this are to develop a ‘commitment to place patient interest above self interest’ and to ‘know economic, psychological, social, cultural determinants of (ill)health’ Curriculum activities such as a journal club, research conferences and research selectives for all students in later years are noted. The School should consider strengthening and developing more transparent links between the course-enabling objectives and the related curriculum learning objectives on the acquisition of knowledge and skills in interpreting research-derived medical evidence to inform practice.

There is evidence of extensive mapping of the curriculum and proposed mapping of assessment to the learning objectives, domain areas and course-enabling objectives. This demonstrates a clear intent to achieve the mission of the School. This is further strengthened by the Evaluation Committee’s proposed long-term evaluation of graduate outcomes. In addition, course resources have been mapped to the four domains, the AMC graduate attributes, the Medical Deans Indigenous Health Curriculum Framework and the Confederation of Postgraduate Medical Education Councils’ Australian Curriculum Framework for Junior Doctors. The School is congratulated on its achievements in this area and is encouraged to complete remaining links in the mapping process, for example linkage of interpretation of evidence and research methodologies to the PPH domain.
2009 Team Commentary

The 2007 Team commented that School of Medicine, Sydney intends the term ‘dutiful’ to include knowledge and skills related to the epidemiological and public health aspects of disease and associated concepts of social justice. The 2007 Team considered that this may lead to some confusion in the Australian context, where ‘duty’ is generally interpreted differently. It was considered that understanding of the School’s objectives would be promoted by the inclusion of a brief explanation of the intended meaning and context of the four areas of course-enabling objectives (ethical, knowledgeable, skilful and dutiful).

The 2009 Team continues to suggest that the inclusion of a brief explanation of the intended meaning of the word ‘dutiful’ within the objectives, perhaps as a footnote to the document, is required to ensure that its meaning is clearly understood by all who read the document.

While the Team was very impressed by the progress of mapping of the curriculum in Years 1 and 2, there is an urgent need to underpin the development of Years 3 and 4 by establishment and dissemination of learning objectives for these years as soon as possible. This issue is discussed further in section 3.

2010 and 2011 Team Commentary

Previous AMC teams had concerns about the use and meaning of the term ‘dutiful’. School of Medicine, Sydney advised that, in the context of the Graduate Attributes of the School, the term ‘dutiful’ refers to the responsibility of the doctor to consider illness and health in a wider context and has incorporated a footnote to the Graduate Attributes to this effect.

The Team encourages School of Medicine, Sydney to include its assessment of its graduate outcomes in its process of curricular evaluation and review.
3 The Medical Curriculum

3.1 Curriculum framework

The medical school has a framework for the curriculum organised according to the overall outcomes which have, in turn, been broken down into more specific outcomes or objectives for each year or phase of the course.

2007 Team Commentary

The Medical School has adopted and developed the University of Queensland curriculum for its Basic Clinical Sciences (BCS) and Communication and Clinical Skills (CCS) domains, and the Fremantle Medical School development of an earlier University of Queensland curriculum for its Professional and Personal Development (PPD) and Population and Public Health (PPH) domains. The Medical Education Unit has been to considerable lengths to ensure that the resources are relevant to the Sydney context and has developed a detailed computer-based curriculum map and repository of objectives and resources for the program. The first 13 weeks of the curriculum were available at the time of the visit. Resources supporting each PBL case included case-specific learning goals and objectives, PowerPoint slides of lectures, additional resource material and periodic self-test material, which was supported by model answers. This material had been prepared to an exemplary standard.

The curriculum map has been prepared with reference to a number of frameworks: the School’s own objectives, the original University of Queensland objectives and the AMC objectives. Mapping to the Confederation of Postgraduate Medical Education Council’s PGY2 objectives is in preparation. This is a considerable and important achievement.

2009 Team Commentary

School of Medicine, Sydney has continued to develop its curriculum from the original University of Queensland course to meet changing needs and developments in practice, and suit local conditions. The curriculum map for the first two years of the course is now well developed and readily accessible to both staff and students. It is clearly a major influence on curriculum planning and explicitly related to program delivery. The Team was impressed that the curriculum map for Years 1 and 2 (MED1000 and MED2000) has been linked directly to several important national curricula, including the postgraduate curriculum for junior doctors.

However, there is no comparable curriculum map for the final two years of the course. The Team encourages the School to make the mapping of Years 3 and 4 a high priority for the latter half of 2009, in consultation with the newly appointed Discipline Leaders.

2010 Team Commentary

The School has a detailed curriculum map in place for Years 1 and 2, but this has yet to be extended to Years 3 and 4. Using such a map in these later years, where teaching is distributed in nature, is even more important to ensure that all required learning objectives are satisfied across the course, and to provide a secure base for blueprinting assessments.

The fundamental context of learning in Years 3 and 4 is immersion in clinical practice with students engaged in various clinical rotations in medicine, surgery, general practice, obstetrics and gynaecology, paediatrics, psychiatry, emergency medicine, intensive care, anaesthetics, and community-based placements. Although the School has now provided a clear framework, the supporting elements are still in development for MED4000. Urgent completion of these is necessary for the effective launch of MED4000.
2010 Supplementary Comments

Since the visit in April, the School has made significant progress with developing the curriculum map for Years 3 and 4. Access to the data is available by contacting the Associate Dean, Teaching and Learning but should be more generally available via Blackboard by the end of October 2010. The School indicated that the MED4000 curriculum map reports would be available for both staff and students to use by late 2010 or early 2011. The Team continues to have some concerns about the integration of clinical knowledge (largely delivered through the full-year, whole-class program of back-to-base topics) and the rotating clinical experiences, particularly as the more specific formative assessment focuses on the former. This issue is addressed further under evaluation, but as evaluation can often drive the ‘real curriculum’, it is included here. The Team urges the Curriculum Management Committee to address this matter, mindful of their desire to deliver an integrated curriculum.

2011 Team Commentary

In 2010, the AMC considered this standard was met, but recommended that the School complete the curriculum map for MED3000 and MED4000, and make it accessible to all staff and students.

The Team was disappointed that the curriculum map for MED3000 and MED4000 was still not complete at the time of the visit, partly due to IT issues and other priorities. While the School has consistently stated a commitment to this work, there was no indication of when it would be available. Completion of this tool is necessary to strengthen the integration between Years 1 and 2 of the curriculum and the clinical component, Years 3 and 4. It is also an important mechanism in supporting consistent delivery of learning across dispersed sites.

Individual disciplines are able to access curriculum information about prior learning as background to the provision of the curriculum in the clinical years. Students also have access to this information. However the current processes are cumbersome and do not support easy review of the course content.

As noted in section 1 of this report, the Team was able to review the curriculum map for MED3000 and MED4000 in November 2011.

3.2 Curriculum structure, composition and duration

The medical school has developed descriptions of the content, extent and sequencing of the curriculum that guide staff and students on the level of knowledge and understanding, skills and attitudes expected at each stage of the course.

The curriculum is based upon principles of scientific method and evidence-based practice, and inculcates analytical and critical thinking.

The curriculum includes those contributions from the biomedical sciences that enable understanding of the scientific knowledge, concepts and methods of clinical science.

The course provides a comprehensive coverage of:

- clinical sciences relevant to the care of adults and children
- clinical skills (medical history construction, physical and mental state examination, diagnostic reasoning skills, problem formulation and construction of patient management plans)
- management of common conditions, including pharmacological, physical, nutritional and psychological therapies.
The course provides a comprehensive coverage of population, social and community health.

The course provides:

- an appreciation of Australian or New Zealand society and their cultural diversity
- development of appropriate skills and attitudes for medical practice in a culturally diverse society
- development of communication skills
- an understanding of personal and professional development issues as they relate to medicine
- an understanding of medical law and ethics.

The course provides curriculum coverage of Indigenous health (studies of the history, culture and health of the Indigenous peoples of Australia or New Zealand).

The curriculum addresses patient safety, risk assessment and quality assurance of medical care.

The course includes curriculum coverage and practical experience of interprofessional education.

2007 Team Commentary

The curriculum is an integrated four-year PBL-based program built on four central domains (Basic Clinical Sciences (BCS); Communication and Clinical Skills (CCS); Professional and Personal Development (PPD); and Population and Public Health (PPH)). A strand of clinical problems runs throughout the program. In the first two years, the theme of the week’s PBL problem dictates the content of associated resource sessions and laboratories, to which all four domains contribute. Early clinical contact in the first two years progresses to substantive learning in clinical settings in the third and fourth years, during which weekly cases will be provided for students to consider, although not in a ‘PBL’ setting. It is proposed that learning in the clinical setting will be supported by an individual clinical mentor, who will take responsibility for ensuring that individual students gain a suitable depth and breadth of clinical experience. Students will also have group supervisors who will be responsible for organising overall teaching for groups of eight students.

A central requirement of the University of Notre Dame Australia is that all students, of any discipline, are required to complete satisfactorily the core curriculum, consisting of modules in philosophy, ethics and theology. While this is a stand-alone program, it has been developed so that it is directly relevant to the medical program. It will generally be completed in the first three semesters. The modification of this course to better suit the particular needs of this group of students is acknowledged.

Basic biomedical sciences will be taught by staff predominantly at the University of Technology Sydney (Ultimo campus). As noted, the University of Technology (UTS) staff have significant previous experience in teaching health sciences, and have significant research backgrounds, but are without collective experience in teaching medical students. The teaching is organised under the BCS domain and members of the domain include a number of medically qualified members. Their role is clearly identified as ensuring that the teaching program maintains a suitable clinical focus. The program has particular strength in the teaching of anatomy through the involvement of a medically qualified staff member who has recently developed a text for the Royal Australasian College of Surgeons on anatomy for basic surgical trainees.
The UTS offers excellent teaching facilities, with a purpose-built anatomy-teaching suite to be completed in 2007. There will be limited exposure to clinical pathology during the initial years by rotating attendance at a large private pathology practice, Douglass Hanly Moir. One student from each PBL group will attend weekly sessions at this pathology practice. Each student will make three such visits during the year.

At this stage, UTS staff are well engaged in developing the first year program, and appear very committed to the BCS domain process for the first year program. However, there is a need for greater coordination between the various educational groups involved in teaching in the BCS domain. The School’s program places particular emphasis on the importance of pathology, and a considerable emphasis on clinical anatomy. The degree of integration of anatomy and pathology into the later stages of the program, including the second year, was unclear. In particular, UTS staff were uncertain about how the proposed close integration of anatomy teaching with medical imaging was to proceed. UTS staff also seemed uninformed about plans for the second year program but were keen to be involved in this. There was also some confusion among staff of Douglass Hanly Moir about their precise role in the program and particularly their involvement in the assessment processes, although this may be a temporary communication issue. The Dean advised that a coordinator in pathology teaching at Douglass Hanly Moir would be announced within a few weeks of the AMC visit.

Pathology specimens are seen as important to the teaching of clinical pathology but the Team noted these would not be accessible until the second year program. The UTS holds a limited collection of such material and students are not scheduled to access the pathology museum at St Vincent’s Hospital Sydney until their second year. This arrangement is included as a clause in the signed Memorandum of Understanding with St Vincent’s and Mater Health. St Vincent’s pathology staff were not well informed regarding their proposed role in the curriculum.

It is intended that the PPH domain will take responsibility largely for providing the framework for consideration of scientific method, inquiry skills, critical appraisal and evidence-based medicine within the PBL structure. In these initial years, the emphasis will be more on the concepts and the need for an evidence-based approach rather than developing expertise in its application. It is intended to develop this further during the clinical years.

Students will develop clinical skills from the first years of the course through the involvement of volunteers, surrogate patients, actual patients and the use of skills laboratories. Specific clinical attachments, which form the majority of the final two years, will build on these foundations, with the latter focussing on the challenges of patients suffering from multiple co-morbidities. The close supervision by the ‘mentors’ during this period, in addition to the group tutors, seems likely to enhance these learning opportunities. The continuation of clinical problems, in the form of weekly cases, into this phase of the course will allow continuing integration of all four domains within the curriculum.

Teaching about management of common conditions will arise, in part, from the content of the PBL and clinical cases. These are planned to continue throughout the course. The integrated approach to developing their learning objectives by the four domain committees should facilitate consideration of the full range of therapeutic interventions. The planned clinical placements in Years 3 and 4, supported particularly by the ‘back to base’ days for reflection and discussion of the weekly cases and the students’ clinical experiences, provide a strong framework to promote effective learning around these issues.
The course will provide training in acute care skills and procedural skills in skills laboratories and support for supervision, through the mentor process, for development of these particular skills with patients. These opportunities are limited to the context of brief clinical attachments in the first two years, other than some intensive workshops during the first year covering both surgical and counselling skills. Additional opportunities will arise during Years 3 and 4.

Some PBL cases incorporate consideration of communication issues. Formal training in communication skills will commence in the first year of the course in the clinical skills laboratory (two hours per week) and progress to the clinical placements in the final years. The students’ communication skills will be formally assessed. Reflection on communication processes by both the students and others they observe forms part of the weekly ‘clinical debriefing’ sessions, which offer a particular strength to this program. Many of the clinical placements will include interactions with a wide range of culturally diverse groups of people. The Team noted that the course includes specific training in managing effective communication by working with an interpreter.

Population, social and community health is an integrated component of the course from the first year through incorporation into the PBL program. There is a particular desire to contextualise public health perspectives to given communities, which will be facilitated through the PBL approach. It is anticipated that issues of social diversity will be addressed partly through explicit consideration of such issues within the context of the PBL program. Cultural diversity issues are also likely to be addressed, in an opportunistic manner, through the ‘clinical debriefing’ sessions. Given that clinical placements will occur within a diverse cultural context, students will clearly be exposed to such issues. It would be of interest to evaluate the efficacy of the proposed methods of addressing these matters as students proceed through the course.

Indigenous health is a high priority area for the School. Senior members of the School are clearly committed to effective engagement on a partnership basis rather than a consultative basis with the local community of Aboriginal peoples. The School has been making some progress, and the first meeting of the Indigenous Health Curriculum Consultative Committee is pending. While recognising the appropriateness of this process, the Team remained unclear about how the course would address Indigenous health issues or how these issues would be resourced, given the competing demands on the limited number of Aboriginal health facilities in the local area.

Although it has made considerable progress in relation to mapping of outcomes and planning for integrating Indigenous health issues into the PBL program, the Team was not satisfied that, at this stage, the School has the mechanisms in place to satisfy AMC accreditation standards in relation to the resourcing and delivery of an effective Indigenous health strand into the curriculum. The School should provide the AMC with a report on progress by 31 January 2008.

A particular strength of the proposed program is its focus on personal and professional development. Students are required to prepare a portfolio of their clinical experiences and to be prepared to discuss one issue arising each week, promoting a process of reflective practice. While preparation of the portfolio is a course requirement, assessment of the portfolio is formative during the first two years and then summative in the final two years. At this stage, the exact form of this process is indicative and evaluation of its impact will be of interest. It has been well received within the School of Medicine, Fremantle program.
The Notre Dame program in philosophy will provide some basis for the Year 2 course in ethics. There is also a course in medical business and law in the final year. Ethical issues are incorporated into the PBL program and will be discussed in a clinical context as issues arise. Training in clinical audit and quality improvement processes is seen as integral within the PBL and clinical debriefing processes, as well as an integral part of clinical skills training and placements.

Interprofessional education is supported to a limited extent within the course. Medical students will be taught by members of other disciplines. The possibility of some joint sessions within the Notre Dame core curriculum between first year medical students and third year nursing program students is being explored. Consideration of effective service delivery in a team context in both PBL and clinical contexts is expected to include consideration of working collaboratively with team members of other disciplines.

2009 Team Commentary

The Team commends School of Medicine, Sydney on the successful implementation of the first two years of the curriculum. The students spoke positively of their experiences, particularly commending the level of engagement with and encouragement by staff. There was clear appreciation of the specific standards to be met to progress to the next year. There are appropriate plans in place for reviewing and refining the program delivered for the first two years of the course, although the process of this was unclear to staff at UTS. Staff at the UTS indicated they were keen to be involved in a review of their contribution to the first two years, mindful that their current contribution was developed without their full awareness of the overall structure and content of the program.

Although some students expressed concerns about their limited exposure to clinical settings in the first two years compared to students in other graduate-entry programs, informal observation by Team members of formative Multi-Station Assessment Task (MSAT) during the visit suggested that the standards being achieved, particularly in clinical interviewing, were satisfactory.

The third and fourth years of the course consist of 3.5 days a week in a clinical placement, half a day of clinical debriefing in that placement, and a back to base day. On the back to base days, half a dozen paper-based short cases will be addressed by the students in a relatively short time. The Team appreciated that the short cases will ensure some commonality of theoretical material to be covered in the various clinical sites but remained concerned that the number of cases may prove to be excessive in the time available. This is discussed further in section 4.1.

While development of the clinical cases for MED3000 is progressing well, with approximately half completed to a stage where discipline-specific comment is being sought on the drafts, there has been very limited development of the curriculum map or specific learning objectives for the individual clinical placements. The learning objectives for MED3000 of the program were not available for review and the MED4000 objectives were not yet in development.

Putative clinical tutors’ understanding of how students would spend their clinical attachment time was often either generic or tentative, and overall there was a lack of coherence over the specific learning goals of clinical placements. This was reflected in the following observations:
• Some discipline leaders within the sub-schools appeared not to have considered how their specific placement would relate to learning opportunities in complementary placements, for example, in the other placements in internal medicine.

• Staff with previous or concurrent involvement in medical student education with other universities anticipated that Notre Dame students would either undertake an identical program to that with which they were familiar or require an increased amount of clinician contact. The extent of this contact was not universally understood.

• Supervisors of some primary care placements anticipated that the amount of clinical contact during the available 3.5 days might be as little as six to eight hours. The Team was not convinced that this would be adequate to support development of competence in the clinical skills best gained in primary care, let alone a positive introduction to the discipline that the majority of students are likely to pursue in their careers. At the very least, there was some confusion about the amount of clinical contact planned for students.

• The proposed mental health experience in Victoria had an excessive focus on restraint and control in some settings, which is unrepresentative of modern practice. It was presumed that this reflected the absence of a discipline leader in this area.

• There was a lack of consistency in goals and inadequate communication across the rural clinical sub-schools.

• There was a lack of clarity about the alignment of the rural components and themes in Years 1 and 2 and the Rural Clinical School objectives.

The planning for MED4000 was understandably at an earlier stage of development but similar issues were evident. Students are to complete an eight-week attachment in ‘anaesthetics’, which is conceptualised to provide a broader learning experience than might be presumed from the title. However, it was not clear that the proposed attachments would be able to provide the type of experiences required, although these have yet to be fully specified. It would appear prudent to review the duration of the ‘anaesthetics’ placement once these have been defined, to ensure that the time and placements allocated are appropriate to the learning required, mindful of the short duration of clinical attachments in other complex clinical areas. The common theme in these observations is the lack of specific learning objectives related to these clinical placements and the lack of the related curriculum map for Years 3 and 4.

The Team understood that the School had planned to appoint discipline leaders at a School level, sub-school heads and sub-school discipline leaders by mid-year but that budgetary restrictions had precluded this. This is discussed further below. During the visit, the Team was informed that the Vice-Chancellor had indicated release of funds to enable this.

School of Medicine, Sydney advised that the aim of the clinical teaching is to immerse the students in the day-to-day clinical activities of medical professionals and to enable the student to apply the knowledge and skills that they have learnt in the preclinical years. The clinical teaching topics will generally be related to the clinical encounters and patient presentations, in essence a curriculum that ‘walks through the door’, however from time to time it may be determined that topic-specific tutorials are needed and the School would require this teaching to occur.

Students are expected to engage in the full range of clinical activities during the rotation including weekends and after hours if applicable. Students advised that they were actively engaged in this way in their course. The Team noted that the total time available for clinical activities during the working week was three days of the five, as one is spent on ‘back to
base’ activities, a half day is spent at their local base, in reflective practice and clinical debriefing, and half a day is reserved for personal study.

Students reported a wide range of clinical experience and teaching staff generally commented positively on student performance. However, the proposed method of evaluating the breadth of student experience, though the Individual Patient Encounter database, had encountered significant technical difficulties and was reported by some to require further consideration of its interface/structure.

Students have been advised to review the relevant syllabus document and textbook prior to commencing a clinical rotation. They are also expected to review their prior learning in the discipline and to undertake all the discipline-relevant short case weeks. The Team was advised that the tension between the fixed whole year back to base case-based learning topics and the often unrelated current clinical placement had led to a significant amount of discipline-specific teaching during terms, with some students unclear which of these to prioritise in their personal study time.

As the students will experience a range of clinical experiences, and be assessed by a variety of clinical teachers, the School is defining a set of core clinical competencies (previously called learning objectives) for each clinical rotation in Year 3 and 4. These will include emergency medicine/anaesthesia, general practice, obstetrics and gynaecology, paediatrics, procedural skills, psychiatry and surgery. The clinical competencies are being disseminated to the clinical teachers via the following methods:

- The Associate Dean, Teaching and Learning has met all the Heads of Clinical Subschools and Discipline Leaders, to discuss the clinical competencies and the process of formative assessment of these competencies.
- Written documents describing the clinical competencies have been provided to all Heads of Clinical Sub-Schools and Discipline Leaders.
- The Heads of Clinical Sub-Schools and the Discipline Leaders have also been provided with copies of the relevant syllabus and curriculum information documents that further detail the curriculum requirements of the clinical years and the clinical competencies (Attachment 10 – Information booklets).

The term ‘learning objective’ will continue to be used in reference to the weekly short case tutorials, journal club and clinical debriefing learning activities. These learning objectives have been completed for MED3000. The School advised that the learning objectives for MED4000 were in progress. However, these were not available for the Team to view during the visit. In addition, all curriculum materials have been completed for MED3000.

2010 Team Commentary

In MED3000 there are eight clinical attachments of five weeks: two, five-week terms in medicine; two, five-week terms in surgery; and one each of paediatrics, psychiatry, general practice, and obstetrics and gynaecology.

The most comprehensive outline of the MED3000 curriculum and teaching and learning requirements is available for students and teaching staff on the MED3000 Blackboard site. In addition, the School has developed a number of documents outlining this information in detail for clinical teachers and students. These include syllabus documents, handbooks and weekly learning objectives. All clinical teaching staff have access to the Blackboard site and
can view the curriculum map for Years 1 and 2 and the current Blackboard sites for Years 1 to 3.

Heads of Discipline, where they have been appointed, Discipline Leaders and clinical school teaching staff have reviewed MED3000 curriculum documents. Their participation has helped to ensure the documents are relevant to current medical practice and that the learning objectives are achievable within the clinical sub-schools.

Students and clinicians reported that the MED3000 terms, were generally providing a broad exposure to common presentations, as is appropriate for this stage of the course.

In Year 4, the School plans that all students will undertake terms in anaesthetics and emergency/critical care, plus intensive care or critical care and community outreach, which may include alcohol and drug centres, Aboriginal medical services, or community psychiatry. The Team considered the change to the anaesthetics term significantly broadened student experience. The clinical competencies required for this program are clearly specified. Students also choose selective placements, which provide additional clinical immersion, from a range of medical and surgical sub-specialties and other clinical practice settings. The School plans that allocation of students to selective terms in MED4000 will take into account the clinical experiences and patient contacts recorded in MED3000 so that any apparent gap in experience is covered and, where possible, special interests accommodated. The Team was not clear what specific process would achieve this balance and considered it should be addressed urgently, both to ensure selection of appropriate complementary selective experiences overall, and to address student uncertainty and disquiet over the next year of their course. This is especially true when no reliable evidence of patient contact data has been generated.

The learning objectives and clinical competencies for the selectives, rural rotation, and elective are not yet developed. The Team considers developing these MED4000 learning objectives and clinical competencies, and distributing these to students and to relevant clinical teachers, to be an urgent matter.

The Team was impressed with the considerable progress made by the Aboriginal and Torres Strait Islander Development team in developing clinical experiences and conducting cultural safety training in Indigenous health in NSW. However, arrangements for relevant Indigenous clinical experiences for students at the Melbourne School require finalising.

In consultation with clinical and curriculum discipline leaders, the School has completed the clinical competencies for the clinical phase of the medical course. While some of these are specific and detailed, such as those developed by the Discipline Head Psychiatry, many are generic. If these clinical competencies remain key to ensuring common objectives are met in any given term across all the relevant clinical sites, further development will be necessary.

A key component of student clinical immersion is the expectation that clinicians who agree to teach the School’s medical students should allow the student to participate in the usual clinical activities the clinician undertakes. These activities could include attending consulting rooms and outpatient clinics, ward rounds, observing or assisting in theatre, observing medical procedures, and clinical meetings.

The School expects that clinicians will, where possible, observe students undertaking clinical tasks and provide them with feedback on their progress towards achieving the discipline’s clinical competencies. Based on student feedback this expectation is mostly not being met.
The Team had serious concerns, given the stage of development of the MED4000 terms, about whether the expectation would prove feasible. The Team considered that early appointment of all discipline heads was essential to ensuring balance was achieved for all students, within the curriculum framework proposed by the School. The early appointment of Heads of Discipline was encouraged by the 2009 Team but by April 2010, only three of these had been appointed. The Team considered that this delay contributed to a lack of definition of required experience in clinical placements including core clinical conditions, procedures and investigations, and to the variable understanding of how teaching in any one site would relate to similar teaching in another.

The School has held meetings for clinical teachers to disseminate teaching plans, including a seminar for the Heads of Clinical Sub-Schools that focussed on curriculum requirements, assessment of the clinical competencies, and the roles and reporting processes for the Heads of Clinical Sub-Schools, Discipline Leaders, and clinical teachers.

2010 Supplementary Comments

As noted in Section 1 of this report, by October 2010, most Heads of Discipline were appointed, although some had been in post for only a short time. The post of Head of Paediatrics was still vacant, with closing dates for applications in November 2010.

By the time of the October 2010 assessment, learning objectives for 28 of the 33 weeks of teaching (via the back-to-base days) were in final review with the remaining five to be completed. Students noted a disconcerting lack of connection between their current clinical rotation experience and back-to-base material in MED3000. Efforts to improve this aspect of the course are recommended.

The School provided the Team with study guides for MED4000 in medicine, surgery, general practice, critical care (emergency medicine, anaesthesia and intensive care) and rural medicine. These documents appeared to give clear guidance on learning goals and opportunities. As Heads of Discipline become more integrated into the medical education team, these guides should become less generic.

Learning objectives for the four selective placements are not specified beyond the generic goals for medicine, surgery and other major disciplines. The Team strongly recommended developing placement-specific objectives and relevant assessment processes. The curriculum places considerable emphasis on selectives in the final year of the program. While selectives offer considerable potential to provide students with a richer, more in-depth understanding of some aspects, which informs their overall appreciation of the discipline, this opportunity was not being grasped or developed. The Team considered that the selectives structure has the potential to be a distinguishing strength of School of Medicine, Sydney, but at present is a vulnerability.

Clinicians are clearly expected to observe students undertaking clinical tasks during their clinical rotations. Feedback from students indicates this is highly variable, and this is acknowledged by the School. The School needs urgently to improve these processes. Deliberate practice leads to expertise and this cannot happen without an expert providing feedback. The School needs confidence that students are achieving at the required level during the year, rather than relying on the end-of-year examination, at which point a student may have to repeat the entire year if underachievement has not been previously detected. The Team acknowledge that Heads of Sub-Schools have been attentive in informally monitoring
student progress, but considers the weakness of the current formal processes are a significant risk to effective student progression. This is addressed further in Section 5 on assessment.

The overall curriculum plan indicated that the PPD and PPH domains will contribute 10% each to MED3000 and MED4000, but it was not clear how this was formally incorporated. The Curriculum Management Committee is encouraged to review this.

The School provided the Team with documents showing the clinical placements of individual students in Years 3 and Year 4. While the planning is well advanced, students indicated that there were still instances of students being allocated equivalent or similar terms in MED4000 to those in MED3000. To ensure appropriate breadth of experience, a defined process is needed to review students’ experience in MED3000 and to allocate their placements in MED4000. As noted above, students in the Melbourne School were still not aware of their specific selective placements, having only been provided with an indicative list of up to three options for each. This contrasted with the explicit details provided to the Team. Students in the Sydney School had received clear allocations in the week prior to the accreditation visit.

2011 Team Commentary

In 2011, the School had implemented the MED4000 year, according to the plans outlined in 2010.

The Year 4 students who met the Team were enjoying their experience, and had detailed information on their rotations. The School had addressed instances of students being allocated similar terms in MED4000 to those allocated in MED3000.

In 2010, the AMC found this standard was substantially met. In order to meet the standard, the School was asked to provide evidence that irrespective of clinical placements, students are achieving similar learning competencies in each core clinical discipline.

The School has taken steps towards achieving similar learning competencies in each core clinical discipline across all clinical sites in MED3000 and MED4000. These steps include:

- It has defined the specific clinical competencies and learning objectives for each discipline and promulgated this information to students and clinical teachers.
- The Heads of Sub-School and local clinical Discipline Leaders review the summative end-of-term assessments for each student for the purposes of identifying poorly performing students, and also to determine if specific competencies are consistently being met by the students at their Clinical Sub-School.
- Analysis of examination performance between clinical school sites. In 2010, this process revealed a significant difference between the performance of the Melbourne and Sydney Clinical School students in the Psychiatry MSAT station that examined the student’s ability to perform a risk assessment. Discussion of this data has led to changes to the delivery of the psychiatric clinical rotation in the Melbourne Clinical School.

Despite these developments, the Team remained concerned at the continuing variability in the clinical and assessment experiences of some students as described by students and staff.

A structure for regular meetings of Heads of Discipline has been established although the group had only met once at the time of the Team’s visit. Clinical discipline heads have established processes for communication with respective local Discipline Leaders and teachers but the degree of communication is quite variable. These lines of communication are essential elements to the integration of the clinical rotations and to the achievement of
uniform learning objectives and assessments across the various learning sites. The Team believes that the allocation of larger fractional appointments to the heads of some disciplines (especially Medicine and Surgery) is required for the Heads to make the necessary progress in discipline specific communication to develop their disciplines.

As noted earlier in the report, the Team considers that until there is a clear and effective curriculum map, the content of which is well understood across the School, implementation of a consistent program will remain a challenge.

The accreditation standards require that medical schools have descriptions of the content, extent and sequencing of the curriculum that guide staff and students on the level of knowledge and understanding, skills and attitudes expected at each stage of the program. A well-developed curriculum map will cover the entire curriculum to enable efficient curriculum planning, where repetition is intentional and generally taken to a higher level on each exposure and unintended duplication eliminated. It should guide teachers in developing material for later in the program so that it builds on prior learning rather than merely repeating it, and indicate the depth of learning required in relation to each identified element.

3.3 Curriculum integration

*The different components of the curriculum are appropriately integrated.*

2007 Team Commentary

The School is to be congratulated on its commitment to an integrated approach to development of the core PBL problems, involving a demanding 10-step process of development and review of each problem by each domain committee in a collaborative manner, and in keeping this process up to date. The resulting course is integrated horizontally, and the outline of Year 2 suggests that this approach will continue into subsequent years. The Professional Portfolio has the aims of assisting students to reflect on their professional development, to ensure their appreciation of their progression through the course, and on how they are progressing through the different components of the curriculum.

2009 Team Commentary

The curriculum for Years 1 and 2 is continuing to progress in a well-integrated manner, with a planned review and enhancement during 2009. Indigenous health issues are included appropriately in PBL cases. As discussed above, there is an urgent need to clarify the process and content of clinical teaching in Years 3 and 4, and effective engagement with the clinical teachers to promote further integration and ensure the delivery of a coherent program, both in terms of content and process.

2010 Team Commentary

The 2009 Team could not clearly discern how the rural components/themes in Years 1 and 2 and the Rural Clinical School curriculum objectives aligned.

The primary objectives of the Rural Clinical School curriculum, as presented in 2010, are:

- to provide students with an immersion in rural clinical practice rotations that will facilitate the further development and consolidation of the clinical skills required for a competent intern in a rural setting;
- to provide students with an enjoyable and rewarding rural experience so as to increase the likelihood of the student returning to rural practice on completion of their degree;
• to enable students to appreciate that rural/regional practice is increasingly being delivered at a specialist, as well as at a primary care level, and to appreciate the differences in roles of all medical practitioners in a regional or rural environment compared with an urban practice environment.

2010 Supplementary Comments
The Medical School’s chosen curriculum delivery model uses broadly dispersed sites. Earlier AMC assessments raised concern about the School’s processes to ensure integration within clinical disciplines across these sites. These mechanisms are developing but remain poorly defined. The School’s submission indicated that these integration processes would be a responsibility of Heads of Discipline, although several of this group had only recently been appointed and there was significant differences among the others as to how actively they were expected to engage in discharging this responsibility. These responsibilities should become clearer as they meet the clinical Discipline Leaders and extend their knowledge of the strengths and gaps in experiences at the various sites.

The School indicated that achieving a consistent approach would also be addressed through the Clinical Years Curriculum Committee. The School’s submission indicated that students would refer perceived clinical curriculum differences between sub-schools to the head of each clinical sub-school and the regular meetings of the Heads of Sub-Schools Committee would discuss these. While all these measures appear appropriate, the Team considers a more specific and proactive process is required.

In addition, the School needs to define what data it will gather to compare students’ experience and to consider the best time to gather this data. Presently, students’ major summative assessment in Years 3 occurs at the end of the year. This reduces the capacity to use assessment results as a measure of comparability of experience. The School had intended to use the Individual Patient Encounter (IPE) data for this purpose. Students record their patient encounters in this database, which is intended to allow the heads of the subschools to monitor students’ overall clinical experience and exposure to patients with particular conditions. However, as noted below, there are a number of questions about the value of the data collected in the IPE.

2011 Team Commentary
In 2010, the AMC found the standard substantially met and required evidence of appropriate integration of the clinical rotation and formal teaching components in the clinical years.

The School has introduced several measures to improve the integration of the clinical rotations with the formal teaching program delivered in MED3000 and MED4000. The MED3000 learning objectives, short case tutorial materials and clinical skills sessions are now available at the beginning of the year. The core critical care curriculum in MED4000 is delivered over the first 12 weeks of the year, allowing students to undertake these learning activities either during or before the critical care rotations. These changes have gone someway to improving the relative disjunct between the formal teaching program and clinical rotations but the School had not yet evaluated the effectiveness of these steps.

The Team commends the work of the Head of the Rural Clinical School. However, there remain significant challenges, and the Team was not convinced of the capacity of the Rural Clinical School at its three sites to provide the spectrum of clinical experience and teaching for students spending the substantive period of MED4000 in a rural setting. Only 14 such students could be accommodated in the Rural Clinical School in 2011, and in 2012, 20
students will need to be accommodated for the School to qualify for the Department of Health and Ageing funding. This is a significant consideration in the future financial stability of the School.

The School staff were confident that this could be achieved and that it may be possible to increase the number to 28. The AMC will expect the School to report on the development of the Rural Clinical School, and evidence of how it is assessing and monitoring the students achievement of adequate breadth and depth in these settings.

In its response to the draft report in October 2011, the School advised that a new Associate Dean of the Rural Clinical School had been appointed.

3.4 Research in the curriculum

The medical course emphasises the importance of research in advancing knowledge of health and illness and encourages, prepares and supports student engagement in medical research.

2007 Team Commentary

The PPH Domain Committee regards itself as carrying particular responsibility for ensuring that students receive an appropriate grounding in clinical research methodology within the PBL framework. All first year students will attend a one-day conference at Lithgow on rural health and an annual research day on campus, when both staff and students will present research. All students are required to participate in a community research or community service project during their course. Students can also practice research methods and experience research practice through journal clubs/research presentations run at UTS, the Darlinghurst campus and at affiliated hospitals. During second year, an assessment of critical appraisal skills will contribute five per cent to the marks for the year. Students in the top 10 per cent of the class will be invited to consider pursuing honours and a research selective in their final year. The Team encourages the School to consider opportunities for exposure to research for all students.

Within a biomedical and clinical context, the depth of learning in scientific methods could be reviewed. Student learning should ensure they can personally pursue answers to evidence-based medicine questions, as well as appreciate the concepts underpinning their topic. The Team encourages the School to explore methods such as short-term research scholarships during the long vacation to promote the active engagement of all students in research.

2009 Team Commentary

Students are actively involved in literature searching and review, and the School intends to involve students in research projects and provide opportunities for students to undertake research during a final year selective. Details of how this will operate in practice still remain to be developed, and will need to be addressed in concert with the School’s efforts to develop its own research culture and expertise.

2010 Team Commentary

The School will be required to report to the AMC on achievements and developments in involving students in research. The honours program (MED 4001) has been approved for 2011. Student interest has been high, with 33 applications for 11 places. The academic model will resemble the successful program from the Notre Dame School of Medicine, Fremantle.
2010 Supplementary Comments

MED4000 terms have had name changes since 2009. The Year 4 Elective Term is the term in which students can conduct a research project. Ten students will be conducting research projects for their honours degree during that term. In addition, every year there are 10 to 15 other research projects available to the students as Summer Projects.

2011 Team Commentary

The 2010 AMC assessment found that the School had met this standard and this has not changed. The Team was updated on the first year (2011) of the honours program undertaken in MED4000. The Population and Public Health domain has now contributed to the students’ exposure to research through a weekly journal club in MED3000 and MED4000, which allows students to critically appraise research articles. In addition, students in MED3000 present a critique of relevant literature as part of formal case presentations.

The new Dean outlined her vision for research for the School, with emphasis on clinical/translational research, epidemiology, public health, health policy, and health systems, and collaborating with other institutions, including those undertaking more basic (wet lab) research.

3.5 Opportunities for students to pursue choices

There are opportunities in the course for students to pursue studies of choice, consistent with course outcomes.

2007 Team Commentary

All students have access to both an elective and a selective placement in the final year.

2009 Team Commentary

The provision of one four-week selective and a four-week elective during the fourth year offers students significant opportunities to gain more experience in areas of interest or weakness, but the range of potential placements for the selective and the processes for directed study during these periods for students encountering difficulties remains to be specified. While it is acknowledged that School of Medicine, Sydney should anticipate providing elective options for students from other medical schools in exchange for placements provided to their students, the process for this has yet to be considered.

2010 Team Commentary

The School is urged to clarify the elective arrangements for its students.

2010 Supplementary Comments

Students have had limited choice in the allocation of selectives. The Team acknowledges the significant task for the School to find sufficient places and to manage the allocation of students. Students indicated the School was receptive to requests for review of their term allocation, but this process will need to be clear to all students. In future years, greater flexibility in the initial allocation would be appropriate. The Team’s impression was that allocating student selectives was driven more by the limited availability of selectives in the Melbourne School rather than the initial plan to deliver individually selected learning to complement MED3000 experiences.
2011 Team Commentary

In 2010, the AMC found this standard was not met and required the School to develop placement-specific objectives for Year 4 selectives and establish processes to identify and address overlap in students’ MED3000 and MED4000 experience by the start of the 2011 academic year.

The School’s report to the AMC in February 2011 confirmed that the School had prepared placement-specific objectives for most, but not all, Year 4 selectives. The Team’s May 2011 visit confirmed that placement-specific objectives for all Year 4 selectives have been developed and that relevant processes for assessment of these selectives had been documented. At the time of the Team’s visit, students had undertaken only a few selectives but overall the accreditation standard has now been met.

The School has clarified the different level of achievement required between MED3000 and MED4000. During the Team’s visit, the School staff outlined the processes used to ensure students have complementary learning experiences in Year 3 and 4. These processes build on the staff knowledge of gaps and strengths in the teaching centres and student preferences. The students’ evaluation of places is also considered when planning placements for the next cohort. The number of selective places available is increasing and there is greater flexibility for students. The flexibility continued to be greater in Sydney than in Melbourne.

3.6 The continuum of learning

There is articulation between the medical course and subsequent stages of training.

2009 Team Commentary

The curriculum map is being related to the curriculum framework objectives of the Australian Curriculum Framework for Junior Doctors, and this has been a consideration in designing the course. The School has been actively engaged in discussions about placements for its graduates, with the expected substantial increase in medical graduates across the country.

2011 Team Commentary

In 2011, students in Year 4 were beginning to plan for their first postgraduate year. Students at the Melbourne Clinical School expressed some anxiety about the limited information provided to them about the intern selection process for both Victoria and New South Wales.

The Team was pleased to learn that the School had acted to ensure Victorian students have access to the relevant information.
4 The Curriculum – Teaching and Learning

4.1 Teaching and learning methods

The teaching and learning methods are appropriate for the content and outcomes of the course. They include those that are inquiry-orientated, encourage students to take responsibility for their learning process and prepare them for lifelong learning.

2007 Team Commentary

The School provided documentation describing a four-year graduate course curriculum adapted from accredited courses from the University of Queensland and University of Notre Dame School of Medicine (Fremantle). The teaching and learning methods utilised are varied and appropriate for covering and attaining the outcomes of the course.

In Years 1 and 2 extensive use of PBL is combined with integrated scheduled lectures, laboratory based classes, small group expert tutorials, clinical and communication skills sessions, clinical debriefing sessions and journal club meetings. PBL groups are small enough to allow effective student participation, and the PBL process is designed to encourage hypothetico-deductive reasoning in the first session of each case. PBL and clinical skills tutors will be trained in facilitating student-centred learning from problem analysis. Students will be involved as subjects in clinical skills sessions. The School should develop policies and processes for obtaining informed consent from students taking part in this activity, and clarify the rights of a student to decline such involvement.

Supporting information, linked to the topic of the case, will be provided by lectures and practical sessions, particularly in basic biomedical sciences. As discussed in Standard 3, resources for the Basic and Clinical Sciences Domain will largely be delivered by the staff of the University of Technology Sydney (UTS) and Douglass Hanly Moir, whereas resources in the other three domains will be delivered by School staff and adjunct staff. The planned high level of integration in the early years depends critically on the establishment of a more effective communication strategy between the School, DHM and UTS staff to allow integration of pathology, anatomy and radiology as planned. The School is addressing this through the appointment of a coordinator in anatomy (appointed), pathology (about to be appointed) and radiology (to be appointed Jan 2008). The School has established a subcommittee of the BCS committee that has the special role to integrate the three subjects.

In Years 3 and 4 students will work predominantly within a mentor model, which involves a student being attached to a senior clinician and, less frequently, in the more traditional block model. The placements will offer opportunities for further developing understanding of clinical problems and processes of clinical decision-making. There is still some uncertainty about the details of clinical attachments and the delivery of clinical teaching. PBL cases will be replaced during these years by up to 10 weekly ‘short cases’. Students will attend ‘back-to-base’ days incorporating lectures, clinical skills sessions and tutorials, during which the cases will be discussed.

There is reliable provision for delivery and use of electronic resources, access to library material and skills laboratories. Staff and students at all levels will be provided with access to an excellent online facility containing all of the lecture content delivered during the course. The School is committed to providing training for all teachers in the program.
2009 Team Commentary

The Team congratulates the School on its successful implementation of Years 1 and 2, which utilise the learning and teaching methods as planned in 2007. Both students and teachers expressed enthusiasm for the course, and it is clear that the foundation years are establishing a solid platform on which to base the clinical years. The Team noted that the School has made its own mark on the established curricula on which its program is based, and is continually developing the program to make School of Medicine, Sydney both an integrated and stimulating student environment for learning.

The relationship between School of Medicine, Sydney and UTS has resulted in high-quality facilities and staffing for the teaching of basic and clinical sciences, including anatomy. Students now have access to an excellent collection of pathology specimens. There has been a commendable increase in the level of understanding and cooperation between School and UTS staff since the last visit. The Team congratulates both universities on resolving some of the difficulties in communication that existed previously. The UTS staff appeared to share a high degree of enthusiasm for creating an enhanced learning environment for School of Medicine, Sydney students and expressed a willingness to consider additional innovations. However it was noted that UTS staff have limited time and resources available for this program, so if substantive further contributions are requested (for example a possible anatomy bridging short course in Year 1), this could only be progressed at the expense of other activities unless resourcing was increased.

It is evident that the lecture material is constantly evolving to reflect better the learning outcomes for enhanced student learning. The provision to UTS teaching staff of the outline and learning objectives for all of the first and second years has resulted in a greatly enhanced capability for better delivery of basic clinical science teaching.

The Team noted the concerted efforts of the School to gain consent in a standardised format prior to student/patient interaction in the University-based clinical learning and assessment environment. It is also noted that students are offered the opportunity to decline to participate as a surrogate patient in clinical skills training sessions without penalty or prejudice.

In relation to Years 3 and 4, the proposed clinical mentor model has evolved to a more conventional approach whereby students are individually attached to a clinical team, often with two or more specialists leading the Team. This approach has strengths in terms of ensuring contact with registrars and Career Medical Officers when the nominated specialist is not available, and providing more exposure to the work expected of junior doctors in addition to specialists. There is a strong commitment to students attending specialists’ rooms for one session a week and, on surgical placements, attending theatre sessions, and this appeared widely appreciated by the clinical teachers met by the Team.

It is proposed that students will address some six to seven paper-based ‘short cases’ during the back-to-base days over a two-hour period. The example cases reviewed by the Team were well written, and had up to 10 specific issues to be addressed by students. These cases are presented to the class asynchronously in relation to their clinical placements (i.e. all students address the same cases in any given week, regardless of the clinical discipline to which they are attached). The Team remained unconvinced about students’ ability to present and discuss these adequately within the time allocated.
School of Medicine, Sydney has provided tutor training during two sessions based on the Darlinghurst campus at the start of the academic year over the last two years, although clearly not all clinical supervisors have yet attended. There are preliminary plans to modify the approach substantially to ensure it reaches clinical teachers in the various subschools, which will be essential to ensuring relatively uniform delivery of teaching within School of Medicine, Sydney model. Many of the General Practitioners who are planning to be involved in the delivery of clinical teaching expressed interest in attending such sessions.

As already noted, the detailed planning of Years 3 and 4 still requires considerable attention, particularly in relation to the maintenance of consistent standards and approaches across a wide diversity of clinical sites. Urgent attention is required to the issue of communication both within and between sites. Once again, the early appointment of Discipline Leaders would significantly assist this process.

2010 Team Commentary

Students in Year 3 were very positive about their experiences in Years 1 and 2, particularly the PBL-based part of the course.

The ‘immersion’ approach to clinical placements has been well received to date by the students, who report good opportunities to be actively involved in assessing and managing patients. The Team suggested a review of formal clinical skills teaching to introduce abnormal clinical signs during Year 2 and to ensure that this teaching complements clinical experiences during later stages of the course.

Achieving consistent approaches to learning and teaching in MED3000 and MED4000 across the clinical sub-schools should be a high priority for Heads of Discipline.

Student expressed some concern, at this relatively early stage of the year, about the pressure to prepare for the back-to-base common learning sessions at the expense of pursuing learning relevant to their clinical placement. The Team agreed there is some risk that this pressure could compromise clinical learning. While most students reported enthusiastic teaching and supervision on their clinical placements, this was not universal and students, without the guidance of more senior years, were unsure whether some of their experiences were adequate. This issue should be addressed by heads of sub-schools and heads of disciplines, where these are in place.

2010 Supplementary Comments

Both the University of Notre Dame Australia’s Schools of Medicine use an Individual Patient Encounter (IPE) database as a learning tool. The purpose of the data collection is to allow the heads of the sub-schools to monitor students’ overall clinical experience and exposure to various disciplines of clinical medicine. As a method of learning, the IPE aims to enable students to record, analyse and reflect on the demographic and disease characteristics of the patients they have seen. The Team recommends the School reconsider if the database is meeting these aims.

Students are expected to enter data after each patient encounter, but were unclear about what constitutes an ‘encounter’. Reports reviewed by the Team suggested the way to classify a patient’s characteristics was unclear. Students also uniformly commented on the time required to enter data, and a sense that this information was of no value to them and of uncertain value to those who would follow them. The earlier technical problems with the database had been overcome, but the persistent nature of the problems had further
undermined commitment to the IPE process. The Team understood there were likely to be significant concerns over the dataset reliability in its present form and that this may prevent confidence in interpreting data from the 2010 MED3000 cohort. The Team recommend that the Curriculum Management Committee, or its appropriate subcommittee, review the IPE process and clarify with students how the process, or some modification thereof, will directly benefit them and students in following years.

In general, students considered they had been provided with a varied and comprehensive initial exposure to clinical medicine that had been stimulating and had considerably enhanced their learning, despite some less optimal rotations for some students.

**2011 Team Commentary**

In 2010, the AMC found this standard was met and recommended the School review the utility and feasibility of the Individual Patient Encounter Database for students and program development.

In 2011, the School advised it had reviewed the use of the Database in acknowledgement of the technical IT problems and the record keeping burden for students. In January 2011, the School launched the Individual Patient Encounter Record form (iPER). This tool has been used by MED3000 and MED4000 students in 2011. The School has told students that the use of the specific form is not compulsory, and they may adapt the form as their record-keeping instrument as they wish. In discussion with the Team, students remained unconvinced about the value of the tool for their learning, and did not consider the new format to be an improvement. The School indicated it was well aware of these student concerns, and would continue to evaluate its suitability. The AMC will expect reports on the School’s progress in developing a tool that meets its aims and is of value to student learning.
5 The Curriculum – Assessment of Student Learning

5.1 Assessment approach

The school has a defined and documented assessment policy which guides student learning towards attainment of the content and outcomes of the course.

2007 Team Commentary

The School is to be commended on the progress it has made in the area of assessment in Years 1 and 2. Assessment procedures for Years 3 and 4 are being finalised. In Years 1 and 2 formative assessments, particularly arising from the mid-year exams, will be used to provide feedback and guidance to students. End-of-year summative assessment will determine progression. The School has achieved a good balance between formative and summative elements. The foreshadowed appointment in 2008 of an academic responsible for assessment will assist in the implementation of the assessment processes. Assessment of the four domains will be integrated in Years 1 and 2.

Assessment approaches have been based on internationally recognised theory and evidence, and assessment is clearly linked with the integrated and thematic structure of the curriculum. The Assessment Committee will work closely with the Medical Education Unit. While it was pleasing to see that staff at the University of Technology Sydney (UTS) had embraced involvement in the School’s assessment process, the Team was concerned that, to date, other teachers external to the School appear to be less involved.

The Team also remained concerned that the Dean will chair the Assessment Committee. This would mean the Dean would not be independent of the assessment process and thus be unable to independently review the assessment outcome of a student who requested such a review, as occurs in many other schools. The Team encourages the School to ensure that, whenever the Dean is the chair of the Assessment Committee, a mechanism exists for ensuring that the review of an assessment outcome is independent of the Assessment Committee.

The final responsibility for assessment writing and marking appears currently to be largely confined to a small number of highly enthusiastic staff, who will have an increasing workload as the curriculum is rolled out. The School is urged to ensure it has the resources to mount and maintain the proposed formative and summative assessment program especially into the clinical years.

2009 Team Commentary

The appointment of an academic Head of Assessment has been successful, resulting in the development of an excellent assessment framework and process. The Team again noted the potential conflict of interest of an appeal process that involves the Dean, if the Dean remains a member of the Assessment Committee, and encourages the School to consider an alternative approach. While the assessment approaches in MED1000 and MED2000 were well developed and had been implemented successfully, the processes for summative and formative evaluation of clinical placements in a variety of clinical settings have not yet been well developed.
2010 Team Commentary

The 2007 AMC Accreditation Report indicated that the School needed a mechanism, independent of any Assessment Committee member, including the Dean, for reviewing the assessment process and considering any school-level appeal. The 2010 Team noted that the ‘University of Notre Dame General Regulations (Sections 9.3 and 9.4) state that appeals against assessment or against final grades should be made to the Dean of the School in which the student is enrolled and thereafter the Provost. In the current, revised organisational structure for School of Medicine, Sydney the Dean is not a member of the Assessment Committee or any curriculum committee that has an assessment role; therefore, the appeals process, as detailed in the University General Regulations, is independent of the Assessment Committee’. This change addresses in full the concern of the 2007 Assessment Team.

Also noted in 2007 was the need for ‘further development of the assessment policy and practices for Years 3 and 4, paying particular attention to the issue of achieving consistency of assessment across teaching sites’. In 2009, concern was similarly raised regarding ‘effective mechanisms to facilitate development of teaching and assessment skills of clinical teachers’. Both these issues remain of concern.

Assessment forms for the professional portfolio have been developed and implemented, after approval by the Personal and Professional Development Domain Committee. One of the criteria for assessing whether the portfolio is satisfactory is the presence of completed formative assessments from each clinical rotation. However, demonstrating effective development of required clinical skills remains a concern.

Formative and summative assessment standards and their use in learning require clarification. Formative assessments of communication and clinical skills take place twice per rotation, but students perceive that clinicians are uncertain of the standard for this assessment. Thus students place little value on the completed forms for guiding them to a pass level by the end of the year. Students are uncertain of the standard of the summative MSAT clinical exam. Many clinicians thought setting the standard at that of a competent intern would undervalue students’ achievements, therefore most are instead assessing students against where they think students should be at the time of assessment. This undermines the summative assessment process.

The School’s multi-site delivery of the medical program requires effort by the School to ensure consistency in assessment across campuses. Assessor training in using assessment tools to ensure consistency of standards across assessors, disciplines, schools and subschools was not evident. In addition, responsibility for reviewing the formative assessment of communication and clinical skills forms with students varies from site to site. This assessment approach should be revised to determine the best educational impact on the student, and rigour and comprehensiveness of portfolio summative assessment.

MED3000 students at various sites seemed uncertain of the nature of their summative assessment. The minimum standard students will be required to attain, to achieve an overall pass and to progress, remains unclear.

School of Medicine, Sydney’s Fitness to Practice Policy identifies student behaviours that may trigger a ‘needs assistance review’ process. The School was represented at the National Forum on the Assessment of Professional Behaviour in Medical Students (Queensland, March 2010), and will be further formalising assessment processes for positive professional
behaviours. Such assessment is currently incorporated in the formative feedback provided to students in clinical debriefing tutorials and clinical rotations.

The School’s Assessment Policy, updated December 2009 indicates the following requirements for MED3000 assessment.

Compliance requirements include:

- attendance at more than 90% of all back-to-base days, including the short case tutorials and Clinical Skills Domain sessions, as well as journal clubs, clinical debriefing tutorials and clinical activities, regardless of illness or other reasons;
- submission of the MED3000 portfolio at the end of the year for summative assessment and a satisfactory grade for the portfolio;
- attendance at the formative written examination;
- passing individual domains at the end of MED3000 summative examination.

The summative assessment requirements for MED3000 are:

- 15% continuous assessment, awarded by the Group Tutor and/or by peer marking through participation in short case tutorials (5%), clinical debriefing tutorials (5%) and journal club (5%);
- 50% written examinations testing knowledge from the Basic and Clinical Sciences Domain Committee, Population and Public Health, and Personal and Professional Development domains, with multiple-choice questions; script concordance questions; and short answer questions based on back-to-base day materials;
- 35% MSAT, addressing learning objectives from the Clinical Skills domain.

Students who pass MED3000 overall but fail one or more domain(s) will fail MED3000.

A similar format is planned for MED4000.

2010 Supplementary Comments

The Head of Assessment continues to chair the Assessment Committee and provides leadership for this area.

In MED3000 15% of the marks are based on continuous assessment components, which are assessments of the material covered in the back-to-base teaching program, and 85% on the end-of-year summative examination.

Assessment overview and training sessions for Discipline Leaders and academic clinicians have been delivered to all clinical sub-schools and are scheduled to be delivered to the Rural Clinical School sub-schools. All formative and summative assessment questions and forms are developed centrally and distributed to sub-schools.

The School is planning standardising and training sessions for the MED3000 clinical MSAT examination in Sydney and Melbourne for both examiners and simulated patients. Written and clinical examinations will be delivered simultaneously in both Sydney and Melbourne. Similar arrangements are planned for MED4000.

In October 2010, the School was preparing for its first offering of the MED3000 summative MSAT assessment. Students had not yet received detailed information on the examination, and they were understandably anxious to have this information, although a mock question
had been made available. However, a written form of a clinical examination is always likely to be less effective than a formative ‘in vivo’ experience. Documents were unclear about the standard against which the MSAT would be assessed in MED3000 and MED4000. The Team’s enquiries suggested the standard would be that of a minimally competent intern. The method to be used to train examiners to internalise this standard was not documented.

The Team were concerned about the summative assessment placements across MED3000. A risk exists of marginal student performance not being formally detected before the end-of-year examinations, and therefore remediation opportunities may be missed. The Team recommended reviewing summative assessment placements and implementing a mechanism to address these concerns.

The School was urged to finalise the assessment requirements’ documentation and definition for MED4000, mindful of the issues that arose during the MED3000 year.

2011 Team Commentary
In 2010, the AMC found this standard was substantially met. As was required to meet the standard, the School provided evidence that students knew the assessment requirements for MED3000 by October 2010, and the requirements for MED4000 by February 2011.

Since 2010, the Medical Education Unit had engaged additional staff and had completed a number of assessor training courses at multiple sites, in an effort to ensure consistency in assessment across campuses in the clinical years.

Changes made to the assessment requirements for MED3000 and MED4000 included the following:

- At the end of each clinical rotation in MED3000 and MED4000, the clinical supervisors complete an assessment of the students’ performance. In total, these contribute 5% towards the students’ final summative assessment. Completed clinical rotation assessment forms will be reviewed by the Heads of the Clinical Sub-Schools to assist in the identification of students who may not be performing at the expected level.
- The continuous assessment component has changed from 15% to 20% of the total mark. To facilitate the process of the continuous assessment, criterion-based marking guides have been developed.
- To facilitate standardisation across multiple clinical teachers, the School has developed marking rubrics in consultation with the Heads of Discipline and clinical teachers. These rubrics outline the criteria for the levels of achievement, and guide the awarding of marks to the students.
- The marking rubrics for MED3000 are now more specific about the expected level of achievement for a third year student. Some assessors had found the previous marking guides confusing. The MED4000 marking guides have been aligned with the competences detailed by the Australian Curriculum Framework for Junior Doctors, with the expected level of achievement being competent to commence internship.

While the improvements to the processes are welcome, further development of the assessment policy and practices is still required. In particular, the marking rubrics need further work to ensure they are sufficiently clear and detailed.

The Team also remained concerned about the summative and formative assessments across MED3000 and MED4000. The Team’s discussions with staff and students confirmed that the
formative assessment processes for the clinical rotations still need improvement to better inform students and staff early of emergent learning difficulties, and to ensure consistency of assessment standards and processes across teaching sites.

The Team recommended reviewing these assessment processes and implementing a mechanism to address these concerns. It was pleasing to hear that the new Dean has made this a priority area.

The Team is also concerned that the process and composition of the summative assessments in the clinical years, means that students can perform very poorly in some disciplines (for example paediatrics) and yet achieve an overall pass grade for the year. A review of the discipline weightings for summative and formative assessments in MED3000 and MED4000 is recommended.

5.2 Assessment methods
The school uses a range of assessment formats that are appropriately aligned to the components of the medical course.

2007 Team Commentary
The School proposes to use a narrow range of assessment formats that are appropriately aligned to the components of the medical course. Although the school is using MSAT stations to assess the ability to interpret information and the processes of clinical reasoning, it could also explore other strategies to test these skills.

Mini quizzes and a mid-year written exam will be utilised for formative assessment. The mid-year written exam will incorporate a problem-based exercise covering the four domains and a MSAT incorporating stations in Basic and Clinical Sciences, Clinical and Communication Skills. Assessment of a portfolio for Personal and Professional Development will contribute to formative assessment. Summative assessment formats at the end of the year include written and MSAT examinations (90 per cent as well as assessment of participation in PBL tutorials 10 per cent).

The Team commends the School on its decision to separate the role of clinical tutors who are involved with assessment from those who will be mentors. The assessment of performance during clinical attachments is incompletely developed.

2009 Team Commentary
The Team noted that the major assessment in Years 3 and 4 would take the form of examinations, and that there would be appropriate processes to promote consistency between the Sydney and Melbourne clinical schools in terms of standards. However, there was concern that the proposed clinical examination, the MSAT, contains only eight stations. The reliability of an eight-station MSAT may be suboptimal, and the Team urges the School to monitor this, and perhaps consider expanding these ‘high-stakes’ examinations, particularly the summative examinations at the end of the year.

The change from the previously proposed mentor-based approach to clinical attachments within a more conventional clinical team is noted as a positive change. This may contribute to better teaching and assessment.

The end-of-year assessments contain 40 per cent of marks related to assessment of clinical skills. Assessment of competence in clinical skills is therefore heavily dependent on
satisfying the portfolio requirements in this domain, which is reliant on a weekly ‘formative’ feedback sheet. This sheet is of generic design and based largely on a tick list on two sides of a page, to be filled out by clinical supervisors. In order to satisfy the portfolio requirement of competence in clinical skills, it appears that at least the final weekly ‘formative’ feedback of each placement is, in fact, a summative assessment. Clarification of the formative or summative nature of these forms would appear necessary for both clinical teachers and students.

The Team remained concerned about the logistics of this process particularly in relation to the assessment load placed on clinical supervisors, although requiring students to be responsible for obtaining the feedback is likely to be of assistance. The proposed generic assessment form does not allow specification and evaluation of placement-specific learning objectives. The Team encourages the School to develop a mechanism to achieve this.

2010 Team Commentary

The Team noted that the reliability of the 2009 eight-station MSAT has been reviewed for both Years 1 and 2 clinical MSAT examinations with Cronbach alphas of 0.64 and 0.67. This led to a decision to increase the assessment time to 120 minutes for MED3000 and MED4000. The Team recommended a report on the subsequent reliability of the 10 x 12-minute station MSAT is recommended. The standardisation strategies that will be used across the Sydney and Melbourne examination venues should also be reported and evaluated.

Confusion prevails amongst clinicians about the standard against which communication and clinical skills assessment are made (intern level or the clinician’s judgment about the student’s progress in relation to the time spent in the course), and students have no confidence in the assessments being made. The School need urgently to clarify the standard expected and to train assessors in how to apply this, with the aim of maximising educational impact.

2010 Supplementary Comments

The assessment form has been revised and the rating scales redeveloped to reflect better the assessment of a clinical competency. The achievement of competency is still defined as the level of a competent intern. The Team remains concerned that this reference point is not seen as appropriate by many clinical teachers, who are interpreting it as the standard expected for a student at the given stage of training.

The students reported significant variability in clinical teachers’ approaches to completing the clinical competency formative assessments. The School had originally envisaged that students’ formative assessment would occur on a weekly basis. In fact, most students are receiving feedback twice or, at most, three times during an attachment. The School may wish to consider revising the frequency guideline of such formative assessment. The value of the feedback received also varies, with some two-thirds of students finding the feedback insufficiently detailed to guide their further learning. The Team considered the Curriculum Management Committee should urgently address this problem, which has been raised in previous reports, so that it is able to demonstrate that student progress is being effectively evaluated during the year and that students are advised at an early stage of any weaknesses in their learning. One way to achieve this would be by formalising the assessment process during clinical attachments, with a focus on demonstrating the relevant clinical competencies.

The School plans that records of patient encounters (IPE records) are part of the summative assessment of the Professional Portfolio. Students will receive a satisfactory grade for the IPE
record printout for each clinical rotation. The students’ record on their reflection of each rotation will also be part of the assessment. Each Head of Clinical School will periodically receive reports on the student IPE entries at their site. The method for determining pass or fail on the portfolio is unclear.

**2011 Team Commentary**

In 2010, the AMC found this standard was not met. It requested evidence that the School had appropriate methods for and timing of assessment of clinical competencies for MED3000 and MED4000.

In its February 2011 report to the AMC, the School outlined the detailed criteria developed to assist those responsible for clinical placements in making their assessments to a common standard. In the May 2011 site visits, the Team explored the processes to facilitate such assessments.

The students continued to report significant variability in MED3000 and MED4000 in clinical teachers’ approaches across sites and disciplines, to completing the clinical competency formative and summative assessments. The School had revised the formative assessment process so it occurs once midway during the attachment. The value of the feedback received also varies, with some students finding the feedback insufficiently detailed to guide their further learning. Some students stated that the clinical supervisors complete the forms without actually viewing the clinical competency and rely on the honesty of students or feedback from other clinical teachers in their assessment.

The School has discontinued the patient encounters (IPE records) as part of the summative assessment of the Professional Portfolio. The Assessment Committee is reviewing how best to document the range of student encounters during their clinical attachments.

The Team acknowledges the work by the School to implement assessment formats that align appropriately to the components of the medical program and specifically, to set common standards for assessment in MED3000 and MED4000 across the clinical sites. Further improvements are still required to ensure consistent standards are set and achieved.

Some clinical supervisors commented that assessment forms are too generic and require further refinement to better suit the particular rotation.

**5.3 Assessment rules and progression**

*The school has a clear statement of assessment and progression rules.*

*The school has clear and transparent mechanisms for informing students of assessment and progression requirements and rules.*

**2007 Team Commentary**

The approach to progression will be compensatory (i.e. students may pass the examination by doing very well in some domains and poorly in others) in the first year. A conjunctive approach is being considered for Year 2, which would require that students achieve a minimum standard in all the domains and or formats. The portfolio is not assessable in Years 1 and 2 but will be assessed in Years 3 and 4.

The School has clear and transparent mechanisms for informing students of assessment and progression requirements. The rules are outlined in the 2008 handbook for students,
Foundations of a Medical Vocation MED1000, and are on the School website. They will be the subject of a lecture delivered by the Year Coordinator.

The School is developing processes for ensuring that the educational impact and utility of assessment items will be reviewed regularly. The School has indicated that it will also externally benchmark with at least one other medical school. A benchmarking process with the School of Medicine, Fremantle will occur within the University.

The Notre Dame core curriculum (ethics, philosophy and theology) is assessed summatively and a pass is required before completion of the course, as is the case in the accredited Fremantle course.

The School has identified a process for students requiring deferred examination or special consideration or required to complete a supplementary examination. The School has also developed a process for identifying and providing remediation for students who are not making expected progress in some, or all, of the course.

2009 Team Commentary
The assessment rules have been implemented as planned. The students considered that these processes had been clearly communicated.

2011 Team Commentary
The assessment rules have been implemented as planned. The students considered that these processes had been clearly communicated.

5.4 Assessment quality

*The reliability and validity of assessment methods are evaluated and new assessment methods are developed where required.*

*The school has processes for ensuring that the educational impact and utility of assessment items are regularly reviewed.*

*The school ensures that the scope of the assessment, and assessment standards and processes are consistent across its teaching sites.*

2007 Team Commentary

It is planned that appropriate criterion referencing and standard-settings processes will be used and all staff involved in question setting and development will be trained. Reliability of assessment will be addressed through statistical analysis using the Cronbach alpha approach. Assessment items will be stored in a database, linked to information about the performance of each item as well as its linkage to learning objectives and graduate attributes. The School is to be commended on its approach to quality assurance of assessment.

In Years 1 and 2, consistency will be achieved by the conducting of all summative assessment centrally. Achieving consistency across teaching sites will be a challenge, particularly in the clinical years when there will be wide dispersal of students across two states. The School plans to achieve this consistency by ensuring assessment in the clinical years is centralised to three sites, those being the Sydney Clinical School, the Melbourne Clinical School, and the Rural Clinical School in Ballarat. The School intends to utilise observers to achieve quality assurance as occurs in AMC clinical examinations for overseas-trained doctors.
2009 Team Commentary
The quality of the assessment processes and methods applied in Years 1 and 2 was very high. The Head of Assessment plays an important role in maintaining quality control of assessment items and papers, both before and after the application of the assessment task. As previously discussed, the Team remained concerned about the School’s processes for maintaining consistency across teaching sites. Assessment of the clinical attachments in Years 3 and 4 are not explicit and appear in need of urgent development. Further, the processes for assessment of student portfolios in Years 3 and 4 are not particularly clear. The Team encourages the School to explore other approaches for promoting consistency between assessors.

2010 Team Commentary
The Team noted that summative assessments for MED3000 will be delivered at both the Sydney and Melbourne Clinical Schools and that consistency in delivering assessment in both sites is a recognised issue. Based on the information provided, the assessment modalities most likely of concern for inconsistent marking are the clinical MSAT examination and the continuous assessment processes.

Although training sessions for assessors had occurred in January, the Team—noting, for example, the lack of appointed discipline heads—formed the impression that few clinicians had received this training. At the time of the visit, the planned training for the Werribee sites had not occurred.

2010 Supplementary Comments
Script concordance test questions are being implemented in Year 3 and 4 in collaboration with the University of Adelaide. Reliability and validity data will be evaluated accordingly. These will be benchmarked with the University of Adelaide MED4000. MCQs will be benchmarked using the AMC test questions database for assessment of international medical graduates.

Staff training sessions and workshops on assessment and question development are delivered in January (professional development week) and at other times as part of the professional development program for academic and teaching staff. Assessment items are developed by group tutors, academic staff, adjunct lecturers, discipline leaders and clinical teachers, reviewed by the relevant domain committee. The standard setting processes are carried out by the Assessment Committee. Formal training in administering the MSAT examination is planned for all examiners for the end of 2010 examination. While the Head of Assessment and the Associate Dean, Teaching and Learning, are to oversee the examination in Melbourne and Sydney, a more extensive exchange of examiners is not anticipated. Such exchange would provide greater assurance of a common standard between examiners familiar with students on their own sites.

2011 Team Commentary
Staff training sessions and workshops on assessment and question development continue to be delivered across the sites.

The School’s existing benchmarking of some assessment components against those of other medical schools and participation in some assessment collaborations is commended. The Team encourages the School to use external expertise in reviewing and benchmarking assessment practices, particularly the summative multi-station assessment tasks, short answer questions and the clinical rotation formative assessments.
The Team had an opportunity to review some examination questions in confidence. The Team considered it important that summative assessment provide adequate testing of students’ interpretation of signs and symptoms across a variety of service delivery settings and recommends the involvement of an external examiner in the development of the questions.

The students would also like to be provided with feedback on their overall performance in each of the four domains at the end of MED3000 and MED4000. The Team was pleased to hear that the Assessment Committee plans to review these processes.
6 The Curriculum – Monitoring and Evaluation

6.1 Monitoring

The school has ongoing monitoring procedures that review the curriculum content, quality of teaching, assessment and student progress, and identify and address concerns.

Teacher and student feedback is systematically sought, analysed and used as part of the monitoring process.

Teachers and students are actively involved in monitoring and in using the results for course development.

2007 Team Commentary

The AMC requires medical schools to have procedures that provide for regular review and updating of its structures and functions to rectify deficiencies and meet changing needs. The Office of the Provost will conduct evaluation external to the School using review processes that have previously been commended by the Australian Universities Quality Agency. The Evaluation Officer will conduct a similar process for activities undertaken by the University of Technology Sydney. Internal processes for ongoing evaluation are largely divested to the Evaluation Committee and the Curriculum Management Committee, and its subcommittees, and are clearly described in the terms of reference.

The Team commends the central structural processes to link evaluation with continuous renewal of student selection, course content, teaching processes, learning resources and assessment. There is provision for effective and continuous review of the learning objectives within the curriculum and for a systematic and comprehensive review in November 2009.

Overall responsibility for successful implementation of the evaluation program resides with the Dean. Review and monitoring of quality is through both the Curriculum Conference and the School’s Evaluation Committee. The Evaluation Committee has been formed and is chaired by the Dean. Membership includes a nominee from the Office of the Provost as well as the Associate Deans from Sydney and Melbourne and the Head of Medical Education. The Evaluation Committee will have student representation. The Committee will be advised by the Medical Education Unit. The Team considered that the Evaluation Committee should include a majority of members who were not integrally involved in curriculum planning and implementation, through their membership of other major committees.

The Team commends the School on the appointment of an academic Head of Evaluation who will start with the School full-time in early 2008 and devote 60 per cent of time to evaluation. The Team encourages the School to consider the need for additional administrative staff to support the evaluation process, as the administrative workload is likely to be substantial. The School has identified a number of areas for evaluation. These include ensuring that content, delivery and assessment match the predetermined learning objectives as well as looking at the resources that will be needed to deliver the curriculum.

Monitoring the quality of the curriculum will be carried out through extensive feedback from tutors, resource providers and students. There will be feedback on PBL cases and associated sessions, assessment, time and infrastructural adequacy, and matching of objectives to content. Multiple methods of information gathering will be used. These will include debriefing sessions, focus groups, surveys and web-based instruments, using both qualitative and quantitative methods.
Of particular interest is the purpose-designed evaluation portal, called Clinical E-log. It is anticipated that the system will be operational by December 2008 and will be used during the clinical years. This portal will be able to track students’ clinical experiences in the various clinical sites including those in Victoria. This will be a valuable resource for tracking the adequacy and range of students’ clinical experiences and may also be suitable for use as an assessment instrument. The potential uses of the portal will become more apparent as its development progresses.

The University will undertake teacher and teaching evaluations as part of the overall quality assurance policy of the University. It consists of questionnaires on the course unit and teacher performance. This will be managed by the Office of the Provost and will be administered anonymously by an administrative person external to the School. The first of these is the Unit Content Evaluation questionnaire, which the School plans to administer in the first semester. This would consider achievement of objectives, content, resources and teaching. As the School’s units are year-long integrated units, this will not only give an indication of the progress of the course but also have an important role in allowing comparison with other courses run by the University.

The other University evaluation units are Teaching Performance Evaluation, Clinical Debriefing Evaluation and PBL Tutor Evaluation. Data from these questionnaires will be sent back to the Dean as well as to the individual tutors. De-identified data will be made available to all staff and may be used to track year-on-year progress as well as to compare performance with the Fremantle School. Data from these evaluations will be considered mandatory parts of portfolios used by staff for promotion purposes.

The Team was concerned about the current process within the University whereby teachers scoring below the 10th percentile on evaluations will be automatically contacted by the Dean for remedial action, when in fact their teaching may not be of poor quality if the mean score is high. The Team supports the School in its intention to review this policy and move towards a criterion-based standard.

Teachers at the University of Technology Sydney (UTS) will also be evaluated using the same instruments and the results will be fed back through the Dean of Medicine to the Dean of Science at the UTS. Staff from the UTS who met the Team were comfortable with this process for evaluation, provided they were consulted about the process and content of the questionnaire. Suboptimal performance by UTS staff will be dealt with in a manner similar to the process used for staff of the School. The Dean at School of Medicine is heavily involved in evaluation and the Team considered that this would be likely to add to her already very high workload. There may be some value in devolving some of these activities to other senior members of the School Executive.

The AMC Team commends the emphasis placed on continual monitoring of the program using a positive, supportive and evaluative approach and one linked closely to staff development.

2009 Team Commentary

The Team was pleased to note that the Evaluation Committee has been expanded and now includes significant membership from outside the School. The academic Head of Evaluation has developed an appropriate evaluation plan with clearly defined priorities and detailed plans for the timing of evaluations of specific parts of the course. Evidence was provided to show that the School responded rapidly and effectively to adverse feedback about a particular
part of the course during 2008. Students were aware of this response and were enthusiastic about participating in further evaluations.

The increasing numbers of students in each year, and the current progression to delivery of all four years of the course, will considerably increase the demands on administrative staff involved in evaluation. The Team considered that the present half time administrative assistant post would need to increase to a full-time position, and that other additional administrative support would be required to implement the program and maintain quality control as intended.

**2010 Team Commentary**

School of Medicine, Sydney has appointed a full-time administrative officer for evaluation.

The School has developed a plan for clinical teacher evaluation, although, at the time of the visit, too few clinical rotations had been undertaken to allow formal reporting of results.

**2010 Supplementary Comments**

The Team noted the School had commenced a review of the MED1000 and MED2000 program, although there were delays in all disciplines engaging in the process. The Team had some concerns that no formal process appeared to be in place to include the results of evaluation of Year 3 in the review. Including Year 3 results would allow reflection on the needs exposed by clinical practice and could identify elements in the earlier program needing further development or reorientation.

As noted previously, the Team had concerns at the apparent lack of formal processes to ensure broad learning experience commonality during the final two years of the course for students across multiple learning sites, and the mechanisms to respond appropriately to any concerns identified. While the Team acknowledged students are, overall, satisfied with their learning experiences to date, better formal processes are needed to support, and to improve, their current experiences. The challenge of maintaining broad commonality of experience will increase considerably next year when multiple Rural Clinical School sites will be used and the selectives introduced, which makes urgent progress on this issue crucial.

As indicated earlier in the report, the Team had concerns about the poor quality of the data entered into the Individual Patient Encounter database.

While many medical schools share the challenges of engaging large numbers of adjunct clinical teachers in quality teaching processes, the Team was concerned the School did not have a comprehensive plan to address this issue. The School had delivered a number of specific teaching sessions, focusing on the Teaching on the Run model, but it was not clear how the School intended to encourage and support those less inclined to attend such courses. This concern was increased by a lack of staff with a specific commitment to clinical teaching development on the Melbourne campus, and lack of time for Medical Education Unit staff in Sydney to engage in such activities. A newly appointed staff member in Melbourne was said to have some experience in clinical teacher development, which was encouraging, but this was not clearly part of his job description. An audit to determine what proportion of all teaching staff have attended teaching development sessions of all types may be a useful starting point to develop alternative ways to engage teachers in teaching skill development.
The Committee indicated it would make changes to the some aspects of MED3000 in 2011. Discipline Leader feedback led to the development of an orientation week for Year 3, focusing on clinical skills and general site orientation. Separate orientation weeks are planned for the Sydney and Melbourne Schools. A common orientation is planned for all Year 4 students in Sydney, including those allocated to the Rural Clinical School. The Population and Public Health Domain Committee also has plans to remedy a weakness in critical appraisal that had been identified in the mid-year formative assessment. There was also some consideration of how to formalise the place of the Personal and Professional Domain in the clinical years.

The Committee was confident it would be able to respond quickly to any issues raised in Year 4, but was also concerned not to be overly reactive to all comments from a single group of students. The Team considered that the Committee should formalise their overall course evaluation process, including seeking feedback from the full range of teaching staff. The Team was mindful that the Year 4 course would be taught across an even wider number of sites than the present Year 3.

2011 Team Commentary

In 2010, the AMC found that this accreditation standard was not met, but it could be addressed by evidence that teacher and student feedback from the clinical years is being systematically analysed, and used as part of the monitoring process. The AMC also identified a number of areas for improvement, including the need:

- to include feedback from MED3000 in the review of MED1000 and MED2000;
- to review formally whether a broad commonality of learning experiences has been achieved across all clinical learning sites and processes to address issues arising;
- to ensure high-quality clinical teaching is provided across the School’s widely dispersed sites, implement processes to review the teaching of adjunct clinical teachers and support them in their professional development as teachers; and
- to formalise plans for the overall medical program evaluation.

The Team commends the School’s emphasis on continual monitoring of the program using a positive, supportive and evaluative approach.

Students continue to be enthusiastic about participating in further evaluations and are generally pleased with the changes made to the program as a result. The School has reviewed elements of MED1000 and MED2000. This has resulted in positive changes to some areas of the program, such as the anatomy curriculum. In other areas, such as pathology and those courses taught by University of Technology Sydney staff, feedback to Heads of Disciplines has been patchy. There is still a need to include feedback from MED3000 in the review of MED1000 and MED2000.

In 2011, the School introduced the Student Evaluation of Clinical Rotation Form to evaluate the clinical sites, clinical hands-on practice and clinical teachers. It plans that students will evaluate their clinical rotation at the end of each rotation. The School gives students a paper-based questionnaire to fill in with the assistance of the clinical co-ordinator of each Sub-School. This process is commended, although there did not appear to have been any formal reporting of results.
As the School has discontinued the Individual Patient Encounter Database and the proposed new Patient Record was not well established, there is still a need to develop a tool to monitor the consistency of student experiences across multiple sites in the clinical years.

6.2 Outcome evaluation

The performance of student cohorts is analysed in relation to the curriculum and the outcomes of the medical course.

Performance is analysed in relation to student background and entrance qualifications, and is used to provide feedback to the committees responsible for student selection, curriculum planning and student counselling.

The school evaluates the outcomes of the course in terms of postgraduate performance, career choice and career satisfaction.

Measures of, and information about, attributes of the graduates are used as feedback to course development.

2007 Team Commentary

The performance of student cohorts will be analysed in relation to the curriculum and the outcomes of the medical course. There is also a clear intention to analyse student performance in relation to student background and entrance qualifications. The School will use this analysis to provide feedback to the committees responsible for student selection, curriculum planning and student support.

A long-term cohort study is being planned to look into graduate outcomes. This will track graduates over 10 years from internship, specifically looking at performance, career choices and progress and specific attributes of graduates. Measures of, and information about, attributes of the graduates will be fed back to the School for course development.

2009 Team Commentary

There have been no graduates yet of School of Medicine, Sydney medical program. However, the plans for implementing the proposed long-term cohort study are being further developed. The School is also considering maintaining contact with graduates in the longer term by providing on-going access to a web-based system for collecting a portfolio of clinical experience. This may well provide benefits both for the graduate and for the School.

Performance of student cohorts should be analysed in relation to the curriculum and the outcomes of the medical course.

2011 Team Commentary

In 2010, the AMC found that the School had met this standard.

The long-term cohort study planned to look into graduate outcomes over ten years is proceeding. 2011 will see the first graduates of School of Medicine.
6.3 Feedback and reporting

The results of outcome evaluation are reported through the governance and administration of the medical school and to academic staff and students.

The medical school provides access to evaluation results to the full range of groups with an interest in graduate outcomes. The school considers the views of these groups on the relevance and development of the curriculum.

2007 Team Commentary

The results of outcome evaluation are reported through the governance and administration of the Medical School and to academic staff and students. An electronic newsletter is proposed to inform students and staff of evaluation results and changes made in response to feedback.

The Team considers that, although the formal University quality audit that is scheduled every six years (and is not due until 2012) is likely to be useful, it will be inadequate to inform the program as it rolls out.

The Evaluation Committee intends to provide feedback to the Curriculum Management Committee and Domain committees, which will be responsible for acting on the information. Some of this may be considered at the annual curriculum conference, where external stakeholders are also invited to participate to consider specific issues.

However, the Team encourages the development of a more explicit statement of mechanisms for feedback from the Evaluation Committee to the various committees.

2009 Team Commentary

As discussed above, the School has already documented one example of rapid remedial action that resulted from unfavourable evaluation by students of a specific course component. The Head of Evaluation has been instrumental in formalising the processes of reporting evaluations to the various committees responsible for decision-making.

The Team found that clinical staff who will be teaching in Years 3 and 4 had little awareness of the School’s processes for program evaluation and monitoring. The School may wish to consider providing additional information to staff in the clinical schools and sub-schools.

2010 Team Commentary

As the School implements MED3000 and MED4000 across the clinical sites, it will need to strengthen its processes for feedback to clinical teachers on evaluation results.

2011 Team Commentary

In 2010, the AMC found the School had met this standard.

In 2011, the processes for reporting outcome evaluation through the governance and administration of School of Medicine and to academic staff and students had not changed.

Some Heads of Discipline indicated that they are not regularly receiving results of outcome evaluation relevant to their area and would find this useful.

The Team found that some clinical staff who teach in Years 3 and 4 in particular still had little awareness of the School’s processes for program evaluation and monitoring, and encourages the School to make this information widely available.
6.4 Educational exchanges

The medical school collaborates with other educational institutions and compares its curriculum with other programs.

2007 Team Commentary

The School collaborates with Australian and international educational institutions. The primary source of educational exchange within Australia will be with the Fremantle School and the University of Queensland. The School also intends to work with the international association of Deans of Catholic medical schools to develop relationships in curriculum and research, and to establish student and staff exchanges. A ‘study abroad’ program is available for students that will involve exchanges with centres in North America and Europe.

2009 Team Commentary

School of Medicine, Sydney continues to interact with the Fremantle School and the University of Queensland. Plans for educational exchanges are continuing but need further development. Some students are unaware of any scheme of overseas exchange.

2011 Team Commentary

In 2010, the AMC found that the School had met this standard.

The School is continuing to collaborate with Australian educational institutions. The primary source of educational exchange in Australia is the Fremantle School of Medicine and to a lesser extent, the University of Queensland and the University of Adelaide.
Implementing the Curriculum - Students

7.1 Student intake

The size of the student intake, including the number of fee-paying students, has been defined and relates to the capacity of the medical school to adequately resource the course at all stages.

The school has clearly defined the nature of the student cohort, and quotas for students from under-represented groups, including Indigenous students and rural origin students.

The school has defined appropriate infrastructure and support to complement targeted access schemes for under-represented groups.

2007 Team Commentary

The proposed student intake for 2008 is 104 domestic students, of who 80 will have Commonwealth Supported Places (CSP) and 24 will be Australian fee-paying students. The School is uncertain at this stage how many of the CSP places will be bonded places, as this has not yet been clarified by the federal government. The maximum number of students the School will enrol will be 120, which is the maximum capacity of the new Darlinghurst campus and the University of Technology Sydney campus facilities for medical students.

The School expects one-third of the student cohort to come from Victoria and that most of these students will return there for their clinical years. The University will not accept overseas students, with the possible exception of a very small number of sponsored students from particularly disadvantaged countries.

The School does not have a specific quota for under-represented groups and Indigenous students in the first year of operation, although it has plans in place to implement an affirmative action policy for the 2009 intake. However, it is engaging with local Indigenous groups, through the Indigenous Health Curriculum Consultative Committee, with the aim of assisting such students both financially and academically to undertake the Sydney School MBBS. The Vice-Chancellor supports this effort and is willing to guarantee financial support, should the committee recommend this. The Team was assured the School would implement an affirmative action policy for Indigenous students after the initial start-up years.

2009 Team Commentary

In 2009, the School has an intake of 112 students (80 CSP and 32 Australian fee paying places). The University does not accept full fee-paying overseas students into the MBBS course. The School has adequate resources at the Darlinghurst campus for this number of students and is in the process of developing resources at the clinical schools and sub-schools. With the School is still in its early stages of development, there remains a high demand for funding of capital costs, equipment, and new initiatives. This is recognised by the University, which has guaranteed provision of sufficient funding so that School of Medicine, Sydney may ensure the medical course is adequately resourced, and thereby meets AMC standards.

The University of Notre Dame Australia is a private university that receives a significant number of CSP for medicine. Recent changes to the policy on domestic full fee-paying students has had limited impact on medical schools. As a Table B provider, Notre Dame is able to offer Australian full fee places. The University receives RUSC (Rural Undergraduate Support and Coordination program) funding for School of Medicine, Sydney, which set targets of 25 per cent of CSP places for students with Rural, Remote and Metropolitan Areas
three to seven locations. In 2008, the School achieved 23 per cent rural enrolments. In 2009, this reached 25 per cent.

The School does not have a specific quota for under-represented groups and Indigenous students but has consulted the community to develop individualised selection pathways and financial support for Indigenous students. School of Medicine, Sydney should consider developing effective processes to encourage participation by appropriately skilled Indigenous students. The Team commends the University’s long-term plan to promote rural and Indigenous student participation in medicine at the School, and notes that the first vacation scholarship program for 20 NSW students was held January 2009.

2010 Team Commentary
In view of the difficulties for the School in finding clinical placements for all students in the short term, the Team considered the present intake of students should not be expanded in the near future.

2011 Team Commentary
In 2011, the medical student intake remained at 112 places, but the mix of places changed to 60 CSP or government-funded bonded places, and the number of domestic full fee places increasing to 52. This change to the mix of students does not impact on the School.

The Team agreed with the view of the 2010 Team namely, that the intake should not expand in the near future.

7.2 Admission policy and selection
The medical school has a clearly defined selection policy and processes that can be implemented and sustained in practice, that are consistently applied and that are intended to minimise discrimination and bias, other than explicit affirmative action in favour of nominated under-represented groups.

The school publishes details of the process, including the mechanism for appeals.

The school has specific admission and recruitment policies for Australian Aboriginal and Torres Strait Islander or New Zealand Māori students.

The intended relationship between selection criteria, the objectives of the medical course and graduate outcomes is stated.

2007 Team Commentary
The Team commends the School for its clearly stated selection policy, which is available on the School’s website. No student will be denied entry based on any personal characteristics including age, gender, race, disability, political beliefs, religious faith or its apparent lack.

The School Selection Committee will administer the selection process. This is a multiple stage process with students initially registering an expression of interest by completing a Notre Dame Sydney supplementary information form. Following this, several components are considered before arriving at a final ranking. These components include:

- GAMSAT (Graduate Australian Medical Schools test);
- GPA (Grade Point Average) from a recognised Bachelor’s degree;
- semi-structured interview.
Grade point average is calculated by ACER (Australian Council for Educational Research) from a completed bachelor’s degree awarded within the last 10 years. A bonus of up to 0.5 points will be awarded to students of rural background. Students with higher degrees at Masters or PhD level will also be awarded bonus points.

The interview is designed to assess personal qualities and attributes of the candidate and includes motivation, communication skills, independence, approach to problem-solving, ability to make decisions in the face of uncertainty, empathy and awareness of challenges facing medicine. The Team had concerns about one other quality that was being assessed in the interview: ‘Empathy and support for the Objects of the University’, as the Objects supplied in the Part 2 submission refer explicitly to teaching within the context of the Catholic faith and values. However, at the preliminary meeting with the Dean, and at the time of the visit, the Team was assured that the structured interview did not measure Catholic faith and that the section was designed to measure empathy through enquiring about the student’s responses to a clinical scenario. The interview pro forma submitted to the Team and the interview training program which was also submitted, did not include reference to assessing religion as a selection criteria.

The interviews will be held in Melbourne and Sydney. Interview panels will consist of two persons, one from the School, or a medical practitioner, and the other a layperson. All persons acting as interviewers will undergo a three-hour training session. The interview process will be evaluated for reliability as well as by feedback from applicants. The School expressed concern about the national ruling that an applicant accepting an interview from Notre Dame would be excluded from further consideration for interview in any other graduate-entry medical school until the following year. Although this is a national issue that affects all graduate medical programs, it has implications for each graduate school in terms of how many students will be offered interviews to minimise the number of excluded students.

Offers of admission will be made in November based on combined scores derived from the components of the selection process. There are no mechanisms for appeals to the admissions process. The School currently has no provisions for deferral of entry or transfers from other universities, but is willing to consider both in exceptional circumstances.

2009 Team Commentary

The University has a clearly stated and justifiable admission and selection process into the Sydney MBBS course, which is available on the website. An appeals process has been implemented. The School’s selection process has resulted in the enrolment of two cohorts of students of high calibre.

The Team remained concerned at the inclusion of a request for applicants to provide their religion on the application form. While it was appreciated that the School might wish to seek this information once students had been selected, its inclusion on the entry form might leave the School open to an inference that it was a determining factor in the admission process. Given the funding of many places by the Commonwealth is on an equal opportunity basis, School of Medicine, Sydney may wish to avoid any such inference by reconsidering this requirement. It was noted that figures provided by the School reported similar numbers of self-identified Catholics among the applicant group as a whole and those gaining a place on the course, confirming that there was no evidence of discrimination for or against those professing a Catholic faith.
The School has also determined that bonus points for selection will be awarded to students with rural backgrounds and Indigenous status, and is commended for these initiatives. As noted above, there is now a policy of affirmative action to provide individualised selection pathways and financial support for Indigenous students, although this has yet to be implemented. The outcomes of this program require careful monitoring to ensure that the School achieves its goals, given that it has yet to result in admission of an Indigenous applicant. The Team encourages the School to consider alternative entry pathways for recruitment and support of prospective Indigenous students. Innovative approaches, such as the provision of a short ‘pre-medical’ course for appropriately chosen students without a scientific background, may be worthy of consideration.

It was noted that applicants are appropriately advised during the process for selection to a clinical school that part of their medical education may take place in rural locations. Students were aware of this requirement.

2010 Team Commentary

The 2009 AMC Report expressed concern that the inclusion of an applicants’ religion on their application form might leave School of Medicine, Sydney, open to an inference that religion was a determining factor in the admission process. The School advised the Team that, ‘as has been the case in previous years, the applicants’ religion is not taken into account in the selection process. The application form for 2011 entry will have this information on a separate front page (with other administrative information) to make it quite clear that this information is not a component of the selection process’.

The 2007 AMC Report suggested the School needed to develop more effective processes to support the recruitment of Indigenous students, including alternative entry pathways and other mechanisms. In 2009, the School advised it had consulted the Indigenous community to develop selection pathways. It now offers an individualised selection pathway for Aboriginal and Torres Strait Islander applicants and does not set minimum GAMSAT or GPA scores for these students. Each applicant is assessed on an individual basis. In the year prior to commencing the course, applicants will partake in two residential preparation courses which will provide opportunities to assess each student’s readiness and, if necessary, to direct applicants to further preparatory courses before commencing the degree program.

The Team congratulates the School on recruiting a small number of Indigenous students, who reported feeling very well supported.

The School is also implementing a variety of strategies to increase the number of rural origin students selected for entry and completing the MBBS course. This will assist the School to achieve the 25% rural target for each entry cohort, and assist with the retention of rural students in the MBBS program.

To gain entry into medicine, students are ranked using a composite score with the following contributing factors: School of Medicine Sydney Application Form score which for applicants who have spent five years in rural areas is augmented; GAMSAT score; GPA in undergraduate degree and interview score. Successful applicants from a rural background are reviewed by staff members of the Rural Advisory Committee, and commitment to and engagement with rural communities is taken into account in the allocation of Medical Rural Bonded Scholarships and Commonwealth Supported Places.
2011 Team Commentary

In 2010, the AMC found the School had met this standard. The School’s admission policy had not changed in 2011.

7.3 Student support

The medical school offers appropriate student support, including counselling, health and academic advisory services, to cater for the needs of students including social, cultural and personal needs.

The school has procedures to detect and support students who are not performing well academically.

The school has policies on the admission of, and procedures for, the support of students with disabilities and students with infectious diseases, including blood-borne viruses.

The school has procedures for identifying and dealing with students with needs related to mental health or professional behaviour issues.

The school has appropriate support for students with special support needs including those coming from under-represented groups or admitted through widening-access schemes.

2007 Team Commentary

Academic staff responsible for PBL teaching and debriefing sessions, are required to provide pastoral care to students. The Year Coordinators will deal with issues where appropriate or may refer students to support available within or external to the University. The University provides pastoral care and student support through the Campus Life and Ministry Office. Student services that are provided by the University include student counselling, academic support services, welfare and financial advice. Counselling is provided on the University’s Sydney campus by the administrative head of the Campus Life & Ministry office, who is the Campus Minister and a registered psychologist. The counsellor advised the Team that students of all faiths can avail themselves of counselling services and that such counselling would be sensitive to the varied beliefs and faiths of students. While this is likely to be true, the Team was concerned that some students’ perception that campus counselling may be coloured by the Catholic belief system may reduce their confidence in accessing such services. The Team encourages the School to provide students with alternative counselling services, perhaps outside the University, to allay such perceptions.

Identification of poor academic performance will initially be achieved through formative examinations. These results are fed back to domain committees. Domain chairs will contact poorly performing students and establish a remedial program. It was not immediately obvious to the Team why domain chairs are responsible for this. It may be more appropriately managed by the Year Coordinators or another staff member who is more involved with the students’ day-to-day activities.

Support services in the clinical years will remain the initial responsibility of the mentor clinician, moving up to Team Leader, Hospital Coordinator, and Year Coordinator as required. Urgent matters will elicit a centralised University response. Students not allocated to mentors will be supported by a hospital coordinator, who will be a paid academic staff member.

Academic support services are also available for students from the Campus Life and Ministry Office for various academic issues like note taking and essay writing skills. Some of these are organised when a need is identified. Students have access to support programs and workshops
such as exam preparation workshops, study workshops and reducing examination stress courses.

The School will comply with all government policies and regulation including:

- criminal record checks;
- working with children check policy (process to prohibit unsuitable people from working with children);
- blood-borne viruses and immunisations (would be students would need to know their infective status in relation to blood-borne viruses and be capable of undertaking exposure-prone procedures); and
- registration with the relevant board.

Students are informed about the School’s Fitness to Practice policy. The information is on the website and in the student handbook. All students must obtain police clearance by the first week of the course as a precondition of enrolment.

Group tutors and year coordinators will monitor and will be the primary source of contact for impaired students. Students with medical illnesses will be assisted to seek appropriate external professional and medical treatment. The School will provide additional support through the University’s Student Life Office and notify the Office of the Provost in cases so stipulated by the General University Regulations.

The School does not have special schemes for supporting students coming from underrepresented groups, although it plans to work towards a special support mechanism for Indigenous students.

2009 Team Commentary

The University has a good reputation for student support and pastoral care. Medical students at the Darlinghurst campus have adequate access to academic support services, welfare, financial advice and student counselling through the Student Life Office and counselling through an independent counsellor.

In Year 1 and 2, early identification of poorly performing students is achieved through the formative assessment process. Appropriate individual remedial programs are established through the Domain chairs. The PBL tutors are also in a position to address possible student/student and student/tutor conflict. In addition, processes are in place to have the PBL coordinator observing PBL sessions where required, in the first instance for a second opinion on specific problems being experienced by one or more students in the group, and in the second instance as part of a pathway to resolution. The PBL tutors undergo continuous training in the form of weekly pre-PBL meetings and debriefings, in consultation with experts in their field, as necessary.

Responsibility for student support and for remediation of poorly performing students who are to be located at the Melbourne Clinical School and the Rural Clinical School is not clearly defined. The Team encourages the School to address this. Additionally, the School does not have special schemes for supporting students coming from under-represented groups, although it has undertaken consultation for a special support mechanism for future cohorts of Indigenous students. Such a mechanism may contribute to greater success in recruiting and, more importantly, graduating students from Indigenous and other minority backgrounds.
The School continues to comply with all government policies and regulations as listed in 2007.

2010 Supplementary Comments
In October 2010, the School’s submission indicated that the School would provide students in Melbourne and in the Rural Clinical School with contact details for local general practitioners and other health professionals. Such practitioners will not have direct involvement in teaching or assessing students. The School has requested a fractional appointment of a psychologist for the Melbourne Clinical School for 2011 with primary responsibility for student support.

The changes to the clinical placement plans have caused students considerable concern. Melbourne subschool students, in particular, have continuing uncertainty over course planning that is causing significant stress. A commitment by the Vice Chancellor that all students should be informed of their 2011 MED4000 placement by mid–August was not achieved. While Sydney students were provided with this information in early October 2010, Melbourne students are still unclear about the specific rotations to which they have been assigned.

For the group of students who were anticipating rural placements in Year 4 in 2011 and who are now allocated placement in Melbourne, there are also financial concerns relating to the increased cost of living in Melbourne. The Team was pleased to hear that the School had agreed to subsidise costs for these students in 2011.

The 2010 School submission indicates that students who require additional educational support are ‘identified through formative and summative assessment results, tutor and Discipline Leader reports, and self-report’. As indicated earlier, the Team was concerned that the School is not collecting clear information on students’ performance through the formative assessment processes. The Team also considers the timing of the summative assessment works against identifying performance issues earlier and allowing timely remediation.

Students noted that on many of their clinical placements they had limited exposure to several senior clinical staff, other than on their GP rotations. They expressed concerns that none of these staff would know them well enough to provide references for postgraduate Year 1 (PGY1) positions when they graduate. The School is encouraged to discuss this issue further with students.

2011 Team Commentary
In 2010, the AMC found this standard was substantially met. It sought evidence that the School could identify students in MED3000 and MED4000 who needed additional academic support and was responding to these needs in a timely and appropriate manner.

The School’s 2011 accreditation submission indicated that students requiring academic support would be identified mainly through feedback from clinical tutors to the Discipline Leaders and Head of School at each site, and from end-of-rotation assessments of clinical competence. Individual learning plans would be put in place at a local level when a need was identified. In practice, this occurred informally, and a more formal process was not supported by the assessment forms. While the Heads of Sub-Schools have a close relationship with their students and a good awareness of their individual performance, the Team recommends the School formalise these processes.
In its response to the draft report, the School outlined ways in which these processes are being formalised, using the mid-rotation assessments to identify students experiencing difficulties. Depending on the seriousness of the problem, the matter might be considered by the Head of the relevant Sub-School or the Head of Student Matters and the Dean.

The School has appointed additional clinical coordination and support staff at the Melbourne Clinical School. Just before the Team’s visit, Melbourne Clinical School students had been notified of specific student support available to them.

The Team commends these developments. It noted that the students at the Melbourne Clinical School still occasionally experienced themselves as distant from the School and communication on important matters, despite the School’s efforts to ensure good communication and support for all students.

7.4 Student representation

The medical school supports and encourages student representation in its governance and curriculum management.

2007 Team Commentary

Elected or appointed student representatives will sit on the major committees including the Curriculum Management Committee, Medicine Selection Committee, Evaluation Committee, Research Committee and Library User Committee. Students will also be invited to the annual curriculum conference. The University also has a Student Association and all students will be members unless they opt out. One elected medical student will become a member of the Student Association Committee. The School is encouraging students to set up a medical students’ society.

2009 Team Commentary

Students have established the Medical Association Notre Dame University, Sydney (MANDUS). A second student organisation, called ROUNDS, has been established for rural students in medicine and nursing. The School is to be commended for achieving wide student representation on the major committees including the Curriculum Management Committee, Medicine Selection Committee, Evaluation Committee, Research Committee and Library User Committee. The MANDUS Executive meets regularly with the School Executive.

2010 and 2011 Team Commentary

Students at each clinical subschool site have elected a student representative. The 2010 School submission indicated there was regular communication between the student representative and the relevant Head of subschool and that a similar structure would be implemented at the Rural Clinical School in 2011.
7.5 Student indemnification

The school has adequately indemnified students for relevant activities.

2007 Team Commentary

The University carries public risk insurance for all students on its campuses and its affiliated hospitals and teaching settings, including electives and selectives, and for travel between teaching sites. The School is advocating that all students also take out their own professional indemnity insurance, and this will be facilitated by the School. In the School’s Stage 2 submission it indicated that such insurance is available for $20 per annum, but since then has been able to negotiate free insurance and will be advising students to apply for this. The AMC Team encourages the School to ensure students are adequately covered for indemnity and public risk before students start their course. Students going overseas for electives also need to be adequately covered.

2009 Team Commentary

The University public risk policy covers students, staff and the public in university and hospital settings provided the activity is part of the curriculum and that there is appropriate educational provision. The School has facilitated access to additional cover for students that include periods of volunteer work and electives.

2011 Team Commentary

The School continues to meet this standard.
Implementing the Curriculum – Educational Resources

8.1 Physical facilities

The medical school has sufficient university-based physical facilities for staff and students to ensure that the curriculum can be delivered adequately.

The school has sufficient clinical teaching site physical facilities for staff and students to ensure that the curriculum can be delivered adequately.

2007 Team Commentary

The School has plans in place for the provision of appropriate physical facilities at its three main locations, the Sydney School and the two clinical schools located in Victoria. In Sydney, there is a five-year agreement with the University of Technology Sydney for appropriate access to the University of Technology Sydney (UTS) educational facilities. This includes access to tutorial and anatomical pathology facilities, and appears adequate for the currently planned for Notre Dame student numbers of 120. If student numbers expand beyond 120, the School will need to consider the sufficiency of available tutorial rooms and anatomical laboratory spaces. In addition, the Team considered that the current planning for hand washing facilities in the UTS practical laboratories will need to be reviewed to ensure that they provide an environment for students to observe best practice in hand washing protocols. The Team encourages the School to address the issues around hand washing facilities at the UTS practical laboratories as a matter of some importance prior to commencement of the first cohort of students.

Construction of the Sydney Clinical School (Darlinghurst campus), located adjacent to Sydney’s St. Vincent’s Hospital campus, is expected to be complete by December 2007. This $21 million facility will provide lecture theatres, seminar rooms, wet laboratories, simulated wards, PBL rooms, clinical skills room, library and administrative space in time for the first intake of students in 2008. The Team was impressed with the progress at the site, and the facilities that have been planned.

With respect to the Melbourne Clinical School, a feasibility study is underway to assess the relative merits of construction of a clinical school facility either on the St. Vincent’s Hospital campus or at an undeveloped site adjacent to the Mercy Hospital at Werribee. The study will be completed by December 2007. This should allow sufficient lead-time for construction to be completed in time for MED3000 students in 2010.

The School’s Rural Clinical School will be based at Ballarat in Victoria. Negotiations are well advanced with the Australian Catholic University to access adequate facilities adjacent to the St. John of God Hospital in Ballarat. Subject to current capital projects being completed within the expected timelines, and no expansion in student numbers, the current planning would appear adequate for student requirements.

2009 Team Commentary

The Sydney School has excellent quality purpose-built facilities in a new seven-storey building at Darlinghurst collocated with the School of Nursing and adjacent to Sydney’s St. Vincent’s Hospital campus. This facility provides seminar rooms, wet laboratories, simulated wards, PBL rooms, clinical skills room, a suite of simulated consulting rooms, library and administrative space. The Team was particularly impressed with the fit out of the simulation areas. The University has a contractual agreement with the University of Technology Sydney (UTS) for appropriate access to the UTS laboratories and academic staff for biomedical
science teaching facilities. Staff and students report general satisfaction with these arrangements.

**Sydney Clinical School**

The Darlinghurst facility will accommodate the central curriculum that runs through the clinical years. At each sub-school site, dedicated space for students has been identified and is being developed for occupancy in 2010. The Team understands that negotiations and plans are well advanced for clinical teaching in 2010 at Auburn, Hawkesbury, Randwick and St Vincent’s (Sydney) hospitals. At Auburn Hospital, a dedicated teaching floor has been built to house the clinical sub-school. At Hawkesbury, a dedicated space at the side of the hospital has been identified and will be renovated this year for medical students. Students on placement at St Vincent’s/Mercy Hospital will utilise the Darlinghurst facility. A small, dedicated office space will also be available to students at the Mater Hospital.

**Melbourne Clinical School**

The University will continue to develop a clinical school at the Mercy Werribee Hospital. This has the support of the State Government and a Capital Development Pool application is before the Australian Government. Until this facility is operational, the University has agreed to lease teaching spaces from Victoria University, which is located adjacent to the hospital at Werribee. The School will lease facilities from the Royal Australasian College of Surgeons for intensive surgical skills sessions. It will also lease two demountable buildings to be placed on the Mercy Werribee Hospital site. One will house staff offices and a temporary library and the other will include a student common room, teaching space and computers for students to access the online curriculum. The main office in East Melbourne will be transferred to the demountables until the definitive clinical school building is built.

The Team encourages the School to develop a longer-term contingency plan in the event that the submission for Capital Development Pool funding for the Werribee Mercy development is unsuccessful ($4.5 million annually forecast for 2010 and 2011).

**Rural Clinical School**

These facilities are not required until 2011. The RCS will have sub-schools at Ballarat, Victoria and Wagga Wagga in New South Wales. The site of the headquarters of the Rural Clinical School will be in Lithgow. Transitional rural funding has been received to commence work on student accommodation and teaching infrastructure at this site. Sydney West Area Health Service has agreed to make land around the Lithgow Hospital available for this purpose. An architect is being briefed. The site master plan now includes the student accommodation. Again, the Team encourages the development of a contingency plan in the event that Rural Clinical School funding is not forthcoming ($2 million annually forecast for 2010-2013).

At Wagga Wagga, space has been identified for educational purposes within the hospital. The hospital also owns several houses adjacent to it that may be suitable for student housing. A rural clinical school application is with the Minister, which if successful, would provide for purpose-built student accommodation in Wagga Wagga. The Vice-Chancellor of Charles Sturt University has offered to develop the required student accommodation. Charles Sturt University is in the process of developing extensive additions to its student accommodation and Notre Dame indicated that economies of scale could be achieved by collaborating. The Pro-Vice Chancellor (Medicine) and the Vice-Chancellor of Charles Sturt University have
met to facilitate collaboration. The Team noted the successful precedent in Western Australia of a partnership with the University of Western Australia for the operation of the Rural Clinical School.

In Ballarat, an agreement has been secured with the Australian Catholic University (ACU) and St John of God Hospital that School of Medicine, Sydney Rural Clinical School medical students will be able to utilise fully all facilities at the ACU Ballarat site. The site includes several large lecture theatres, student recreation facilities, a refurbished library and all IT resources, including linkage to Notre Dame library services. In addition, there are teleconferencing facilities, seminar rooms and clinical skills training facilities. The ACU facility is located immediately adjacent to the St John of God Hospital in Ballarat. The ACU also owns several houses adjacent to the hospital and has indicated that these may be leased to the Rural Clinical School. The Hospital is also including some hospital-based facilities for Notre Dame medical students in its current redevelopment. The School is redeveloping a small space within the St John of God Ballarat site for students.

The Team encourages the University to review its decision to establish an independent clinical sub-school at Wagga Wagga. The first cohort of RCS students will need facilities by 2011. There is a need for clear definition and alignment between the sub-school components of the RCS to ensure that all students receive appropriate learning experiences.

**2010 Team Commentary**

In 2010, the School implemented the MED3000 program for the first time. The Team was able to visit a wide range of clinical sites where students were undertaking Year 3 placements. Students were very positive about the clinical experience available and the enthusiasm of their clinical teachers.

At most sites, the University was using existing physical facilities, some of which had been refurbished to meet MED3000 teaching and student requirements, but expected further developments when both clinical years are implemented.

The Rural Clinical School sites will be needed for MED4000 in 2011. The three sites will be Wagga Wagga, Ballarat and Lithgow. In April 2010, the Dean outlined plans to make Wagga Wagga the focus of the Rural Clinical School rather than Lithgow. This decision has been based in part on the Dean’s connections to this site, and on the expanded range of clinical services.

From its visit to Wagga Wagga, the Team confirmed the potential to develop the University’s presence and the clinical teaching facilities here, building on impressive, wide ranging specialist services and enthusiasm for and engagement in teaching from the local clinicians, as well as the interest of the local health services. The Team agreed that clinical teaching capacity appeared adequate for the plans for students to complete one-year placements in Wagga Wagga. The University of New South Wales also has a Rural Clinical School site in Wagga Wagga, and early communication and negotiation will be required to ensure that the plans for the development of the site and the facilities progress smoothly and effectively.

The Team did not visit Lithgow or Ballarat on this occasion but noted the change in RCS location to Wagga Wagga would reduce the demand on services and facilities in Lithgow and Ballarat compared with those planned in 2009.
2010 Supplementary Comments

In October 2010, the School provided detailed information to the Team on the progress of planning for capital works at a wide range of sites.

Capital infrastructure is being developed at Werribee, Auburn, Lithgow, Ballarat, Wagga Wagga and Hawkesbury. The University has secured an Australian Government Health and Hospital Fund grant to develop clinical schools at Werribee and Auburn and an RCS Capital Grant to develop the Rural Clinical School at Lithgow, Ballarat and Wagga Wagga.

At Auburn and Hawkesbury, lecture rooms, tutorial spaces and academic offices are available, some shared with students with other hospital staff. Facilities for students were generally adequate at Hawkesbury and Auburn Sub-Schools. The Team viewed plans for a dedicated teaching and research facility at Auburn Hospital, planned for completion in April 2012. This will provide dedicated teaching/lecture rooms, academic offices, computer room, common room and overnight rooms for Notre Dame students.

At St Vincent’s Hospital, Sydney, Notre Dame students and staff share lecture rooms and tutorial space with University of New South Wales and hospital staff. Students and clinical teaching staff may also use computer and teaching spaces across the road in the Notre Dame School of Medicine building.

The University has refurbished two rooms and a small reception area in the Health Service building at Lithgow Hospital. One room is set up for computer access and the other for group tutorials. The Head of the Lithgow Sub-School has an office close by. An 800 m$^2$ rural clinical school is being developed on land adjacent to the Hospital, and the University plans to ensure the facility is available by the end of 2011. The plans appear appropriate, and if the importance of site in the School is to grow, these developments will be essential.

In Victoria, the University is developing a clinical school on Crown land adjacent to the Werribee Mercy Hospital, which should be completed by January 2012. While facilities have been sufficient for Year 3, the Team was concerned that they will be stretched to capacity when Year 4 is in place in 2011. The School should monitor this carefully.

In Ballarat, the University plans to continue and extend its arrangements to lease facilities for student accommodation and additional teaching locations if required from the Australian Catholic University. Space within the historic Bailey’s Mansion, adjacent to St John of God’s Hospital, is also to be refurbished for the Notre Dame RCS staff and students by 2011.

Development plans at Wagga Wagga have changed since the April 2010 visit. Plans for a separate building within the Calvary Hospital precinct are being discussed, but it is too early to estimate a work commencement date. For 2011, when there will be four to seven Rural Undergraduate Steering Committee-funded students in general practices per rotation in Wagga Wagga and the surrounding area, the University will use space within the Little Company of Mary Centre, part of Calvary Hospital. Student accommodation is either currently available, or negotiations to rent suitable accommodation close to completion at all rural sub-schools.

The School has extensive plans for capital developments to support its distributed students and staff. These should largely be in place by the end of 2011: Wagga Wagga by December 2010; Ballarat, Lithgow and Auburn by December 2011; and Werribee by January 2012. The current temporary arrangements are largely adequate until then. The School is encouraged to seek student and staff feedback on the appropriateness and adequacy of the facilities across
the School’s sites, particularly during this transitional period. The School’s annual reports to the AMC should report on the progress of the capital development plans.

2011 Team Commentary
In 2010, the AMC found this standard was substantially met. To meet the standard, it required evidence that the facilities at Werribee were sufficient to deliver MED3000 and MED4000 by the start of the 2011 academic year, and that plans for capital development at clinical teaching sites were progressing.

In February 2011, the School provided an update on the development plans at each of the major clinical teaching sites. In May 2011, the Team visited Werribee and Sunshine Hospitals and held teleconference meetings with staff and students at a number of other sites.

The Team congratulates the School on its substantial building program to support its clinical schools, and its progress since the October 2010 AMC assessment.

The Team confirmed that important progress had occurred on the Mercy Werribee site. The new Clinical School is being built at Werribee Hospital and should be completed by November 2011. There is teaching space on each ward, and two seminar rooms. The new library facility opened in 2010 and is supported by a part-time librarian.

The 2011 follow-up assessment did not include a full review of the facilities available to students on the University’s Sydney campus. Previous assessments have found these to be of high quality. However, Team members did identify a need for review of the pathology specimens used in the integrated anatomy, pathology and radiology workshops.

The School subsequently reported that this work would be undertaken in early 2012.

8.2 Information technology

The school has sufficient information technology resources and expertise for the staff and student population to ensure the curriculum can be delivered adequately.

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

2007 Team Commentary
Information technology services for the School are currently provided by The University of Notre Dame Australia Information Service. New staff have been employed for the Sydney campuses to establish a reliable campus IT service and to address the emerging needs of the new School, especially with the completion of the Darlinghurst building.

The services provided have progressively shifted from Fremantle-based IT services to Sydney-based IT services. All services provided from Fremantle are now subject to service level agreements with stringent service availability deliverables. Currently, approximately 60 per cent of the IT services for the Sydney campus are provided locally. The School plans progressively to increase the proportion of locally provided services, except where this is not sensible or economic, such as with ‘Blackboard’ and with the Student Management and Financial Systems.
The Darlinghurst campus is linked to the Broadway campus of the University with multiple redundancy links and has a duplicate system for disaster recovery. The Darlinghurst site will be fully wireless-enabled and operational in November 2007, allowing three months for comprehensive testing.

All facilities are network managed, including audio-visual services, and appear adequate. A web-based service system will be utilised for delivery of learning materials to remote sites, including the Rural Clinical School. An encrypted SSL link will be used but video linkages for remote sites will not be used.

The School is encouraged to ensure that all involved parties have easy and reliable electronic access to any School materials that will assist their educational or research contributions to the School’s outcomes. The Team was impressed with the standard of information services planning, service delivery and availability, and commends the University and involved staff.

The Darlinghurst Library facility is under construction and will be completed in June 2007. Recruitment of library staff is under way and appears sufficient. The library service is provided as part of a corporate service. The School has a budget of $150,000 to $200,000 per annum, which is only for print materials, including journals. An adequate collection of electronic educational resources has been finalised. The facility is adequate for proposed student and School requirements. A Library Committee will be convened once a Librarian has commenced duties.

The Team commends the School on the design and electronic emphasis for the Darlinghurst campus library, and for the level of educational materials to be provided both within the School and remotely.

2009 Team Commentary

Information and communications technology underpins delivery of the Notre Dame Sydney curriculum, primarily via the Blackboard-based portal. The Team was impressed with the commitment and excellent communication by central University staff in the provision of an extensive and high-quality IT infrastructure across the distributed clinical sites.

The Darlinghurst campus is linked to the Broadway campus of the University with multiple redundancy links and has a duplicate system for disaster recovery. The Darlinghurst site is fully wireless-enabled although students complained that there were black spots in the School. All IT services are network-managed, including audio-visual services, and appeared adequate. A web-based service system will be utilised for delivery of learning materials to remote sites, including the Rural Clinical School. The Team regarded the information provision to students and staff as impressive. The platform appears able to cater for growth in both size and enhanced interaction, and the server appears adequate for carrying larger files and links to outside websites. However, the Team noted that not all facilities in all clinical schools are ready to be rolled out. The Team looks forward to being reassured that the logistics of this arduous task is complete.

The Darlinghurst Library facility includes access to computer-based reference systems, library support staff and a reference collection deemed adequate to meet curriculum and research needs. Each PBL room has copies of essential texts and reference materials. The School intends that the sub-school sites will be similarly resourced.

The Team commends the School’s commitment to provision of access to an extensive collection of electronic educational resources including journals, which will be available to
all students, regardless of physical location. However, the Team had concerns about library facilities in some sub-schools. There was no library at Hawkesbury Hospital nor ready remote access for students to the Darlinghurst library facilities. The library at Auburn Hospital was new and was expected to develop. There was specific space and workstations available for students to access journals and books remotely. The plans for provision of library facilities in Melbourne, especially at the Mercy-Werribee site need clarification.

2010 Supplementary Comments

The School continues to rely heavily on information and communications technology to delivery course material and communicate with students and staff.

As School of Medicine, Sydney has expanded, the need for upgraded IT facilities has become evident, not only so that students and staff across the School’s campuses can access necessary material, but also to manage the dispersed units. The University has expanded its IT capacity during 2010. For teaching, plans were outlined to enhance capacity, allowing students to access real-time or pod/vod-casted teaching sessions such as grand rounds. Students now typically connect through their hospital’s network. The University also has plans for a virtual private network that will allow administrative and academic managers to access central university policies, files and forms. The Acting Dean considered the improvements in the University’s infrastructure during 2010 provided a good basis on which to roll-out these developments during 2011.

On the April and October 2010 visits, AMC Team members had opportunities to visit the library facilities at a number of the clinical teaching sites. Many of these are modest facilities, only providing access to one core textbook per discipline, which students supplement with online access to e-books, journals and databases. Students would welcome access to a wider range of texts to support broader and deeper learning. This Team endorses this assessment. Other texts are available from the Darlinghurst campus by inter-loan, but this does not allow students to browse more spontaneously a range of major texts and gain a more rounded immediate understanding of a given learning issue.

2011 Team Commentary

In 2010, the AMC found this standard was substantially met and requested evidence that library facilities available to staff and students at clinical sites were adequate to meet curriculum and research needs.

In 2011, the University had secured a grant to purchase texts for the clinical site libraries, particularly at Werribee. The School needs to work with the health services to ensure there are library facilities of an equivalent standard at all clinical sites, and that the facilities include core texts for all years.

The new library facilities at Sunshine Hospital provide a pleasant and spacious learning space.

The School’s submission outlined a new project, funded by the Department of Health and Ageing, to link the Rural Clinical School sites with School of Medicine, Sydney, via videoconference, enabling teaching at Darlinghurst to be delivered to the Rural Clinical School sites and vice versa. The project will also provide for facilities to allow for video meetings and collaboration between the staff at Darlinghurst and the Rural Clinical School sites.
8.3 Clinical teaching resources

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.

2007 Team Commentary

The School’s current academic and clinical staffing plan appears to be the minimum needed to deliver on the outcomes of the School. This plan should be reviewed regularly. Particular attention should be given to the early recruitment of directors in pathology and radiology.

The number of student placements and specialty allocations identified to date appears adequate for the proposed intake of 104 students in 2008 as they progress to their clinical years in 2010. Currently, from Year 3, 56 students will be allocated to the Sydney Clinical School, 40 to the Melbourne Clinical School and eight to the Rural Clinical School in Ballarat. Significant progress has been made in identifying non-metropolitan placements through the Rural Clinical School, and negotiating arrangements with a number of divisions of general practice in both New South Wales and Victoria.

The number of student placements and specialty allocations identified to date appears adequate for the proposed intake of 104 students in 2008 as they progress to their clinical years in 2010. Currently, from Year 3, 56 students will be allocated to the Sydney Clinical School, 40 to the Melbourne Clinical School and eight to the Rural Clinical School in Ballarat. Significant progress has been made in identifying non-metropolitan placements through the Rural Clinical School, and negotiating arrangements with a number of divisions of general practice in both New South Wales and Victoria.

In general, facilities at sites identified for student clinical placements will be sufficient for the School’s placement plan. However, where more than one medical school has students there is a need for more detailed and agreed arrangements to ensure facilities are available and sufficient for students from all involved universities.

The Sydney Clinical School facility will be completed by December 2007. There is a feasibility study under way to determine the preferred site of the Melbourne Clinical School and arrangements are being progressed regarding access to the Australian Catholic University facilities in Ballarat.

The School has explored a wide range of potential patient contact opportunities, extending geographically from Brisbane to Ballarat. The School has identified a significant patient contact load available in areas which may to date have been considered underutilised, particularly in peripheral public and private hospitals and specialists rooms. However, concerns have been expressed that accessing this patient contact load could adversely impact on the availability of the limited pool of clinician teachers within the health sector, many of whom provide teaching and clinical services in both the public and private sectors. Planning for exposure to Indigenous health settings is under way but not finalised.

As discussed in Section 1.6, a significant issue identified by the Team was the level of communication with relevant institutions and medical schools whose activities may affect the delivery of the curriculum. The Team encourages the School, as a matter of some urgency, to
focus on strengthening relationships with interested medical schools to ensure that long-term working relationships are secure and mutually positive.

**2009 Team Commentary**

The School has identified sufficient clinical placements to accommodate the students in 2010 and thereafter. Clinical exposures in Years 3 and 4 will be integrated through three clinical schools: the Sydney Clinical School, the Melbourne Clinical School and the Rural Clinical School.

Students are scheduled to enter the clinical years in 2010. The Team was encouraged by the level of planning and development undertaken at Sydney clinical teaching sites, and the apparent goodwill and level of collaboration with collocated medical schools for clinical placements. The Team understands that negotiations and plans are well advanced for clinical teaching in 2010 at Auburn, Hawkesbury, Randwick and St Vincent’s (Sydney) hospitals, and that collaborations have been formed successfully with co-located medical schools at these sites.

However, there are still unexplored areas of potential collaboration such as joint appointments and shared intern preparation programs that could be progressed. The number of student placements and specialty allocations identified appears adequate for the current student intake as they progress to their clinical years in 2010. Given the driving ethos of the Notre Dame Sydney medical program, the Team encourages the School to consider pursuing greater exposure to rural and Indigenous health settings for clinical teaching and clearly identified and defined opportunities for selectives in Year 4.

While relationships with Melbourne and Deakin universities are on a much stronger footing than at the visit in 2007, the Team encourages the University to continue to clarify the degree of planned integration and level of resource sharing (e.g. clinical skills and simulation facilities) through formal agreements. The signing of an agreement with Melbourne for operational requirements is a significant step and is commended.

In relation to clinical teaching resources, the areas of greatest concern for the Team are the Melbourne Clinical School (Mercy Werribee) and the Rural Clinical School. There are significant difficulties with communication between the Sydney School of Medicine and the Melbourne Clinical School at Mercy Werribee, particularly concerning the number of agreed hours per week for clinical rotations, both within the hospital and in general practice. These need to be resolved before students start rotations in early 2010. The Team recommends that the School undertake detailed planning of the 2010 clinical teaching program at Mercy Werribee as a matter of urgency.

Similarly, there appear to be significant communication difficulties between the component parts of the Rural Clinical School, related primarily to consistency across clinical placements and the role of the Associate Dean. At SJOG, Ballarat there are a wide range of potential patient contact opportunities, and this area of planning seems well advanced and the clinical leadership is enthusiastic and well prepared.

Overall, the Team acknowledged the plans for development of clinical facilities, but remained concerned about the stage of development of many of these, given the relatively short time before the clinical program commences. The Team considered that plans for the development of both the curriculum and the facilities for Years 3 and 4 would need to be...
confirmed during 2010. There were additional concerns that the necessary staff and facilities at Mercy Werribee and the Rural Clinical School required considerable development.

Plans for clinical teaching in Victoria at St Vincent’s and Western Health and within General Practice did not appear to be well advanced. There was also a need for more detailed planning of the clinical teaching program to be implemented in 2010 at the Mercy Werribee site.

Implementation of the clinical program was to be facilitated by the early appointment of the Heads of the Sub-Schools and Discipline Leaders across all clinical sub-schools. These appointments have been delayed for budgetary reasons. The Team considers that early appointment to these positions is essential to the detailed planning and delivery of the clinical program to ensure the necessary staff resources are in place for students to commence in 2010. The Team understood that at the time of the visit the School had identified but not employed most of these staff.

2010 Team Commentary

The School has appointed Discipline Leaders at clinical sub-schools to oversee the training that medical students receive in their specialty. Discipline Heads, when appointed, will monitor and advise their respective Head of the Clinical Sub-School concerning the suitability of clinical training.

The 2009 Team suggested that School of Medicine, Sydney review its proposed clinical placements to ensure a satisfactory breadth of clinical exposure to enable all students to meet the learning objectives. The School has appointed Clinical Placements Officers in both the Sydney and Melbourne Clinical Schools, whose duties include the monitoring of medical students’ clinical experiences during these placements, in order that students’ clinical training meets the stipulated clinical competencies. The flexibility of the selective terms in MED4000 was planned to permit additional clinical training placements to be undertaken in either generalist or sub-specialist terms to ensure adequate student clinical experiences. The Team gained the impression from students that they were not aware of these judgments on their performance and respective allocations, and some considered they had been allocated repeated placements that they had completed satisfactorily. Clarification of the policy and its application is recommended.

Several excellent clinical attachments had been implemented in MED3000 for Sydney students involving enthusiastic and committed clinical staff at Hawkesbury, Auburn, St Vincent’s Sydney and St Vincent’s Melbourne. Students were very pleased with their clinical experience.

MED3000 students at Werribee Mercy in 2010 had begun rotations in medicine, surgery, obstetrics and gynaecology, psychiatry, paediatrics and with local GPs. At the Werribee Mercy site, students will be able to undertake clinical rotations in medicine, surgery, obstetrics and gynaecology, psychiatry, paediatrics and general practice in the local Werribee area. Students who met the Team reported positively on their clinical experience.

As mentioned earlier, in April 2010, the School presented plans for changes to the configuration of teaching placements at the Rural Clinical School that would make greater use of Wagga Wagga. The School outlined plans for 12 Year 4 students to have a year-long immersion in Ballarat and 12 to have this experience in Wagga Wagga with a range of terms and selectives. Rural general practice, community outreach and hospital exposure will be
delivered at Lithgow and a range of other regional sites. In addition, the School is planning in 2011 to provide immersion in clinical practice in Wagga Wagga in MED3000 for eight students.

The decision to establish the Head Office of the Rural Clinical School in Wagga Wagga requires a clear collaborative agreement between the University of Notre Dame Australia and the University of New South Wales. While the Team was persuaded that there is sufficient capacity at the private and public hospitals to accommodate students from both universities, the Team encourages the Dean and the Acting Head of the Rural Clinical School to progress, as a matter of urgency, a combined curriculum mapping exercise to maximise collaborative delivery and minimise duplication at this site.

**2010 Supplementary Comments**

As noted earlier in the report, changes in leadership, the relatively late appointments of several Heads of Discipline and Discipline Leaders and changes in plans for the development of the Rural Clinical School created concern for the AMC about the capacity of the School to meet the accreditation standards relating to clinical teaching resources.

There has been substantial progress since the April 2010 visit but considerable work remains to be done. The curriculum has been developed for each of the core rotations in MED4000. As the Heads of Discipline are all located in Sydney, and generally have clinical positions at St Vincent’s Healthcare Services, the student allocation to MED4000 posts there are well advanced.

Sydney students have quite detailed information on their Year 4 placements, but Melbourne students still had a range of options for their selectives. These arrangements must be finalised urgently. Some of these placements may be additional rotations at Werribee Mercy. Students expressed some concerns about whether these placements have sufficient capacity for further students beyond that already used for MED3000. As noted above, defining additional learning competencies for such selectives will be necessary to ensure such placements are seen as distinctly different to those already completed. In general, the Team considers that the School’s placement plan is achievable for 2011, and that students will receive an adequate breadth of experience.

The Team visited two of the main clinical teaching sites in October 2010: Werribee Mercy and Lithgow.

There had been significant developments at Werribee Mercy and steps were in place to provide additional oversight of the MED4000 program. However, clarification of selective placements was still in progress. Students reported that the MED3000 program had worked well for most of them, but the continuing uncertainty and changes in the proposed arrangements for their clinical program was a source of continuing anxiety. While the Team acknowledged the pressure of impending examinations without a prior cohort’s experience to guide expectations, the level of this anxiety was significantly greater than that present among the Sydney cohort. The Melbourne School is encouraged to finalise arrangements and convey the decision to students as soon as possible. The Melbourne students noted that they were not able to apply for the Northern Territory selective made available by the former Acting Dean. The students would welcome clarification of the accuracy of this information, or reasons for this decision.
The Team’s visit to Lithgow confirmed the potential for further development of this site. Lithgow Integrated Health Services consists of a 46-bed public hospital, 14-bed private hospital, nursing home and hostel, and a community health centre. It provides 24-hour emergency care with on-call medical services, surgery, general medicine, obstetric (about 250 births per year) and palliative care services. There are four general practices, three of which have indicated an interest in teaching Notre Dame students. The area is serviced by general practitioners and visiting specialists. The Team was impressed with the services and staff available and was assured that students would have a well-supervised experience that would enable them to achieve the required clinical competencies and learning objectives. While only four students will have year-long placements at Lithgow in Year 4 in 2011, another four will undertake their rural selective there.

The Rural Clinical School will not be able to meet Australian Government requirements in 2011, needing 25% of the students undertaking 50% of their clinical training in rural settings. The School has notified the Department of Health and Ageing. While there is more optimism about achieving these placements for 2012 than there was a few months ago, and the Acting Associate Dean, Rural Clinical School has been influential in this change, much uncertainty remains. Early appointment of a successor to the Acting Associate Dean, Rural will be crucial.

The School relies significantly on sessional appointment of VMO staff in teaching roles. Such staff are generally not on-site beyond their immediate clinical commitments to the given institution, and it is important that their junior staff are engaged and supported as facilitators’ of student learning.

The School continues to develop plans for ensuring all students experience providing health care to Australia’s Indigenous people. While these plans have been delayed by the loss of a key staff member, the School has moved quickly to fill this gap.

As one of Australia’s newest medical schools, School of Medicine Sydney is establishing links to hospitals, clinics, and other health services in Sydney, Melbourne and their surrounding rural areas, where a number of established medical schools already operate. The AMC requires each medical school to engage actively with the other medical schools whose activities may impact on the delivery of the curriculum, so that access to appropriate clinical training experience can be sustained. While there has been some progress in the relationships between School of Medicine, Sydney, and other medical schools sharing learning facilities, the Team considers further liaison is needed to assure these institutions that placement plans are coalescing and will not be subject to further change. This is an issue at present, and will require the early attention of an incoming Dean, whether or not that Dean envisages further changes.

While there appears to be a clear written understanding over rural placements in Ballarat and a written memorandum with the University of Melbourne regarding St Vincent’s, Melbourne, arrangements with Western Health in Victoria are not formalised, and should be, mindful that this is an area of expansion for both UNDA School of Medicine, Sydney, and the University of Melbourne. The AMC requires these arrangements to be documented and, particularly in the current changing environment of medical education, regularly reviewed to ensure that placement plans are sustainable.

It is too early to judge if the School’s planning will ensure that the outcomes of the clinical teaching programs delivered in the clinical facilities match those defined in the curriculum but the experience of the students thus far is encouraging.
2011 Team Commentary

In 2010, the AMC found this standard was substantially met. For the School to meet the standard, the AMC required evidence:

- that clinical placements and clinical tutors for all MED3000 and MED4000 students had been confirmed by 1 December 2010
- that the School was actively engaged with relevant institutions, including other medical schools whose activities may impact on the delivery of the curriculum by April 2011
- by August 2011, that the School’s clinical placement plans for 2012 will enable students to meet course objectives

At the time of the Team’s visit in May 2011, the School had successfully introduced MED4000, following a one-week orientation program in Sydney for all MED4000 students in late January. As required, the School had confirmed clinical placements and clinical tutors for MED3000 and MED4000 before the MED4000 program was introduced.

Students in MED3000 and MED4000 who met the Team were enjoying their clinical experience. Students in Sydney were enjoying a broad and stimulating range of clinical placements.

As was planned, the Melbourne Clinical School’s MED4000 program was delivered at multiple sites, since the Werribee Mercy Hospital is now able to support only the pre-intern medicine term, which includes two weeks of consultant palliative care, and some selectives in Psychiatry, Obstetrics and Emergency, as well as providing the home base for Back-to-Base days. The students’ experience in critical care specialties and complex medicine or surgery will continue to be provided at other sites for the foreseeable future.

Melbourne Clinical School students particularly commended their experience in the critical care specialties, in which four students spend four weeks each in the Intensive Care Unit at St Vincent’s, Anaesthesia at St Vincent’s, and the Emergency Department at Sunshine.

In addition, the Melbourne School students each complete single days in a large local private dermatology clinic, and in the renal dialysis unit, and a four-week rural placement in Ballarat focusing on ophthalmology, ear nose and throat and rural general practice. Students also complete two, four-week selective placements, one working singly or in pairs, as part of clinical teams in the medicine departments at Western Hospital, and the other as an ‘advanced community’ placement, in Aboriginal health or large local health care cooperatives with substantial immigrant health services.

The School acknowledges the complexity of these arrangements, but indicated that they were working well. While students were generally very complimentary about their experience, they identified some areas of repetition such as palliative care, some areas where the experience was very variable, and some areas which were very dependent on a few key staff being available. The students were however pleased with the rapid response by the year coordinators to any problems that had arisen with their clinical placements.

To support the delivery of the clinical program, the School is engaging with other medical schools whose clinical teaching occurs in some of the same health services. The relationship with the University of Melbourne continues to be the least well developed.

As noted earlier, a number of documents have been prepared to formalize agreements with clinical services within Western Health. Although these were yet to be signed, it was
understood that Western Health was generally favourably disposed to these agreements. However, it appeared, despite informal contact with the University of Melbourne staff related to these clinical sites, formal and high level communication that would limit the risks of future misunderstandings, and would support smooth student access had not occurred. Such documentation is strongly encouraged by the AMC.
Appendix One  Membership of the 2007, 2009, 2010 and 2011 AMC Assessment Teams

The 2007 Assessment Team

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Executive Summary 2007

An Australian Medical Council (AMC) assessment team visited the University of Notre Dame Australia School of Medicine Sydney from 14 to 18 May 2007 to assess the plans for the delivery of a four-year graduate-entry medical course, leading to a degree of Bachelor of Medicine, Bachelor of Surgery (MBBS). The curriculum will be based on the one adopted and developed by the Notre Dame School of Medicine Fremantle, which was acquired and developed from the MBBS curriculum at The University of Queensland. The SoMS has adopted the learning objectives, curriculum and teaching methods, and school management structures of the Fremantle School but will remain directly responsible for the curriculum, assessment and quality assurance.

Construction of the Sydney Clinical School (Darlinghurst campus), located adjacent to Sydney’s St. Vincent’s Hospital campus, is expected to be complete by December 2007. This $21 million facility will provide lecture theatres, seminar rooms, wet laboratories, simulated wards, PBL rooms, clinical skills room, library and administrative space in time for the first intake of students in 2008. The School is also utilising University of Technology Sydney (UTS) academic staff and facilities to provide a significant part of the biomedical science education curriculum to Years 1 and 2 students.

The SoMS will have three clinical schools, based in metropolitan Sydney, Melbourne and rural Victoria.

The Team identified the following areas of strength, and areas requiring consideration and development. These are outlined in respect of each of the nine standards.

1. The Context of the Medical School

Areas of strength:

- clearly articulated governance structures, roles and responsibilities
- progressively developing autonomy of the Sydney Campus and School
- strong leadership from the Dean and members of the Executive, leading to a very high level of organisational and strategic planning
- a strong committee system which is functioning well and achieving results, especially in curriculum development
- strong academic and clinical educational expertise of a number of UNDA staff
- the engagement of UTS staff with the processes in the School, leading to important contributions to the research capacity of the School; basic medical sciences teaching capability; and educational resources, both in facilities and in educational materials
- exploration of a clinical education approach involving a ‘mentor model’, with the potential to provide an enhanced educational experience
- an approach of increased use of private hospital and general practice student exposure and experiences in clinical training
- the partnership approach to Indigenous health with a view to embedding Indigenous health issues across the curriculum.
Areas that will require consideration and development include:

- clarification for external stakeholders which University officer is authorised to negotiate and resolve issues, particularly related to clinical placements
- more effective communication of the School’s intentions and approach to external stakeholders, particularly other interested universities, and particularly in the area of clinical training
- resolution of the complexity and tensions resulting from multiple locations for clinical placements across States, health services and facilities currently utilised by one or more other medical schools
- attention to the administrative staffing plan, which appears insufficient for the expected workload
- review and monitoring of the academic staffing plan, including the limited number of full time positions, to ensure it is sufficient to deliver School outcomes
- progression of the planned senior academic appointments in Radiology and Pathology as soon as possible
- further development of the research program and capacity, particularly for UNDA staff
- progression of the implementation of the partnership approach to Indigenous health, with demonstrated outcomes available for 2008.

2. The Outcomes of the Medical Course

Areas of strength:

- clear statement of the School’s mission and most graduate attributes
- clear linkage of teaching and assessment goals to Learning Objectives
- the clear structure and integration of the four domains within the curriculum
- extensive mapping of the curriculum and proposed mapping of assessment to the Learning Objectives of the School, the goals of the AMC and the Postgraduate Medical Education Councils’ curriculum
- the proposed long-term evaluation of graduate outcomes.

Areas that will require consideration and development include:

- clarification of the overarching terms in the statement of graduate attributes, particularly the word ‘dutiful’ to ensure that it is clearly understood in an Australian context
- completion of the remaining links in the mapping process, for example linkage of interpretation of evidence and research methodologies across the domains
- clear articulation of the role of research and the place of the Indigenous health strategy within the mission statement of the School.
3. The Medical Curriculum

Areas of strength:

- development of existing accredited programmes with considerable commitment to provide an integrated PBL based course
- modification of the Notre Dame Core Curriculum to better meet the needs of medical students
- effective collaboration between UTS and the School in developing the BCS domain, and the measures to ensure direct clinical relevance throughout this programme
- a strong focus on personal and professional development within the course, including the Professional Portfolio process
- the careful review of the UQ and SoMF curricula and processes undertaken to ensure local relevance and local ownership of the course.

Areas that will require consideration and development include:

- enhancement of communication between the various groups contributing to teaching in pathology to ensure efficient and timely collaboration in the delivery of the pathology component
- clarification of how the proposed close integration of anatomy teaching with medical imaging is to proceed
- review of the proposed depth of learning of methods of scientific enquiry in a biomedical and clinical context
- exploration of methods of providing research opportunities to all students, and short-term scholarships, particularly during the long vacation, to promote active engagement in research
- informing of UTS staff, as a matter of priority, about the curriculum content in Year 2 and subsequent years.

4. The Curriculum – Teaching and Learning

Areas of strength:

- the use of hypothetico-deductive reasoning in small group PBL in Years 1 and 2 in addition to lectures, laboratory based classes, small group expert tutorials, clinical and communication skills sessions
- well developed plans for integration of anatomy
- access to basic science teaching expertise at UTS
- enthusiasm for involvement in teaching of staff from the School, UTS, Douglass Hanly Moir Pathology and the various clinical sites
- excellent provision of information and resources for students and staff via the School website
- a broad commitment to teaching development training for all staff, including clinical staff.
Areas that will require consideration and development include:

- engagement in more frequent dialogue with DHM and UTS to facilitate integration of pathology and radiology with the well developed anatomy stream, which should be achieved by the end of 2007
- clarification of the process of delivery of clinical teaching
- development of a process of informed consent for students acting as subjects in clinical skills sessions, and clarify the consequences for a student who prefers not to be involved.

5. The Curriculum – Assessment of Student Learning

Areas of strength:

- academic appointment of an Assessment Officer from 2008 onwards
- established assessment policies and plans for standard-setting and determination of grades
- assessment based on internationally recognised and validated approaches
- clear links between assessment and the integrated and thematic structure of the curriculum
- well established plans for the use of formative assessment in Years 1 and 2
- clear provision of information about assessment to the students
- proposal to benchmark with at least one other medical school.

Areas that will require consideration and development include:

- ensuring a mechanism for review of the assessment process and consideration of any school-level appeal which is independent of any Assessment Committee member
- broadening of those personnel trained in, and involved with, assessment writing and marking to include more adjunct staff
- ensuring that the assessment process tests a broad range of student skills, including clinical reasoning and interpretation of information
- further development of the assessment policy and practices and resourcing for Years 3 and 4, paying particular attention to the issue of achieving consistency of assessment across teaching sites.

6. The Curriculum – Monitoring and Evaluation

Areas of strength:

- plans for the longitudinal study of graduate outcomes
- clear plan for evaluation and ongoing monitoring of staff teaching performance and student progress
- identification and appointment of an academic with responsibility for evaluation
- plans for dissemination of evaluation findings to students to ensure that they understand the outcomes of their feedback
- inclusion of UTS in evaluation processes
• well developed process for curriculum review already in place with widespread engagement.

Areas that will require consideration and development include:
• consideration of mechanisms to achieve on the Evaluation Committee a majority of members with a perspective independent of other major committees
• clarification of priorities for evaluation of specific aspects of the course and teachers
• consideration of the likely need for further administrative support for evaluation
• pursuing the proposed criterion-referenced approach to teaching evaluation scores, in preference to the present percentile-based approach favoured by the University
• development of a more explicit statement of the mechanisms for feedback from the Evaluation Committee to the committees responsible for implementation of the curriculum.

7. Implementing the Curriculum – Students

Areas of strength:
• limitation of student numbers to a maximum cohort size of 120, matching the facilities of the School
• clearly stated and justifiable admission and selection process
• extensive pastoral care support within the Catholic framework of the School and University
• proposal for wide student representation on committees.

Areas that will require consideration and development include:
• provision of easier access to external counselling services, particularly for students of varying cultural or religious backgrounds
• development of affirmative action processes to support recruitment of, and successful course completion by, Indigenous students
• consideration of the division of responsibilities for remediation of poorly performing students.

8. Implementing the Curriculum – Educational Resources

Areas of strength:
• access to UTS facilities for Years 1 & 2
• purpose built Medical School facilities at Darlinghurst, on target for completion
• excellent information technology infrastructure, reliability, performance and staff expertise
• extensive educational resources, with an emphasis on electronic access to learning materials and web-based learning, and purpose built library facilities at Darlinghurst
• significant utilisation of private hospitals, and specialist and general practices for clinical educational experiences.
Areas that will require consideration and development include:

- ensuring that hand washing facilities in the UTS practical laboratories meet infection control requirements and promote best practice in hand washing protocols
- ensuring that interested universities are actively engaged in a shared understanding and transparent negotiations regarding the UNDA clinical model in private and public health services
- pursuing further negotiation and conclusion of agreements with key universities and health services regarding details of student placements, including sharing of facilities and proposed payments to clinical teachers
- exploration of the broader implications of the School’s plans on the availability of clinical teachers.

9. Continuous Renewal

Areas of strength:

- clear structural processes to link evaluation with continuous renewal of student selection processes, course content, teaching processes, learning resources and assessment
- provision for continuous and comprehensive review of the learning objectives within the curriculum.

Areas that will require consideration and development include:

- development of succession planning outside the main Sydney School, particularly in relation to senior staffing to safeguard future leadership and key academic positions.
Executive Summary 2009

Following the recommendations of the original 2007 Australian Medical Council (AMC) Assessment Team, a team visited The University of Notre Dame Australia (UNDA) School of Medicine Sydney from 4 to 7 May 2009, with a brief to review the detailed plans for Years 3 and 4, and the implementation of the first two years of the course. The Team visited the Medical School in Darlinghurst, the Clinical Schools based in metropolitan Sydney and the Mercy-Werribee site in outer Melbourne, and the rural Clinical Sub-School based at St John of God in Ballarat. At most sites, the Team met with staff, students and clinicians. This Report presents the Team’s findings against the AMC Standards.

The Team congratulates School of Medicine, Sydney on its successful implementation of Years 1 and 2 of the program. At the time of the Team’s visit, the first cohort was part way through Semester 3. The Team met with a large number of students who were very supportive of the program. Development of Years 3 and 4 is under way, with many clinical teachers having been identified and demonstrating enthusiasm. However the Team considered that the early appointment of the proposed Discipline Leaders, both in the Medical School itself and in the various Clinical Schools, is essential for detailed planning and a smooth rollout of Year 3 in 2010. The Team had considerable concerns about the limited progress on learning objectives and a coherent framework across clinical sites to ensure successful outcomes for students during their clinical attachments. There were additional concerns about student placements in the Rural Clinical School.

The AMC Team was impressed with a number of aspects of the Notre Dame School of Medicine Sydney including:

- A well defined mission statement that has been disseminated and understood by key stakeholders.
- A high degree of autonomy that has facilitated the development and implementation of the new course, which is a distributed model.
- The clear lines of responsibility and authority for the curriculum and its resourcing.
- The strength of leadership from the Dean, which has been pivotal to the successful implementation of Years 1 and 2.
- The constructive partnerships with the Department of Human Services Victoria and Institute of Medical Education and Training (IMET) New South Wales (NSW), and improvement in the relationships with other NSW and Victorian universities.
- The recognition of the unique challenges faced by the Indigenous health sector and development of effective relationships in this sector locally and nationally, with a high calibre consultative committee and appropriately qualified staff in place.
- The engagement with the Cerebral Policy Institute and the Cunningham Centre for Palliative Care and a planned research pathway for students.
- The achievement of delivery of the first two years of the program in a manner that has been well received by the first two years of students.
- The high-quality basic science teaching at University of Technology Sydney (UTS), with staff showing a willingness to pursue continual evaluation and renewal of materials to better reflect the learning outcomes and overall structure of Years 1 and 2.
- The excellent provision of information and resources for students and staff via the School website.
The effective methods of evaluation of staff teaching performance and course materials in Years 1 and 2, with evidence of rapid response to students’ serious concerns.

The effective methods of monitoring student progress, particularly via the innovative Individual Patient Encounter database.

The student representation on committees.

The excellent quality of the purpose built facilities at the Darlinghurst campus.

The successful negotiations with the proposed sites for clinical teaching in Years 3 and 4 and co-located medical schools.

The AMC Team identified a number of areas (including some identified in 2007) for consideration by the University and for further reporting in periodic reports to the AMC.

Previously noted in 2007

- Further attention to the administrative staffing plan, which requires adjustment to manage the increasing workload, particularly in support for assessment and evaluation.
- The review and monitoring of the academic staffing plan, particularly the urgent appointment of discipline leaders to oversee the detailed planning of the Year 3 clinical placements.
- The further progression of the partnership approach to Indigenous health.
- The further development of the research program and capacity, particularly for School of Medicine staff, with consideration of developing collaborations with science staff at University of Technology Sydney (UTS).
- The completion of the commitment to clarify the overarching terms in the statement of graduate attributes, particularly the word ‘dutiful’.
- The clarification of the process of delivery of clinical teaching, and the provision of detailed information to all clinical teachers.
- Ensuring a mechanism for review of the assessment process and consideration of any school-level appeal which is independent of any Assessment Committee member, including the Dean.
- The further development of the assessment policy and practices for Years 3 and 4, paying particular attention to the issue of achieving consistency of assessment across teaching sites.
- The consideration of the likely need for further administrative support for evaluation; although it is noted that a half-time administrative assistant is in place, it should be anticipated that full-time support will be required once Years 3 and 4 have been rolled out.
- The development of more effective affirmative action processes to support recruitment of, and successful course completion by, Indigenous students; there is an urgent need for implementation of alternative entry pathways, and mechanisms to effectively identify and recruit Indigenous students.
- The clarification of the responsibilities for remediation of poorly performing students.

Additional areas from 2009

- The urgent progression of the proposed appointments of discipline leaders, with clear reporting and communication lines and a starting date of July 2009, to ensure that the clinical placements for Year 3 have a consistent overall approach and that student
experiences at the various sites are equally likely to meet the learning objectives of Years 3 and 4.

- With the completion of the current Dean’s term, ensuring that there is continuity in leadership to ensure the ongoing successful development and delivery of the program.
- The improvement to the new governance and management structure, to ensure clear reporting lines and areas of responsibility.
- The review of the committee structure to ensure its appropriateness for the development of Years 3 and 4.
- Ensuring that staff, as outlined in the forward staffing plan, are appointed in a timely manner in all three clinical schools and sub-schools, mindful of the need for succession planning.
- As a matter of urgency, improving the Terms of Reference and defining the reporting relationships for individual staff and School of Medicine Sydney (SoMS) committees.
- The clear definition and communication of the responsibilities of hospital and community practitioners for Years 3 and 4.
- The development of a tripartite agreement between Notre Dame, Deakin University and the University of Melbourne with reference to student clinical placements and sharing of resources.
- The completion of the learning objectives for the clinical phase of the program, as a matter of urgency, in collaboration with discipline heads and discipline leaders.
- The dissemination of the learning objectives and anticipated outcomes to all clinical teachers within the clinical schools as soon as possible.
- The engagement of UTS staff, as a matter of priority, in the review of the Years 1 and 2 curriculum content.
- Clarity about the alignment of the rural components/themes in Years 1 and 2 and the Rural Clinical School curriculum objectives.
- The review of proposed clinical placements to ensure a satisfactory breadth of clinical exposure to enable all students to meet the learning objectives.
- The review of the processes for developing and evaluating teaching skills amongst those contributing to clinical placements.
- The review of the Year 4 placement ‘Anaesthetics’ to ensure that the learning objectives and the time commitment are congruent.
- The review of the clinical contact hours during the primary care placement in Year 3 and specification of a consistent minimum expectation.
- The urgent attention to the need for better communication of the detailed planning of clinical placements both within and between sites. The early appointment of discipline leaders, both in the central Medical School and in the various Clinical Schools, would assist this process.
- Effective mechanisms to facilitate development of teaching and assessment skills of clinical teachers.
- The formal review of the reliability of the eight-station Multi-Station Assessment Task (MSAT).
- The clarification of the evaluation process for clinical staff and provision of information to staff in the Clinical Schools.
- The clarification of the support structures for students in the clinical sites, particularly those based at sites that are geographically separated from the Darlinghurst School.
• The removal of the applicant’s religion from the student application form, as agreed in 2007.
• A greater exposure to Indigenous health settings for clinical teaching.
• More detailed planning of the clinical teaching program to be rolled out in 2010 at the Werribee Mercy site.
• The clear identification of opportunities for selectives in Year 4.
• The clear definition and alignment between the sub-school components of the Rural Clinical School.
• The additional detail on requirements for the preparation for internship program.
Executive Summary 2010

The AMC’s *Assessment and Accreditation of Medical Schools: Standards and Procedures* describe the procedures by which an institution may seek assessment of a proposal to establish a new medical program. This involves an assessment of plans before the program is introduced, and subsequent follow-up assessment if required. In 2005, the AMC assessed and accredited plans for the introduction of a four-year, graduate-entry medical program at the University of Notre Dame Australia (UNDA), Fremantle. In 2007, the AMC then considered plans for the four-year, graduate-entry medical program to be offered by the University’s School of Medicine, Sydney. As students graduating from these two programs receive different qualifications, and the programs are managed and run as distinct academic programs, the AMC has assessed and accredited the two programs separately.

The AMC requires institutions establishing a new program to present the following for the first accreditation assessment:

- the full course outline with details for at least the first two years;
- details of the financial, physical and staff resources available to design and implement all years of the course, and to support the course when fully established; and
- an institutional assessment of strengths and weaknesses.

The 2007 assessment resulted in the AMC accrediting the medical program being established at School of Medicine, Sydney, for the maximum possible period, being until two cohorts have graduated (2013). At this time, the AMC considered the School had good structures and clear plans to support the medical program implementation. As the University chose to present the detailed curriculum plans for the medical program in stages, the AMC completed a follow-up assessment in 2009 to consider the development of plans for years 3 and 4 of the medical program, which were to be implemented from 2010. This assessment noted the successes in establishing the Medical School and implementing the early years of the medical course at the Sydney campus. It also raised concerns about the progress towards implementing Years 3 and 4, and the organisation of the resources necessary to make this phase a success. The AMC decided to complete a further assessment in 2010.

The 2010 AMC Team visited the School and clinical teaching sites in April. Shortly after the visit, the University advised that the Dean of the School had resigned. Because of the importance of School leadership in this busy implementation phase, particularly in a School that had made a limited number of appointments to leadership positions, the AMC concluded that it was not able to complete its assessment of the program and would need to review the program implementation in the changed circumstances. An AMC Team completed this assessment in October 2010 and reported to the AMC Medical School Accreditation Committee at meetings on 26 October and 4 November 2010. The Committee considered the draft report of the 2010 assessments and made recommendations on accreditation within the options described in the AMC accreditation procedures.

This report presents the Committee’s recommendation on accreditation as endorsed by the AMC Directors and the detailed findings against the AMC accreditation standards.

Decision on Accreditation

Under the *Health Practitioner Regulation National Law Act 2009*, the AMC may grant accreditation if it is reasonably satisfied that a program of study, and the education provider
that provides it, meet an approved accreditation standard. It may also grant accreditation if it
is reasonably satisfied the provider and program of study substantially meet an approved
accreditation standard, and the imposition of conditions on the approval will ensure the
program meets the standard within a reasonable time. Having made a decision, the AMC
reports its accreditation decision to the Medical Board of Australia to enable the Board to
make a decision on the approval of the program of study for registration purposes.

The AMC’s finding is that the University of Notre Dame Australia, School of Medicine
Sydney medical program substantially meets the accreditation standards. Since April 2010,
there has been concerted attention to ensure the School can deliver all years of the program in
2011. However, further change in School leadership will occur early in 2011, and appropriate
senior academic leadership able to manage the delivery of the medical program at a level
consistent with AMC standards remains a challenge. The School is also yet to resolve some
key issues concerning curriculum delivery and review, assessment and clinical training.

The AMC Guidelines, Assessment and Accreditation of Medical Schools: Standards and
Procedures outline the procedures the AMC follows a medical school’s progress is
unsatisfactory. If the Medical School Accreditation Committee finds progress required on
accreditation conditions is not being achieved or is unlikely to be achieved, the AMC
Directors may:

- place further conditions on the accreditation. The Directors could specify actions to be
taken or issues to be addressed by the medical school and/or further restrict the period of
accreditation; or
- withdraw accreditation from the medical school, if it considers that the school is unable
to deliver the medical course at a standard or in a manner compatible with the
accreditation guidelines. In this case, the AMC will work with the
medical school to facilitate arrangements for the enrolled students to complete an accredited medical
course.

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

- That the period of accreditation of the Bachelor of Medicine, Bachelor of Surgery course
  of School of Medicine Sydney, University of Notre Dame Australia be changed to expire
  on 31 December 2011;
- (ii) That this period of accreditation be subject to satisfactory progress reports from the
  School as follows:
  - By 1 December 2010, evidence that clinical placement and clinical tutors for all
    MED3000 and MED4000 students have been confirmed (Standard 8.3).
  - By 1 February 2011, evidence of academic leadership with sufficient autonomy and
capacity to deliver the medical program—either a new Dean or alternative effective
leadership, supported by effective senior clinical leaders (Standard 1.2).
  - By the commencement of the 2011 academic year:
    - development of placement-specific objectives for Year 4 selectives and
      establishment of processes to identify and address overlap in students’
      MED3000 and MED4000 experience; (Standard 3.5)
    - evidence that the School has provided the assessment requirements for
      MED3000 to students and MED4000 to students by the start of the 2011
      academic year; Standard 5.1)
- evidence that the assessment methods and timing of assessment of clinical competencies are appropriate for MED3000 and MED4000; (Standard 5.2)
- evidence that facilities at Werribee Mercy Hospital are sufficient for the delivery of MED3000 and MED4000 in 2011 (Standard 8.1).
- By 29 April 2011, a report on the School’s response to accreditation standards concerning governance and staffing (1.1, 1.3, 1.4, 1.5, 1.6, 1.8, 1.9), curriculum (3.2, 3.3), students (7.3), and educational resources (8.2; 8.3).
- By 1 August 2011, evidence that clinical placement plans for 2012 will enable students to meet course objectives (Standard 8.3).
- That the AMC conduct a follow-up review in May 2011 in order to determine if the School has successfully implemented the full course and if it can continue to sustain delivery of the program at a level compatible with AMC standards. This assessment will be the basis for the Medical School Accreditation Committee’s recommendation to the AMC Directors on the continuing accreditation of the program and institution beyond December 2011.

Overview of findings

The findings against the AMC accreditation standards are summarised below.

<table>
<thead>
<tr>
<th>1. Context (Governance, autonomy, course management, educational expertise, budget, health sector, research context, staff)</th>
<th>Substantially meets the standards.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Areas of strength</strong></td>
<td>Standards 1.7 and 1.10 are met</td>
</tr>
<tr>
<td>• The appointment of an external accreditation advisory group to assist the School to respond to AMC accreditation standards</td>
<td></td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td>Standard 1.1 is substantially met.</td>
</tr>
<tr>
<td>• Consider how Heads of Discipline, the Curriculum Management Committee, and Heads of Sub-Schools respectively address any identified issues in curricular delivery (Standard 1.1)</td>
<td>The AMC requires evidence of processes to address issues of variation in curriculum delivery and student experience across the School’s dispersed clinical sites (by April 2011)</td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td>Standard 1.2 is NOT MET but can be addressed by evidence of academic leadership with sufficient autonomy and capacity to deliver the medical program, either a new Dean in post by 1 February 2011 or alternative effective leadership, supported by effective senior clinical leaders (see also Standard 1.8)</td>
</tr>
<tr>
<td>• Ensure effective academic leadership of the medical program with clear responsibility for the educational program and sufficient autonomy to direct resources (Standards 1.2 and 1.5)</td>
<td></td>
</tr>
</tbody>
</table>
### Areas for improvement

<table>
<thead>
<tr>
<th>Areas for improvement</th>
<th>Standard Met</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure the Curriculum Management Committee has an executive rather than advisory role in curriculum evaluation, review and development; determining curricular content; and ensuring broad congruence of learning opportunities across all learning environments (Standard 1.3)</td>
<td>Standard 1.3 is substantially met. The AMC requires evidence that the Curriculum Management Committee has the responsibility, authority and capacity to review and develop the curriculum (by April 2011)</td>
</tr>
<tr>
<td>Develop a risk management plan to address the significant risk posed by the School’s dependence on a small number of staff with specific expertise in medical education, all currently based in Sydney (Standard 1.4)</td>
<td>Standard 1.4 is substantially met. The AMC requires evidence that the School has a plan enabling access to sufficient educational expertise for developing and managing the medical program at a level consistent with AMC standards (by April 2011)</td>
</tr>
<tr>
<td>Clarify the financial sustainability of School of Medicine, Sydney (Standard 1.5)</td>
<td>Standard 1.5 is substantially met. The AMC requires evidence of ongoing autonomy for budget and resource allocation to allow the objectives of the medical program to be achieved (by April 2011)</td>
</tr>
<tr>
<td>Further communicate with health services concerning specific teaching plans at each site and the School’s expectations of clinicians (Standard 1.6)</td>
<td>Standard 1.6 is substantially met. The AMC requires evidence in the form of written agreements showing that the uncertainties of some health services concerning Notre Dame teaching requirements have been addressed, and that the School has consolidated relationships with key rural sites (by April 2011)</td>
</tr>
</tbody>
</table>
## Areas for improvement

- Fill the remaining vacant Discipline Head and Discipline Clinical Leader positions (Standard 1.8)
- Review the governance structure and develop a risk management plan to address the significant risk posed by the School’s dependence on a very small number of senior clinical staff (Standard 1.8)

**Standard 1.8 is NOT MET but can be addressed by the development of a senior staffing risk management plan following a review of the appropriateness of the governance structure for the School’s dispersed teaching model. The AMC needs assurance that the governance structure will provide sufficient academic staff and senior leaders to support this model during the AMC accreditation period (by April 2011). (See also Standard 1.2)**

## Areas for improvement

- Ensure teaching development is available onsite for both sessional academic staff and other clinical teachers at the Melbourne and Rural Clinical Schools (Standard 1.9)

**Standard 1.9 is substantially met.**

The AMC requires evidence of processes for development of clinical teachers at all the clinical schools (by April 2011)

## 2. Outcomes of the medical program

Meets the standards.

## 3. Curriculum (framework, structure, content, duration, integration, research, choices, continuum)

Substantially meets the standards.

### Areas of strength

- Implementation of Years 1 and 2 (MED1000 and MED2000) has been successful.
- Student experience of MED3000 has been largely positive.

### Areas for improvement

- Complete the curriculum map for MED3000 and MED4000 and make accessible to all staff and students (Standard 3.1)
- Review the contribution of the Population and Public Health domain to MED3000 and MED4000 to ensure continuing development of skills relevant to research (Standard 3.4)

**Standards 3.1, 3.4 and 3.6 are met.**
<table>
<thead>
<tr>
<th>Areas for improvement</th>
<th>Standard 3.2 is substantially met.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establish formal communication systems between Discipline Heads and Clinical Discipline Leaders to ensure course objectives are consistently implemented across all clinical teaching sites (Standard 3.2)</td>
<td>The AMC requires evidence that irrespective of clinical placements, students are achieving similar learning competencies in each core clinical discipline (by April 2011)</td>
</tr>
<tr>
<td>Areas for improvement</td>
<td>Standard 3.3 is substantially met.</td>
</tr>
<tr>
<td>Review the integration of clinical knowledge (largely delivered through the full-year, whole-class program of back-to-base topics) and the rotating clinical experiences, making clearer the relative importance of components, such as by emphasis in assessment (Standard 3.3)</td>
<td>The AMC requires evidence of appropriate integration of the clinical rotation and formal teaching components in the clinical years (by April 2011)</td>
</tr>
<tr>
<td>Areas for improvement</td>
<td>Standard 3.5 is NOT MET but can be addressed by developing placement-specific objectives for Year 4 selectives and establishing processes to identify and address overlap in students’ MED3000 and MED4000 experience (by the start of the 2011 academic year)</td>
</tr>
<tr>
<td>As a matter of priority, define placement-specific objectives and relevant assessment processes for the MED4000 selectives (Standard 3.5)</td>
<td></td>
</tr>
</tbody>
</table>

4. Teaching and learning

Meets the standards.

Areas of strength

- The varied and comprehensive initial exposure to clinical medicine available to MED3000 students

Areas for improvement

- Review the utility and feasibility of the Individual Patient Encounter Database for students and course development (Standard 4.1)
<table>
<thead>
<tr>
<th>5. Assessment</th>
<th>Substantially meets the standards.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Areas of strength</strong></td>
<td>Standards 5.3 and 5.4 are met</td>
</tr>
<tr>
<td>• Benchmarking various assessment components against those of other institutions</td>
<td></td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td></td>
</tr>
<tr>
<td>• Report in 2011 on implementing the MED3000 assessments including:</td>
<td></td>
</tr>
<tr>
<td>• evaluating the learning impact of the various assessment methods used in Year 3 at the end of 2010</td>
<td></td>
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<tr>
<td>• the standard-setting methodology for summative written and clinical exam</td>
<td></td>
</tr>
<tr>
<td>• processes used to ensure assessment standards and processes across teaching sites (including examiner training) are the same and the success of these processes after the experience of 2010</td>
<td></td>
</tr>
<tr>
<td>• implications of this review for assessments in MED4000 (AMC standard 5.4)</td>
<td></td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td>Standard 5.1 is substantially met.</td>
</tr>
<tr>
<td>• Finalise and document plans for the end-of-year MED3000 summative assessment in 2010 (Standard 5.1)</td>
<td>The AMC requires evidence that the School has provided the assessment requirements for MED3000 to students (now) and MED4000 to students (by the start of the 2011 academic year)</td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td>Standard 5.2 is NOT MET but can be addressed by evidence that the methods for and timing of assessment of clinical competencies are appropriate for MED3000 and MED4000 (by the start of the 2011 academic year)</td>
</tr>
<tr>
<td>• Establish a robust process across MED3000 and MED4000 for assessment of clinical competencies during the year to better inform students and staff of emergent learning difficulties (Standard 5.2)</td>
<td></td>
</tr>
<tr>
<td>6. Monitoring and evaluation</td>
<td>Substantially meets the standards.</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td>Still substantially meets the standards.</td>
</tr>
<tr>
<td>- Include feedback from MED3000 in the review of MED1000 and MED2000 (Standard 6.1)</td>
<td>Standards 6.2, 6.3 and 6.4 are met</td>
</tr>
<tr>
<td>- Review formally whether a broad commonality of learning experiences has been achieved across all clinical learning sites and processes to address issues arising (Standard 6.1)</td>
<td>Standard 6.1 is NOT MET but can be addressed by evidence that teacher and student feedback from the clinical years is being systematically sought, analysed and used as part of the monitoring process</td>
</tr>
<tr>
<td>- Ensure high-quality clinical teaching is provided across the School’s widely dispersed sites, implement processes to review the teaching of adjunct clinical teachers and support them in their professional development as teachers to (Standard 1.6 and 6.1)</td>
<td></td>
</tr>
<tr>
<td>- Formalise plans for the overall medical program evaluation (Standard 6.1 and 6.2)</td>
<td></td>
</tr>
<tr>
<td>7. Students (intake, admission, support, representation)</td>
<td>Substantially meets the standards.</td>
</tr>
<tr>
<td><strong>Areas of strength</strong></td>
<td>Still substantially meets the standards.</td>
</tr>
<tr>
<td>- New pathways to support the admission of Indigenous students and students of rural origin</td>
<td>Standards 7.1, 7.2, 7.4 and 7.5 are met</td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td>Standard 7.3 is substantially met.</td>
</tr>
<tr>
<td>- Provide student support services in Melbourne and the Rural Clinical School (Standard 7.3)</td>
<td>The AMC requires evidence that the School is able to identify students in MED3000 and MED4000 who need additional academic support and that it responds to these needs in a timely and appropriate manner (by April 2011)</td>
</tr>
<tr>
<td>8. Resources</td>
<td>Substantially meets the standards.</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Areas of strength</strong></td>
<td></td>
</tr>
<tr>
<td>• The facilities at the School’s Darlinghurst and Broadway Sydney sites</td>
<td></td>
</tr>
<tr>
<td>• The School’s extensive plans for capital development to support its distributed students and staff, which should largely be in place by the end of 2011</td>
<td></td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td></td>
</tr>
<tr>
<td>• Seek student and staff feedback on the appropriateness and adequacy of the physical facilities across the School’s sites during the present transitional period (Standard 8.1)</td>
<td></td>
</tr>
<tr>
<td><strong>Standard 8.1</strong> is substantially met.</td>
<td></td>
</tr>
<tr>
<td>The AMC requires evidence that the facilities at Werribee are sufficient to deliver MED3000 and MED4000 in 2011 (by the start of the 2011 academic year) and that plans for capital development at clinical teaching sites progress to ensure continued adequate delivery of the curriculum (in annual reports)</td>
<td></td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td></td>
</tr>
<tr>
<td>• Review and enhance library resources available to students at sub-school clinical teaching sites to support broader and deeper student learning (Standard 8.2)</td>
<td></td>
</tr>
<tr>
<td><strong>Standard 8.2</strong> is substantially met.</td>
<td></td>
</tr>
<tr>
<td>The AMC requires evidence that library facilities available to staff and students at clinical sites are adequate to meet curriculum and research needs (by April 2011)</td>
<td></td>
</tr>
<tr>
<td><strong>Areas for improvement</strong></td>
<td></td>
</tr>
<tr>
<td>• Review availability of support for clinical teaching in settings largely supported by VMO staff (Standard 8.3)</td>
<td></td>
</tr>
<tr>
<td>• Formalise and document arrangements for use of clinical teaching facilities, working with other medical schools in circumstances where UNDA shares sites, with a process of regular review to ensure that placement plans are sustainable (Standard 8.3)</td>
<td></td>
</tr>
<tr>
<td>• Finalise development plans for the Rural Clinical School for a 2012 intake by June 2011 (Standard 8.3)</td>
<td></td>
</tr>
<tr>
<td><strong>Standard 8.3</strong> is substantially met.</td>
<td></td>
</tr>
<tr>
<td>The AMC requires evidence:</td>
<td></td>
</tr>
<tr>
<td>• that clinical placements and clinical tutors for all MED3000 and MED4000 students have been confirmed (by 1 December 2010)</td>
<td></td>
</tr>
<tr>
<td>• that clinical placement plans for 2012 will enable students to meet course objectives (August 2011)</td>
<td></td>
</tr>
<tr>
<td>• that the School is actively engaged with relevant institutions including other medical schools whose activities may impact on the delivery of the curriculum (by April 2011)</td>
<td></td>
</tr>
</tbody>
</table>
Appendix Three Groups Met by the 2007, 2009, 2010 and 2011 AMC Assessment Teams

Medical School Executive Staff:
Associate Dean (Melbourne)
Associate Dean (Rural)
Associate Dean (Sydney)
Associate Dean, Teaching and Learning
Chief Financial Officer, University Notre Dame Australia (teleconference)
Dean, School of Medicine Fremantle
Dean, School of Medicine Sydney
Dean, School of Philosophy and Theology
Deputy Vice-Chancellor Sydney Campus
Director of Medical Education
Executive Dean
General Practice Placement Clinicians
Executive Officer, School of Medicine Sydney
Financial Advisor to the Chancellor (Perth) (teleconference)
Head of Medical Education Unit
Head of PPH and Head of Student Matters
Pro Vice Chancellor, Strategy and Planning (Sydney) (teleconference)
Vice-Chancellor

Medical School Committees and Groups:
Assessment Committee
Basic and Clinical Sciences Domain Committee
Clinical Years’ Committee
Communication and Clinical Skills Domain Committee
Curriculum Management Committee
Evaluation Committee
Medical Education Unit
Personal and Professional Development Domain Committee
Population and Public Health Domain Committee
Research Committee
Selection Committee

Medical School Staff and Students:
Campus Minister and Head of the Campus Life Office
Clinical Dean Western Health
Clinical Director Bethlehem
Domain Chair, Basic and Clinical Sciences
Domain Chair, Communication and Clinical Skills
Domain Chair, Personal and Professional Development
Domain Chair, Population and Public Health
Medical School Staff and Students cont.:

Head of Aboriginal and Torres Strait Islander Development
Head of Assessment
Head of Auburn Sub-School
Head of Ballarat Sub-School
Head of Evaluation
Head of Hawkesbury Sub-School
Head of Indigenous and Rural Health Unit
Head of IT
Head of Lithgow Sub-School
Head of Melbourne Sub-School and Years 3 and 4 Academic Coordinator (same person)
Head of Research
Head of Selection
Head of Student Matters
Head of Sunshine Hospital Sub-School
Head of SVMH Sub-School
Head of Teaching and Learning
Head of Wagga Wagga Sub-School
Head of Werribee Mercy Sub-School
Head Prospective Students Office
Head, Indigenous Health
Heads of Disciplines
Library staff
MANDUS Student Executive Sydney
Medical students

Rural Student Coordinators / Administrative Officers Ballarat, Lithgow and Wagga Wagga (videoconference)

Senior Lecturer in Medical Education
Senior Medical Administrative staff
Year 1 and 2 teaching staff
Year 1 Coordinator
Year 2 Coordinator
Year 4 Academic Coordinator & Discipline Leader General Practice (same person)

Health Facilities and Health Sector

Auburn Hospital:

Clinical teaching staff
Director Medical Services
Hospital Coordinator
Senior staff
Calvary Hospital
Chief Executive Officer
Clinical teaching staff
Senior staff

Calvary Health Care Sydney:

Chief Executive Officer
National Chief Executive Officer
Children’s Hospital Randwick
Chief Executive Officer
Clinical teaching staff

133
Douglass Hanly Moir Pathology Staff:
Director of Histopathology - DHM
Medical Director and Director of Cytopathology - DHM
Senior DHM staff

General Practitioners:
Chief Executive Officer, Eastern Division of General Practice
Chief Executive Officer, Hobsons Bay/Western Division of General Practice
Chief Executive Officer, Westgate Division of General Practice
General Practitioners, Central Sydney General Practice Network
General Practitioners, Eastern Division of General Practice
General Practitioners, Hawkesbury Hills Division of General Practice
Treasurer and other Divisional members, Westgate Division of General Practice

Lithgow Hospital:
Discipline Leaders and clinical teaching staff

Mater Hospital:
Discipline Leaders and clinical teaching staff
Executive Director
Notre Dame Mater Hospital Coordinator
Senior staff

St Vincent’s Hospital:
Chief Executive Officer
Discipline Leaders and clinical teaching staff
Executive Director
Senior staff

St John of God Hospital Ballarat:
Chief Executive Officer
Discipline Leaders and clinical teaching staff
Senior staff

St Joseph’s Hospital:
Executive Director
Senior staff

Sunshine Hospital:
Chief Executive Officer
Clinical Discipline Leaders
Executive Medical Director, Western Health
Consultant at Emergency Department
Wagga Wagga Base Hospital
Rural Sub-School Heads of Disciplines and Senior Discipline Leaders Wagga Wagga (videoconference)
Senior staff, Wagga Wagga Base Hospital

Werribee Mercy Hospital:
Chief Executive Officer
Discipline Leaders and clinical teaching staff
Senior staff
Other:

Associate Director, Workforce Development and Leadership, New South Wales Health

Chief Executive Officer and Director of Nursing, Valley Hospital & South Eastern Hospital

Chief Executive Officer, Sydney West Area Health Service

Chief Executive Officer, Western Health

Clinical teaching staff, Hawkesbury Hospital

Cunningham Centre for Palliative Care and CP Institute

Deputy Director General, New South Wales Health

Director, Institute of Medical Education and Training

Director, Service and Workforce Planning, Victorian Department of Human Services

Executive Director, Medical Services, Greater Southern Area Health Service

New South Wales Health senior staff

Placement Committee Head, Sydney West Area Health Service

Senior staff, Aboriginal Medical Service

Universities:

Associate Professor from School of Engineering & Science, Victoria University

Dean, Faculty of Medicine, The University of New South Wales

Dean, Faculty of Medicine, The University of Sydney

Dean, School of Medicine, The University of Melbourne

Dean, School of Medicine, University of Western Sydney

Deputy Vice Chancellor, Victoria University

Executive and Academic Staff, University of Technology Sydney

Foundation Dean, Faculty of Health and Behavioural Sciences, Deakin University

Head, School of Medicine, Deakin University

Manager, Campus Operations, Australian Catholic University Ballarat