



Australian
Medical Council Limited

**Accreditation of the
University of Tasmania, School of Medicine
MBBS program**

Accreditation Report

2016

Contents

Executive summary 2016	1
Key findings of the AMC's 2016 accreditation assessment of the University of Tasmania, School of Medicine medical program	6
Introduction	13
1 The context of the medical program	17
1.1 Governance.....	17
1.2 Leadership and autonomy.....	21
1.3 Medical program management	22
1.4 Educational expertise.....	24
1.5 Educational budget and resource allocation.....	25
1.6 Interaction with health sector and society	26
1.7 Research and scholarship.....	28
1.8 Staff resources.....	30
1.9 Staff appointment, promotion & development	32
2 The outcomes of the medical program	34
2.1 Purpose.....	34
2.2 Medical program outcomes	36
3 The medical curriculum	39
3.1 Duration of the medical program	39
3.2 The content of the curriculum	40
3.3 Curriculum design	42
3.4 Curriculum description	45
3.5 Indigenous health	46
3.6 Opportunities for choice to promote breadth and diversity.....	47
4 Learning and teaching	49
4.1 Learning and teaching methods.....	49
4.2 Self-directed and lifelong learning.....	51
4.3 Clinical skill development	51
4.4 Increasing degree of independence.....	52
4.5 Role modelling	53
4.6 Patient centred care and collaborative engagement	53
4.7 Interprofessional learning.....	54
5 The curriculum – assessment of student learning	55
5.1 Assessment approach	55
5.2 Assessment methods.....	57
5.3 Assessment feedback	58
5.4 Assessment quality	59
6 The curriculum – monitoring	62

6.1	Monitoring.....	62
6.2	Outcome evaluation	63
6.3	Feedback and reporting	64
7	Implementing the curriculum - students	66
7.1	Student Intake.....	66
7.2	Admission policy and selection.....	68
7.3	Student support.....	70
7.4	Professionalism and fitness to practise	71
7.5	Student representation.....	71
7.6	Student indemnification and insurance	72
8	Implementing the curriculum – learning environment	73
8.1	Physical facilities.....	73
8.2	Information resources and library services	74
8.3	Clinical learning environment	75
8.4	Clinical supervision.....	77
Appendix 1	Membership of the 2016 assessment team.....	80
Appendix 2	Groups met by the 2016 assessment team.....	80

Figures and tables

Figure

Figure 1: Committee Structure	19
-------------------------------------	----

Tables

Table 1: 2016 School of Medicine intake	66
Table 2: Student numbers 2011 – 2015.....	66
Table 3: Attrition figures from 2013 - 2015	67
Table 4: Clinical school allocation, Years 4 and 5	76

Executive summary 2016

The University of Tasmania, School of Medicine is seeking reaccreditation of its medical program. The School offers a five-year Bachelor of Medicine/Bachelor of Surgery (MBBS) program. The medical program has 120 students per cohort, with 75% school leaver and 25% graduate or transfer students.

Years 1 and 2 are predominantly medical science-based with introductory clinical skills, Year 3 blends an academic program with ward-based practice, and Years 4 and 5 include clinical attachments and scheduled teaching. The program comprises four domains: Science and Scholarship, Clinical Practice, Health and Society, and Professionalism and Leadership. Years 1 to 3 are delivered primarily at the Medical Sciences Precinct in Hobart's city centre, and Years 4 and 5 are based at one of three clinical schools in Hobart, Launceston or the Rural Clinical School in the north-west of Tasmania.

Accreditation process

According to the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2015*, accredited medical education providers may seek reaccreditation when their accreditation is due to expire. The accreditation of the University of Tasmania, School of Medicine five-year MBBS program expires on 31 December 2016.

Accreditation is based on the medical program demonstrating that it satisfies the accreditation standards for primary medical education. The provider prepares a submission for reaccreditation. An AMC team assesses the submission and visits the provider and its clinical teaching sites.

An AMC team completed the reaccreditation assessment. It reviewed the School's submission and the Tasmanian University Medical Students' Society report, and visited the School and associated clinical teaching sites in the week of 9 – 13 May 2016.

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

Decision on accreditation

Under the *Health Practitioner Regulation National Law*, the AMC may accredit a medical program if it is reasonably satisfied that the program of study and the education provider that provides it meet the accreditation standards. The AMC may also grant accreditation if the program of study and the education provider substantially meet the accreditation standards, and imposing accreditation conditions will lead to the program meeting the standards within a reasonable time.

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

Reaccreditation of established education providers and programs of study

In accordance with the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2015*, section 5.1, the accreditation options are:

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

The AMC is satisfied that the University of Tasmania, School of Medicine's medical program substantially meets the approved accreditation standards.

The 20 October 2016 meeting of the AMC Directors agreed:

- i. That the five-year Bachelor of Medicine/Bachelor of Surgery (MBBS) medical program of the University of Tasmania, School of Medicine be granted accreditation to **31 March 2023**;
- ii. That accreditation of the program is subject to meeting the monitoring requirements of the AMC, including satisfactory progress reports; and to the following conditions:

2017 conditions:

- Demonstrate that the medical program's revised governance structures and functions are operating in a timely and effective manner and are understood by staff and stakeholders (Standard 1.1.1).
- Define the function of the Assessment Committee showing how it interacts with the Academic Progress Review Committee; and define the Clinical Disciplines Committee's interaction with the Clinical Training Committee (Standard 1.1.1).
- Provide finalised terms of reference and membership for the Clinical Disciplines Committee, Academic Progress Review Committee and the Medicine Stakeholder Engagement Advisory Group (Standard 1.1.2).
- Provide evidence of stakeholder consultation on the program's purpose, curriculum, graduate outcomes and governance via the Medicine Stakeholder Engagement Advisory Group, and the mechanism by which this consultation informs the program (Standard 1.1.3).
- Demonstrate clearly defined arrangements for the academic head of the medical program from 2017 onwards (Standard 1.2).
- Demonstrate that the revised curriculum governance structure is effective, by providing details regarding how curriculum developments are led, consulted on, piloted, ratified, implemented and evaluated (Standard 1.3.1).
- Provide evidence of a formal agreement with the Tasmanian Health Service that proves a partnership to promote medical education and training, addressing the governance framework for management of the relationships in committees and individual roles, and the operational aspects such as clinical placement agreements, conjoint appointments, staff development and conflict resolution processes (Standard 1.6.1).
- Develop an engagement strategy to promote medical education and training in Indigenous health that is informed by Indigenous people (Standard 1.6.2).
- Provide evidence that there are appropriate senior discipline leads to deliver the medical program, specifically in paediatrics, obstetrics and gynaecology, Indigenous health, general practice, professionalism and ethics (Standard 1.8).
- Demonstrate that appointment and promotion policies balance teaching, research and service functions to maintain adequate program delivery (Standard 1.9).
- Include the program's purpose in program communications and materials, such as an overarching program guidebook for students and staff containing the purpose and overall curriculum view (Standard 2.1).

- Provide evidence that AMC Graduate Outcome Statement 4.1 applies within the program (Standard 2.2).
- Demonstrate plans and progress in the alignment of discipline specific curriculum content and assessment across the clinical sites (Standards 2.2 and 3.2).
- Provide evidence of comparable achievement of outcomes across sites in the major clinical disciplines, by comparing results in clinical, written and portfolio assessments (Standard 2.2).
- Develop an overarching curriculum framework that:
 - Demonstrates a mechanism to illustrate improved vertical integration of domain content in the curriculum, and consistent associated unit-level outcomes, such as a curriculum / outcome map (Standard 3.3).
 - Defines the place of case-based learning within the curriculum (Standard 3.3).
 - Develops a framework for the Indigenous health curriculum to ensure students receive a cohesive experience in Indigenous health across the curriculum (Standard 3.5).
- As part of the overarching curriculum framework, embed interprofessional learning in the program's curriculum for all students and allocate appropriate resources to ensure its sustainability (Standard 4.7).
- Provide evidence that the Wilkinson Review recommendations have been addressed, and provide details regarding any changes to the program's assessment philosophy and processes (Standards 5.1 and 5.4).
- Document the formal process used to align learning outcomes to assessments (Standard 5.1).
- Provide details regarding the relationships and functions of the Academic Progress Review Committee, including any criteria and progression rules used in its decision-making process (Standard 5.1).
- Develop assessment blueprints for each year or phase of the program (Standard 5.2.2).
- Implement standard setting models for Years 1 to 3, and evaluate the standard setting methods used in Years 4 and 5 (Standard 5.2.3).
- Provide evidence that information regarding student cohort performance is available for consideration by the relevant year committees and the Tasmanian Medical Program Committee, and that student cohort performance feedback is disseminated to supervisors and teachers (Standard 5.3.3).

- Demonstrate standardised processes to ensure consistency of summative and formative clinical assessments across clinical sites and ongoing quality assurance (Standard 5.4.2).
- Develop and implement a comprehensive program evaluation framework, and show how this links into the governance structure of the medical program (Standard 6.1).
- Formalise a systematic approach to evaluating the performance of cohorts of students and graduates in relation to the outcomes of the medical program (Standard 6.2).
- Formalise the process of making evaluation results available to stakeholders and considering their views in renewal of the program (Standard 6.3).
- Formalise and publicise support processes for recruitment and retention of future Aboriginal and Torres Strait Islander students (Standard 7.2).
- Confirm student representation on the program committees (Standard 7.5).

Key findings of the AMC's 2016 accreditation assessment of the University of Tasmania, School of Medicine medical program

1. The context of the medical program	Substantially met
--	--------------------------

Standards 1.1, 1.2, 1.3, 1.8 and 1.9 are substantially met; Standard 1.6 is not met.

2017 conditions

Demonstrate that the medical program's revised governance structures and functions are operating in a timely and effective manner and are understood by staff and stakeholders (Standard 1.1.1).

Define the function of the Assessment Committee showing how it interacts with the Academic Progress Review Committee; and define the Clinical Disciplines Committee's interaction with the Clinical Training Committee (Standard 1.1.1).

Provide finalised terms of reference and membership for the Clinical Disciplines Committee, Academic Progress Review Committee and the Medicine Stakeholder Engagement Advisory Group (Standard 1.1.2).

Provide evidence of stakeholder consultation on the program's purpose, curriculum, graduate outcomes and governance via the Medicine Stakeholder Engagement Advisory Group, and the mechanism by which this consultation informs the program (Standard 1.1.3).

Demonstrate clearly defined arrangements for the academic head of the medical program from 2017 onwards (Standard 1.2).

Demonstrate that the revised curriculum governance structure is effective, by providing details regarding how curriculum developments are led, consulted on, piloted, ratified, implemented and evaluated (Standard 1.3.1).

Provide evidence of a formal agreement with the Tasmanian Health Service that proves a partnership to promote medical education and training, addressing the governance framework for management of the relationships in committees and individual roles, and the operational aspects such as clinical placement agreements, conjoint appointments, staff development and conflict resolution processes (Standard 1.6.1).

Develop an engagement strategy to promote medical education and training in Indigenous health that is informed by Indigenous people (Standard 1.6.2).

Provide evidence that there are appropriate senior discipline leads to deliver the medical program, specifically in paediatrics, obstetrics and gynaecology, Indigenous health, general practice, professionalism and ethics (Standard 1.8).

Demonstrate that appointment and promotion policies balance teaching, research and service functions to maintain adequate program delivery (Standard 1.9).

Commendations

In the context of significant change, the strong School and program leadership to build academic staff engagement in the program, and the quality of the program across the School and its sites (Standard 1).

The commitment to medical education research demonstrated by key academic staff that informs teaching and learning in the program (Standard 1.7).

Recommendations for improvement

Include Indigenous community representation on the Medicine Stakeholder Engagement Advisory Group (Standard 1.1).

Clarify the process and reporting lines between the Tasmanian Medical Program Committee and the School Learning and Teaching Committee (Standard 1.3).

Clarify the relationship between the Menzies Institute and the medical program, and define a formal agreement regarding the role of Menzies in informing teaching and learning in the medical program (Standard 1.7).

Demonstrate sustained efforts to actively recruit academic and professional Indigenous staff (Standard 1.8).

Ensure psychometric expertise is available to support the assessment processes, given the absence of the Medical Education Unit and the program's dispersed educational expertise (Standard 1.8).

2. The outcomes of the medical program	Substantially met
---	--------------------------

Standard 2.1 is substantially met and Standard 2.2 is not met.

2017 conditions

Include the program's purpose in program communications and materials, such as an overarching program guidebook for students and staff containing the purpose and overall curriculum view (Standard 2.1).

Provide evidence that AMC Graduate Outcome Statement 4.1 applies within the program (Standard 2.2).

Demonstrate plans and progress in the alignment of discipline specific curriculum content and assessment across the clinical sites (Standards 2.2 and 3.2).

Provide evidence of comparable achievement of outcomes across sites in the major clinical disciplines, by comparing results in clinical, written and portfolio assessments (Standard 2.2).

Commendation

The clinicians' enthusiasm for medical student education which emphasises the goal to attract graduates back to their local areas to enhance the local health services (Standard 2.1).

Recommendation for improvement

Identify local strengths, needs and priorities through consultation with stakeholders and reflect these in the program's outcome statements (Standard 2.2).

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

Standards 3.3 and 3.5 are substantially met.

2017 conditions

Develop an overarching curriculum framework that:

- Demonstrates a mechanism to illustrate improved vertical integration of domain content in the curriculum, and consistent associated unit-level outcomes, such as a curriculum / outcome map (Standard 3.3).
- Defines the place of case-based learning within the curriculum (Standard 3.3).
- Develops a framework for the Indigenous health curriculum to ensure students receive a cohesive experience in Indigenous health across the curriculum (Standard 3.5).

Commendation

The breadth of opportunity for students in additional study, international placements, electives and extracurricular activities; and the leadership of these activities within the program (Standard 3.6).

Recommendations for improvement

Strengthen the vertical development of clinical skills in the program in line with the Brazil Review (Standard 3.3).

Confirm the purpose, feasibility and resourcing of the proposed curriculum database, together with the timeline for availability of a curriculum database to staff and students (Standard 3.4).

4. Teaching and learning	Met
---------------------------------	------------

Standard 4.7 is substantially met.

2017 condition

As part of the overarching curriculum framework, embed interprofessional learning in the program’s curriculum for all students and allocate appropriate resources to ensure its sustainability (Standard 4.7).

Commendations

The diversity of learning and teaching methods employed to engage and facilitate students’ learning (Standard 4.1).

The longitudinal Kids and Families Program from Year 1 to 3 and the Years 4 and 5 patient-centred Patient Partner Program (P3) provided at all sites (Standard 4.1).

The School’s positive role modelling of professional behaviours (Standard 4.5).

Recommendations for improvement

Offer refresher tutor training and additional communication to tutors and students in the delivery of CBL, DOCES and other structured learning activities across sites (Standard 4.1).

Advocate for and implement technology-enhanced learning and ensure adequate and appropriate staff and resourcing to support planned initiatives (Standard 4.1 and 1.8).

Improve communication to Years 1 to 3 students about the requirements of the portfolio and the benefits of early engagement for their development as reflective learners (Standard 4.2).

5. The curriculum - assessment of student learning	Substantially met
---	--------------------------

Standards 5.1 to 5.4 are substantially met.

2017 conditions

Provide evidence that the Wilkinson Review recommendations have been addressed, and provide details regarding any changes to the program’s assessment philosophy and processes (Standards 5.1 and 5.4).

Document the formal process used to align learning outcomes to assessments (Standard 5.1).

Provide details regarding the relationships and functions of the Academic Progress Review Committee, including any criteria and progression rules used in its decision-making process (Standard 5.1).

Develop assessment blueprints for each year or phase of the program (Standard 5.2.2).

Implement standard setting models for Years 1 to 3, and evaluate the standard setting methods used in Years 4 and 5 (Standard 5.2.3).

Provide evidence that information regarding student cohort performance is available for consideration by the relevant year committees and the Tasmanian Medical Program Committee, and that student cohort performance feedback is disseminated to supervisors and teachers (Standard 5.3.3).

Demonstrate standardised processes to ensure consistency of summative and formative clinical assessments across clinical sites and ongoing quality assurance (Standard 5.4.2).

Commendation

The comprehensive mechanisms for identification of students in difficulty, and the implementation of well-coordinated and multipronged remediation (Standard 5.3.1).

Recommendation for improvement

Develop a consistent feedback policy for summative and formative assessments (Standard 5.3.2).

6. The curriculum - monitoring	Substantially met
---------------------------------------	--------------------------

Standard 6.1 and 6.3 are substantially met, and Standard 6.2 is not met.

2017 conditions

Develop and implement a comprehensive program evaluation framework, and show how this links into the governance structure of the medical program (Standard 6.1).

Formalise a systematic approach to evaluating the performance of cohorts of students and graduates in relation to the outcomes of the medical program (Standard 6.2).

Formalise the process of making evaluation results available to stakeholders and considering their views in renewal of the program (Standard 6.3).

Commendation

The plans for a systematic approach to evaluation that will monitor the considerable efforts that are going into program and governance development (Standard 6.1).

7. Implementing the curriculum – students	Met
--	------------

Standards 7.2 and 7.5 are substantially met.

2017 conditions

Formalise and publicise support processes for recruitment and retention of future Aboriginal and Torres Strait Islander students (Standard 7.2).

Confirm student representation on the program committees (Standard 7.5).

Commendations

The School's success in increasing the proportion of rural-origin students entering the program (Standard 7.1.2).

The comprehensive set of student supports available, and the functional and effective set of mechanisms for identifying and managing students at risk (Standard 7.3).

The professionalism and fitness to practise policies and procedures that are well-constructed, and are practical and effective in terms of implementation (Standard 7.4).

8. Implementing the curriculum- learning environment	Met
---	------------

All standards are met.

Commendations

The excellent physical facilities available to students and staff at Launceston Clinical School and the Rural Clinical School (Standard 8.1).

The rural clinical placement experiences provided to all students in each year of the program, particularly the longitudinal healthcare experience for 40 Year 4 students at the Rural Clinical School (Standard 8.3).

The strong teaching culture observed across the clinical sites, and the enthusiasm and commitment of the clinical teachers whose contributions are valued by the students (Standard 8.4).

Recommendations for improvement

Delineate a clear mechanism to define space priorities at the Hobart Clinical School (Standard 8.1).

Develop a solution to extend MyLO student access in the clinical years across clinical sites (Standard 8.2).

Consolidate orientation materials and resources provided to clinical teachers across the clinical sites (Standard 8.4).

Strengthen recognition and celebration of clinical teaching contributions (Standard 8.4).

Introduction

The AMC accreditation process

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

The purpose of AMC accreditation is to recognise medical programs that produce graduates competent to practise 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 for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2012* list the graduate outcomes that collectively provide the requirements that students must demonstrate at graduation, define the curriculum in broad outline, and define the educational framework, institutional processes, settings and resources necessary for successful medical education.

The AMC's Medical School Accreditation Committee oversees the AMC process of assessment and accreditation of primary medical education programs and their providers, and reports to AMC Directors. The Committee includes members nominated by the Australian Medical Students' Association, the Confederation of Postgraduate Medical Education Councils, the Committee of Presidents of Medical Colleges, the Medical Council of New Zealand, the Medical Board of Australia, and the Medical Deans of Australia and New Zealand. The Committee also includes a member of the Council, and a member with background in, and knowledge of, health consumer issues.

The AMC appoints an accreditation assessment team to complete a reaccreditation assessment. The medical education provider's accreditation submission forms the basis of the assessment. The medical student society is also invited to make a submission. Following a review of the submissions, the team conducts a visit to the medical education provider and its clinical teaching sites. This visit may take a week. Following the visit, the team prepares a detailed report for the Medical School Accreditation Committee, providing 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, together with a recommendation on accreditation to the AMC Directors. The Directors make the final accreditation decision within the options described in the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council*. The granting of accreditation may be subject to conditions, such as a requirement for follow-up assessments.

The AMC and the Medical Council of New Zealand have a memorandum of understanding that encompasses the joint work between them, including the assessment of medical programs in Australia and New Zealand, to assure the Medical Board of Australia and the

Medical Council of New Zealand that a medical school's program of study satisfies approved standards for primary medical education and for admission to practise in Australia and New Zealand.

After it has accredited a medical program, the AMC seeks regular progress reports to monitor that the provider and its program continue to meet the standards. Accredited medical education providers are required to report any developments relevant to the accreditation standards and to address any conditions on their accreditation and recommendations for improvement made by the AMC. Reports are reviewed by an independent reviewer and by the Medical School Accreditation Committee.

The University, the Faculty and the School

The University of Tasmania was established in 1890 as Australia's fourth university, and is Tasmania's only university. The University employs approximately 1,200 academic and 1,600 professional and technical staff members, and has approximately 33,800 students.

The University organisational structure consists of nine faculties and institutes:

- Faculty of Arts
- Australian Maritime College
- Tasmanian School of Business and Economics
- Faculty of Education
- Faculty of Health
- Faculty of Law
- Institute for Marine and Antarctic Studies
- Menzies Institute for Medical Research
- Faculty of Science, Engineering and Technology

The Faculty of Health was restructured in 2011 and is now comprised of two schools; the School of Medicine and the School of Health Sciences, which together offer 16 undergraduate courses. The Faculty is located at four campuses within Tasmania: Sandy Bay, Hobart, Launceston and Cradle Coast; and two campuses in Sydney, New South Wales (though these are not related to the medical program).

The School of Health Sciences comprises Health Sciences and Community Care, Nursing and Midwifery, and the Centre for Rural Health. The School of Medicine has four divisions: Medicine, Pharmacy, Psychology and Paramedicine. The Division of Medicine delivers the MBBS program. In 2015, the Tasmanian Medical Program celebrated the 50th anniversary of the commencement of its first cohort.

The medical program is a five-year program that takes most students as school leavers. Years 1 and 2 are predominantly medical science based with introductory clinical skills, Year 3 blends an academic program with ward-based practice, and Years 4 and 5 are based across three clinical schools, and include clinical attachments and scheduled teaching. The program is organised on four domains: Science and Scholarship, Clinical Practice, Health and Society, and Professionalism and Leadership. Teaching is spread over 13-week semesters in Years 1 and 2, and extended 18-week semesters in Years 3 to 5.

In 2016, the program has 560 medical students enrolled from Years 1 to 5. In each of the five years of the program, there are approximately 100 domestic Commonwealth supported places, and 20 to 25 international student places. The student society is the Tasmanian University Medical Students Society (TUMSS).

The first three years of the program are delivered primarily at the Medical Sciences Precinct in Hobart's city centre, collocated with the Menzies Research Institute, and adjacent to the Royal Hobart Hospital, and approximately ten minutes' drive from the University of Tasmania main campus.

The final two years of the program are based at the following clinical schools:

- Hobart Clinical School, in the Royal Hobart Hospital precinct
- Launceston Clinical School, in the Launceston General Hospital precinct (200 km north of Hobart)
- Rural Clinical School based at the Northwest Regional Hospital, Burnie (356 km north west) and Mersey Community Hospital (280 km north west).

Accreditation history

The AMC first accredited the University of Tasmania, School of Medicine's six-year school-leaver Bachelor of Medicine / Bachelor of Surgery (MBBS) program in 1991 for five years to 1996. In September 1995, accreditation was extended to ten years until December 2001, subject to the School meeting conditions in the areas of curriculum development, administration and management, and staffing. A follow-up visit was conducted in 1998, and continued reporting was required around curriculum development, consolidation of organisational structures, and maintenance of relationships with the state health department.

In 2001, the AMC conducted a reaccreditation assessment and identified significant concerns for urgent attention in management, curriculum and staffing. The AMC extended the School's accreditation for one year and required detailed and prioritised plans to address the issues identified. The AMC convened the Tasmania Review Group to advise the School on the requirements of the accreditation standards. In 2002 the AMC found that the School had responded positively, and extended accreditation until December 2005.

In 2002 the School of Medicine notified the AMC of its plans to introduce a new five-year medical program and in 2004 the AMC invited the School to proceed to a Stage 2 assessment of the proposed new program. The AMC conducted a major change assessment in 2005, and granted accreditation until 2011, subject to a 2007 follow-up assessment. The six-year MBBS program was also granted accreditation until 31 December 2011 to enable its teach-out.

In 2011 the School submitted a comprehensive report and request for extension of accreditation to the AMC. The AMC accepted the comprehensive report, and extended accreditation until 31 December 2016, subject to reporting. The School's 2013 and 2014 progress reports were accepted.

In November 2014 the School informed the Medical School Accreditation Committee of its intention to transition the MBBS program to a Masters degree from 2017. In 2016, the School advised the MD proposal remained in development with a 2018 or 2019 commencement anticipated.

The AMC began planning the reaccreditation assessment of the five-year MBBS program in 2016. It appointed an accreditation team to complete the assessment. The AMC team reviewed the School's submission and the Tasmanian University Medical Students Society's report, and visited the School and associated clinical teaching sites in the week of 9 – 13 May 2016.

This report

This report details the findings of the 2016 accreditation assessment.

Each section of the accreditation report begins with the relevant AMC accreditation standards.

The members of the 2016 AMC team are at **Appendix 1**.

The groups met by the AMC team in 2016 are at **Appendix 2**.

Appreciation

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

1 The context of the medical program

1.1 Governance

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

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

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

The medical program is operating in a climate of change and this was the overarching theme in its governance. There had been significant recent and ongoing change in the health sector, the University, the Faculty, the School and in the governance of the medical program.

During 2016, the health service is transforming its three regional services into a state-wide service and its relationship with the School was not yet clear. University restructures had led to the Faculty of Health becoming the University's largest faculty, resulting in governance changes in the Faculty and School of Medicine. Staff reprofiling was underway across the University, the School of Medicine had a new head and the Division of Medicine and the medical program's governance had been extensively reviewed. New medical program committees and structures were being implemented during 2016 meaning the program's internal governance structures and functions could not be fully defined at the time of the assessment. As a result of change at all these levels, the linkages between University academic governance, Faculty and School program structures were not always clear to those within the structure or to the team.

At a state level, the School and University operate in the context of the Tasmanian Health Service which was changing from three Tasmanian Health Organisations (South, North and North-West) to a single state service. How the new structure related to the School and University was not yet clear. Health partnerships with the School are discussed at Standard 1.6.

At a university level, the University's Strategic Plan 2012 onwards, *Open to Talent*, had led to substantial restructuring, with the Faculty of Health restructured in 2013. While the University reportedly plans to move to a three super-faculty structure, the Vice Chancellor and Provost indicated that minimal further change was anticipated for the Faculty of Health.

The Faculty of Health comprises the School of Medicine and the School of Health Sciences. The School of Medicine oversees the delivery of programs in its four divisions being

Medicine, Pharmacy, Psychology and Paramedicine. The Division of Medicine delivers the medical program. This report will refer to the education provider as 'the School' unless it is specifically referring to the Division.

The Faculty and School are represented in the University governance in a number of ways. The Head, School of Medicine sits on the University Senate. The Faculty Board which represents its health disciplines reports to the Senate. The School Learning and Teaching (L&T) Committee reports to the Faculty L&T Committee, which in turn reports to the University L&T Committee of which the Faculty L&T chair is a member.

At a faculty level, the Faculty L&T Committee has representatives from each of the two Schools and develops the learning and teaching strategy around technology, simulation, assessment formats, learning methods and student load.

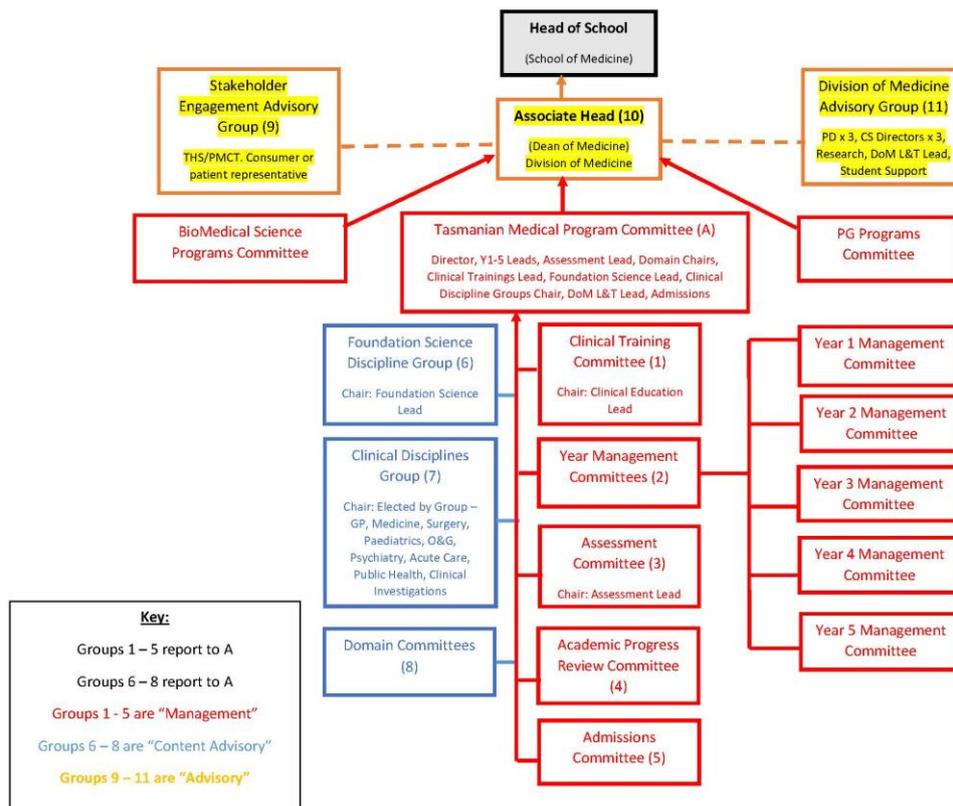
At a school level, the School of Medicine L&T committee is chaired by the Associate Head L&T and has representatives from the medical program and biomedicine. The School L&T Committee was undergoing a process to realign its purpose with the strategic aspirations of the University. It is required to communicate external regulatory processes into the divisions of the School of Medicine.

At a division level, the medical program's governance structures and functions were undergoing substantial change, with a revised structure being implemented from January 2016. Previously, the Division of Medicine Executive Team (DoMET) managed the program. DoMET's sub-committees were the Years 1 to 3 Committee, Years 4 to 5 Committee, and three clinical school management committees.

The new governance structure places the Tasmanian Medical Program Committee (TMPC) as the curriculum committee and successor to DoMET. The Tasmanian Medical Program Committee reports to the Head, Division of Medicine, who in turn reports to the Head, School of Medicine. The TMPC is a strategic and operational group that brings together the clinical school leads, domain and year chairs. It is responsible for the design and delivery of the curriculum, and its terms of reference also encompass admissions, student support and evaluation.

The program's revised committee structure is shown in Figure 1. Reporting to the TMPC are five year committees and four new domain committees (discussed at Standard 1.3), new assessment and progression committees, and new clinical training and discipline committees. The changed assessment structure aims to consolidate assessment processes across the program, and the increased governance around the clinical years intends to better align curriculum and processes state-wide. There is a greater focus on advisory groups, with the new domain groups positioned to improve curriculum integration, and the division and stakeholder advisory groups to facilitate advice and information to and from the program.

Figure 1: Committee Structure



The new Assessment Committee will oversee assessment in the program, its chair will sit on TMPC, and its recommendations will be considered by TMPC. In 2015, the School commissioned a review of assessment in the program and a first task of the Assessment Committee will be consideration of the recommendations of the Wilkinson Review on Assessment. It will consider its assessment philosophy and principles and will evaluate its membership as it evolves (see Standard 5). The Academic Progress Review Committee was also new and will oversee progression in the program. Its terms of reference are yet to be agreed.

The Admissions Committee was already established, and the School advised its terms of reference and membership would be reviewed in 2016. It had not been determined if an Evaluation Committee would be formed, and TMPC was expected to assume this role meanwhile.

The School has clinical schools in Hobart, Launceston and the Rural Clinical School in the North West at Burnie and Devonport. Prior to 2016, each clinical school had its own Clinical Schools Committee. The new Clinical Training Committee replaces these and draws together representatives of the three sites, including clinical school directors, directors of clinical training, chair of the Clinical Disciplines Committee and domain chairs or representatives. Its terms of reference are yet to be ratified. It will be an important new committee with the responsibility for the state-wide delivery of the clinical years' programs to the requirements of the TMPC. It will consider the

recommendations of the School's 2015 Burgess Review of Clinical Schools, which recommended equivalence of opportunity, learning outcomes and alignment of key academic dates across the program.

The Clinical Disciplines Committee is a new group comprised of discipline leads which was yet to define its terms of reference. Some of the discipline/ curriculum leads are not yet identified. The Committee will be both strategic and operational, and aims to engage clinical staff across the state with the curriculum of each discipline. It plans to aid vertical integration, including formalising discipline input across the program and ensuring consistent opportunities at each site in the clinical years. Most of the members of this committee do not have substantive university appointments and therefore a substantial operational role would be difficult to sustain. Its interaction with the Clinical Training Committee is important to define.

There are two new advisory groups that provide advice to the Associate Head, Division of Medicine: the Division of Medicine Advisory Group (DOMAG) and the Medicine Stakeholder Engagement Advisory Group (MSEAG). DOMAG provides strategic and operational advice on the Division's education and research programs, including biomedical science programs, postgraduate programs and the medical program. Its membership includes the three School program directors, the three clinical school directors, and the directors for student support and admissions.

The new Medicine Stakeholder Engagement Advisory Group is similar to the School's previous Accreditation Steering Group, which included members from the Faculty, the medical profession, the state health service, and the community. Its terms of reference were yet to be finalised. The School intends to establish regular meetings and table evaluation data for discussion. The Medicine Stakeholder Engagement Advisory Group's advice will feed into DOMAG. It was noted that the Medicine Stakeholder Engagement Advisory Group did not have an Indigenous community member and this is recommended. The School acknowledged that further effort was required to communicate the new School governance structure to the local medical profession and related organisations.

The new committee structure was early in its evolution at the time of the assessment visit. Many committees were newly formed, with some still yet to meet or confirm their terms of reference. The overlapping roles of many committee members in the new structure will require some discipline for each member to remain aware of their function in a particular committee. The School will need to ensure that the strategic and operational responsibilities of committees are clear, and will need to balance representation and authority for decision making in a timely manner as this structure proceeds. A delineation of where decisions are taken, recommendations are ratified and implementation occurs will be essential as these committees start to work together.

The extent of recent change in the health sector, the University, School and program has been taken into account by the team when considering risks for program delivery. While

the new structure appeared workable and had the support of staff across the clinical sites, domains and disciplines, it was recognised that the change was in its initial stages and will require close monitoring in the short term by the AMC to confirm that it develops as intended.

Outstanding terms of reference and membership are required for the Clinical Disciplines Committee, Academic Progress Review Committee and the Medicine Stakeholder Engagement Advisory Group. If an Evaluation Committee is formed, its terms of reference and membership should also be provided.

The School is required to demonstrate that the revised governance structures and functions are understood by staff and stakeholders, and are operating in a timely and effective manner. This should include the function of the Assessment Committee showing how it interacts with the Academic Progress Review Committee; and the Clinical Disciplines Committee's interaction with the Clinical Training Committee.

The School is required to provide evidence of stakeholder consultation on the program's purpose, curriculum, graduate outcomes and governance via the Medicine Stakeholder Engagement Advisory Group once established, and the mechanism in which this consultation informs the program.

In the context of these significant internal and external changes, the team was impressed with the strong School and program leadership to build academic staff engagement in the program, and the quality of the program across the School and its sites.

1.2 Leadership and autonomy

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

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

At the University of Tasmania, academic leadership of health professional programs is at the level of the head of division. The Head, Division of Medicine, also known as Associate Head, Medicine, is the senior academic position with operational responsibility for the Tasmanian Medical Program. This position reports to the Head, School of Medicine.

The Head, School of Medicine commenced in January 2016, and in relation to the medical program is responsible for mobilising university resources for the program, and has assumed responsibility for being the primary contact for formal agreements with the program, both with the University and the Tasmanian Health Service.

The Head, Division of Medicine has authority to manage the medical program, and chairs the Tasmanian Medical Program Committee (TMPC) which manages curriculum content, learning processes and assessment practices.

Within the Faculty of Health, the Head, Division of Medicine has the authority to manage the MBBS, Bachelor of Medical Research and Master of Public Health (MPH) programs. For external relationships, the Head, Division of Medicine is the formal contact for the AMC, Australian Health Professional Regulation Agency, Medical Board of Tasmania, Postgraduate Medical Council of Tasmania, teaching hospital medical directors, the Tasmanian regional GP training provider (General Practice Training Tasmania) and other organisations directly involved in teaching into medical programs.

The Head, Division of Medicine initially commenced as Professor of Medical Education / Dean in April 2014 and is contracted to the role until December 2016. At the time of the assessment, arrangements for 2017 were under deliberation. The visible leadership and engagement of the Head of School and Head of Division have been instrumental in guiding development and this continued level of leadership is fundamental to the program's future. Confirmation of clearly defined arrangements for the academic head of the medical program from 2017 onwards is required.

1.3 Medical program management

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

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

The Tasmanian Medicine Program Committee (TMPC) is a strategic and operational management group for the medical program. Chaired by the Head, Division of Medicine, its membership includes the chairs of the committees that report to it. It has the authority to plan, implement and review the program, agreeing on feasibility and desirability of whole of program changes in curriculum and assessment. Some decisions may require additional approval, for example if TMPC's decisions result in staffing or resource reallocations, these recommendations are formally referred to the Division Head who consults School Finance.

Further, the School Learning and Teaching (L&T) Committee receives TMPC minutes and recommendations and must approve some decisions regarding changes to curriculum, assessment, unit content or nomenclature, course amendments or new courses. The Associate Head L&T is not a standing member of TMPC but can be co-opted. The School L&T Committee is responsible for communication to TMPC regarding any University changes, such as exam processes or semester dates. While the L&T Committee has aspirations to be strategic its role is more operational. Clarification of the process and reporting lines between TMPC and the School L&T Committee is recommended.

The previous Years 1 to 3 Committee is now the Year 1, Year 2, and Year 3 committees. The Years 4 and 5 Committee is now split as two year committees. Year committees are responsible for the delivery of the relevant academic year of the curriculum to the intended standards and quality, and will ensure horizontal integration, negotiation with discipline groups, and setting and scoring of assessments. Membership includes all faculty members engaged in teaching. The School intends that managing Year 4 and Year 5 as separate years state-wide will align the curriculum across sites and facilitate students being able to change clinical schools without disadvantage. Year committee members commented that the new structure will allow extra capacity to focus on “more than assessment”, which had consumed the previous combined committees.

There are four new domain committees that will be responsible for the vertical integration across the program to ensure the graduate outcomes for the domain can be met by students. Domain committees will contribute to curriculum design/revision, negotiate with discipline groups and ensure that assessment setting and scoring reflects the domain content. Membership includes all faculty members engaged in teaching in the relevant domain. The domain committees each have a representative on each year committee. The new domain committees will ensure the domains are considered in all curriculum decisions.

It is intended that TMPC and its sub-committees will promote needed curriculum integration and harmonisation of the program across sites. The cross-representation on the domain and year committees is intended to operate as a domain / year matrix to facilitate integration of the curriculum across the program, and to assure the School that all graduate outcomes are met. There is also cross-representation into the assessment committee and into other programs.

In Years 4 and 5, there is much overlap between the Clinical Practice Domain Committee, the Year 4 and Year 5 Committees, the Clinical Training Committee and the Clinical Disciplines Committee. Members of these groups indicated general understanding of their specific roles and of their responsibilities to liaise with each other regarding overlaps in scope. The School has designed the structure to be collaborative and to engage all in the curriculum management process. It expects that as clinical school harmonisation occurs over time that meetings will diminish.

While the new matrix governance structure will promote engagement and input from year, discipline, and domain groups, it may complicate and prolong decision making processes. Evaluation of the function of this matrix structure to ensure timely decision making will be necessary. The School is required to demonstrate that the revised curriculum governance structure is effective, by providing details regarding how curriculum developments are led, consulted on, piloted, ratified, implemented and evaluated.

The University has TEQSA (Tertiary Education Quality Standards Agency) registration and has processes to assess the level of qualification awarded. The Faculty of Health

completed a compliance project against the Australian Qualifications Framework in 2014, and the MBBS program was found to achieve or exceed Level 7 or Level 8 learning outcomes.

The Faculty of Health plans to introduce a Level 9 medical degree structure, commencing with the 2018 or 2019 entry cohort. The AMC was notified mid-2015 of this likely development. The Division of Medicine Advisory Group planned to consider a strategy for the MD across all sites later in 2016. Confirming arrangements with conjoint staff will be key to successful implementation of an MD. The AMC will await further notification in due course.

1.4 Educational expertise

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

The School previously had a Medical Education Unit with up to three academic positions which was disbanded following a 2013 review. The model adopted instead is one of distributed expertise and responsibilities in curriculum and assessment across the program.

There was evidence of in-house educational expertise across the academic staff involved in the medical program, with strong leadership by the Head, Division of Medicine. In recent years, the School has encouraged stronger engagement with national and international medical education debates and scholarship. The School has supplemented in-house expertise by engaging appropriate external expertise to assist in reviews of aspects of the medical program, and training of academic staff. Over the period 2014-15, five curriculum reviews were commissioned. These included a Review of Curriculum by Professor Richard Hays, Assessment by Professor Tim Wilkinson, University of Otago; Rural Medical Education by Professor Tarun Sen Gupta, James Cook University; Review of the Clinical Practice Domain by Associate Professor Victoria Brazil, Bond University; and a Clinical Schools Review by Professor John Burgess, University of Tasmania.

Indigenous expertise in the medical program is mediated via the senior lecturer in Public and Population Health / coordinator of the Health and Society domain, who also works as a general practitioner at the Aboriginal Health Service and is a member of the binational Leaders in Indigenous Medical Education Reference Group. This staff member contributes educational and culturally sensitive expertise to the content of the curriculum. There were established relationships with the Tasmanian Aboriginal community, and members of the Tasmanian Aboriginal Centre to inform and deliver elements of the Indigenous health curriculum. The dependence on one staff member represents vulnerability in the program with regard to succession planning and capacity building (see also Standard 1.8). Plans to strengthen the University and School's

engagement with Indigenous people are discussed at Standard 1.6, which have potential to further involve Indigenous expertise in the program.

1.5 Educational budget and resource allocation

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

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

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

The Division of Medicine has an identified line of responsibility and authority for the medical program. The medical program operates fiscally as a 'school' with budget delegation and authority sitting with the Head, Division of Medicine. The Division of Medicine has an operational budget to deliver the medical program.

The School of Medicine uses an activity-based budgetary structure which aligns cost-centres to the divisions. The Division of Medicine has specific accounts for medical education, technical services, administrative services, medical program Years 1 to 3, Biomedical Sciences, Hobart Clinical School, Launceston Clinical School and postgraduate health programs.

The Faculty sets the divisions' operational budgets as part of the annual University budget process. The Division of Medicine has direct input into its funding priorities in this process. The Division Head has financial delegation to direct resources appropriately and within budget to achieve the objectives of the program. Staffing is the major cost element in the Division of Medicine's budget. The majority of funds for staff development, infrastructure, equipment and other division-based activities are held centrally by the School.

The University central tax is around 53%, and the School of Medicine has the flexibility to alter internal contributions among its divisions and programs as needed. The Faculty and School hold discretionary funds which divisions may apply for in addition to core operational funding.

Financial management capacity is in place to assist with modelling future constraints and accommodating future needs for the School and Division. The School Business Manager works with the Head of School and Division to ensure that adequate resources are available to deliver the medical program.

The School indicated that the medical program is in a sound financial position. The School can apply to spend its surplus and in the last year has invested over \$1.2million in laboratory equipment, simulation equipment and computers as part of its equipment

restoration asset management plan. The Faculty of Health has strategic incentive funds available which can be leveraged for learning and teaching initiatives.

The School receives additional income from the University for research infrastructure development. The Commonwealth Government provides a grant for the Rural Clinical School under the Rural Clinical Training Scheme. The Commonwealth also funds clinical training in some areas such as the Patient Partner Program and some clinical placements. There were concerns that clinical training funds may be withdrawn by the Government in future. Any impact on the medical program of loss of clinical training funds should be included in future progress reports.

Other financial risks to the program include the need to confirm arrangements for sessional and tenured appointments with the Tasmanian Health Service which may lead to some transitional costs (see conjoint appointments at Standard 1.8). Additionally, it was unknown whether the reconfiguration of the Tasmanian Health Service may lead to higher payment for clinical placements. Updates should be included in future progress reports.

The School identified it would require additional resources to develop its proposed MD program, and to develop IT enabled learning and teaching resources for the program (see Standard 4.1).

1.6 Interaction with health sector and society

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

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

The Tasmanian health system is undergoing significant structural change. The Department of Health and Human Services (DHHS) Tasmania's June 2015 white paper *One Health* outlines the change from three previous Tasmanian Health Organisations (South, North and North-West) to a single state-wide Tasmanian Health Service (THS) from July 2015, with a new governance structure. The DHHS will purchase clinical services from the THS. The University leadership stated that they viewed the restructure as an opportunity to improve the alignment of academic and clinical services to strengthen a 'one State, one University' approach.

The THS Chief Executive Officer, who commenced in February 2016, indicated that the *One Health* recommendations regarding changes to specific hospital medical services

were at the early stages of implementation. The plan encompasses clinical service delivery across four sites with an articulated community offering. Each clinical service area will have medical and business unit leadership, and the relationships between hospital services and the Primary Health Network are being refined and developed. The THS CEO has regular meetings with the Vice Chancellor and has also met the newly appointed Head, School of Medicine. The Tasmanian Health Service CEO expressed the view that 'education is implicit' in health delivery, reflecting on his experience in other health and education jurisdictions.

The terms of reference of the new THS Governing Council allow for two university representatives, and these roles are filled by the Dean, Faculty of Health and the Chair, School Quality and Safety Committee. The Head of the School Clinical Training Committee is an observer. It was noted that the University representatives actually serve as 'company directors' and are therefore not in a position to report to the University on the evolution of the THS. This raises the question as to whether there is true University representation on the Council.

There are two further intended THS committees, the first being the Tasmanian Health Teaching and Research Committee. This Committee's planned terms of reference provide for membership of the Provost, the Head of School, and the Head, Division of Medicine. Second, an operational committee working under the THS Governing Council with responsibility for co-ordinating education, workforce and research is also intended. The final membership and terms of these committees were not available at the time of the visit. There will need to be capacity for these committees to signal to the School where implementation of *One Health* impacts on program delivery.

There is multi-level engagement between the University and THS. The Vice Chancellor and Provost engage with the state health minister regarding the policy for Health-University engagement. The Faculty Dean sets the agenda for the Faculty's external engagement with THS and provides health policy advice to the minister in other roles. The Head of School is the primary liaison contact with THS for medicine. There is cross-representation at these levels on DHHS and University interview panels.

There was evidence that School and Clinical School academic staff had robust and established relationships with their local hospital management and clinical staff. Launceston Clinical School reported formal agreements with its local health service and general practice sites. Evidence of community engagement was apparent at all three clinical sites.

Discussions between THS and the University about conjoint health-university appointments were ongoing. DHHS indicated that the changes in THS governance had slowed progress regarding review of conjoint arrangements and the expectations of both parties were still being clarified. It was anticipated that a process for conjoint appointments would be in place by the end of 2016. Finalisation of a uniform approach to conjoint appointments should be progressed as soon as possible.

The team heard evidence of high-level support for partnership between the University and THS, however formal agreements between the University and THS regarding the medical program were not in place, in part due to the recency of the THS restructure.

In view of the amount of change in the structure and governance in both organisations, a new formal agreement between the University and THS regarding the medical program is required. This agreement should reference a shared purpose and confirm the governance framework for management of the relationships regarding the medical program, including committees and individual roles. It should also outline how partnerships are operationalised regarding clinical placement agreements, conjoint appointments, staff development and conflict resolution processes.

The critical importance and complexity of Indigenous engagement and leadership was acknowledged at all levels of the University and School. The University recognised it could improve its engagement with Tasmanian Aboriginal communities and had implemented a strategy to do so. The University's Aboriginal Policy Working Group, chaired by the recently appointed inaugural Pro-Vice Chancellor for Aboriginal Research and Leadership, includes the Head, Division of Medicine. This Group intends to improve engagement of the Tasmanian Aboriginal communities in University affairs.

The School has a relationship with the Tasmanian Aboriginal Centre (TAC) and its Tasmanian Aboriginal community. The TAC are involved in aspects of the program's Indigenous health curriculum and clinical placements. The TAC representatives expressed concern that local medical graduates do not subsequently engage with TAC as doctors, and that Indigenous students are not entering the medical program. The underpinning reasons for this are demonstrably complex. The School is encouraged to continue its engagement and partnership with the Tasmanian Aboriginal communities.

The School demonstrated willingness to continue working with the resources of the University to develop an appropriate Indigenous engagement strategy. Clarity around wider University supports for Indigenous health education in the medical program, together with resources to support Indigenous health education are required. The School is required to develop an engagement strategy to promote medical education and training in Indigenous health that is informed by Indigenous people.

1.7 Research and scholarship

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

The Faculty and School have a strategic plan for research focused on growing research output. It identified its research strengths in dementia, neuroscience and cognition, biomedicine, health care system improvement, and chronic disease. The School of

Medicine had demonstrated increased research performance in recent years, particularly due to key appointments in Biomedicine.

There are affiliations with a range of institutes. In the Faculty, there is the Wicking Dementia Research and Education Centre, and in the School there is Health Services Innovation Tasmania (HSIT) established in collaboration with the Commonwealth and State Governments to assist in the redesign of clinical services state-wide. The Royal Hobart Hospital Research Foundation also collaborates with School staff. In Launceston, Clifford Craig Medical Research supports local medical research, which has included medical education research and involved Launceston students. At the Rural Clinical School, there are also research opportunities and supervisors available for students.

In Hobart, the medical school is co-located with the Menzies Institute for Medical Research. The research capability of the Faculty is deeply intertwined with the performance of the Menzies Institute, which has a clearly articulated research strategy framed around well-defined research pillars. Co-location with Menzies has improved research synergy, increased Category 1 funding, and quality publications have been an outcome. The extent to which this has informed learning and teaching in the program is less clear.

The School supports the biomedical research emphasis of the University, while also highly valuing educational scholarship. School of Medicine staff include a number who have high-profile national and international reputations in the scholarship of teaching and learning. Staff are consistently working as lead or partners on Office of Learning and Teaching grants. Medical education research projects include the interprofessional learning toolkit and projects in Launceston, and interprofessional aged care at the Rural Clinical School. The commitment to medical education research demonstrated by key academic staff that informs teaching and learning in the program is commended.

Students are exposed to research active staff from Year 1 in the Medical Sciences Precinct. The School indicated that most students undertake at least one kind of research project during the program, such as a clinical audit, and conversations with students indicated there are many opportunities in each clinical school. The intercalated BMedSc (Hons) that follows Year 3 of the program is undertaken by five to ten students each year. There is also a growing number of higher degree research students with 59 enrolled with the Division of Medicine, up from 12 in 2012.

The School has agreed to move to an AQF Level 9 extended Doctor of Medicine program in 2018-19, pending Academic Senate submission and AMC review. The Menzies Institute is strongly supportive of the proposed MD program. There is an acknowledged need to engage clinical partners and health services around health service and practice research. The relationship between the Head, Division of Medicine and the new Menzies Institute Director will be an important relationship to support the University's research vision.

It is recommended that the School clarify the relationship between the Menzies Institute and the medical program, and define a formal agreement regarding the role of Menzies in informing teaching and learning in the medical program. This will impact on the move to an AQF9E level qualification and student research placements and supervision.

1.8 Staff resources

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

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

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

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

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

The Division of Medicine has 134 permanent academic staff and 335 casual academic staff. At the time of the assessment visit it had a number of key academic staff vacancies. There were vacant clinical discipline lead positions in paediatrics, general practice and obstetrics and gynaecology, and academic lead positions were vacant in professionalism and ethics, public health, and pathology. The Indigenous health lead position was also not filled (see Standard 1.4).

The School identified that the restructures of the University and the health service have led to difficulties and delays in recruitment of academic staff, particularly those with a clinical or health system role. It indicated that while there are generally discipline leads in each area, appointing state leads is entwined with *One Health* being established. The University academic re-profiling process was also in progress.

The School advised that appointment to the paediatric discipline lead role was in progress but not finalised at University level pending Tasmanian Health Service/ University workforce training agreements. The chair in obstetrics and gynaecology remained vacant, and had been for at least ten years, with a clinical academic lead based in Launceston. A leadership position in general practice was vacant, however the School had strengthened academic general practice with increased FTE across two roles, one of which was a new appointee. Anaesthetics and radiology no longer had a high level University academic appointment, though clinical academic staff at each site had

responsibility for curriculum content in these areas. Ophthalmology also had teachers who contribute to the discipline content.

Academic clinical appointments in these disciplines are limited by the availability of academic staff in Tasmania, and the School has demonstrated processes to ensure adequate discipline input and coverage. However, the School is required to provide evidence that there are appropriate senior discipline leads to deliver the medical program, specifically in paediatrics, obstetrics and gynaecology, Indigenous health, general practice, professionalism and ethics.

The medical program had no identified academic or professional Indigenous staff. Further, resourcing in the Health and Society domain was thin around Indigenous health in particular, as the domain lead role is 0.7 FTE and this person assumes the role of Indigenous health lead and Aboriginal student recruitment and support. The School indicated that it had been unsuccessful in its attempts to recruit an Aboriginal lead, though the budget remained available for this position. It is appreciated that the Tasmanian context adds complexity to recruitment. Sustained efforts to drive recruitment of academic and professional Indigenous staff are encouraged, and the appointment of a senior academic Indigenous health lead is required.

As discussed at Standard 1.6, agreement with THS around a transparent process for conjoint appointments and performance management of such roles is required. The process for conjoint approvals had been slow with staff reporting lack of clarity around requirements, applications on hold due to the health restructure, and lack of follow-up. Clinical academic staff reported being disillusioned and were at risk of becoming disengaged with the medical program. An agreement around conjoint appointments will be advantageous to attracting good clinicians to work in the academic-health science space. Both the School and THS indicated their willingness to finalise a conjoint agreement.

At the time of the visit, the staff reprofiling process was due to commence in the School in line with an overall University approach to drive optimal staff profiles. The principal vision relates to increasing research performance. In other areas of the University, reprofiling has involved rationalisation of administrative staff to free-up resource for strategic appointments. Separately, some academic staff raised concerns regarding increased casualisation of the workforce. The impact of proposed staff reprofiling on academic expertise and delivery of teaching in the program will be important to observe, and an update should be included in the next AMC progress report.

Overall, there appeared to be adequate professional staff to support delivery of the program. It was noted that academic and professional staff work separate to each other. Professional staff are allocated to units, committees or events as required and may work across different courses in the School. Allocation of professional staff to the new committee structure was underway at the time of the visit, and it appeared that secretariat support would be adequate.

The former Medical Education Unit had two FTE professional staff who continued to support assessment. However, the School had been unable to gain approval to recruit a psychometrician apparently due to uncertainty as to whether the role was professional or academic. Ensuring that psychometric expertise is available to support the assessment processes, given the absence of the Medical Education Unit (MEU) and the dispersed educational expertise, is recommended.

Technical staff will be included in the University re-profiling process and there appeared to be a move to centralise IT services. Staff and students reported no concerns regarding general IT staff support. Some academic staff indicated a need for IT support for an approved online learning repository, development of a curriculum map and other teaching and learning resources. Similarly, these initiatives may benefit from formalised access to Faculty learning and teaching expertise or recruitment of such staff to the School. It is recommended that the School allocate adequate teaching and learning and technical staff to support planned initiatives (refer to Standard 4.1).

The School has appropriate processes for the community members who participate in teaching and learning activities in the program. Volunteers for clinical skills teaching and OSCE assessments receive short training sessions, and Clinical Teaching Associates in the sensitive examination program, or volunteer patients in the Patient Partner Program receive more extensive orientation and extended education.

Staff are indemnified by University insurance policies which include indemnification for activities undertaken in the medical program.

1.9 Staff appointment, promotion & development

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

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

The School has processes for development and appraisal of staff. The University's expectations around teaching are included in annual performance management reviews.

Academic staff raised concern that the University weighted research rather than education as being of critical importance to future strategic directions and promotion decisions. There were perceptions of unrealistic expectations on the research outputs of educationally orientated staff in the School. The team heard that promotion has only occurred on the grounds of Category 1 grant success for one School staff member in the recent past. The School plans to work with the University to delineate pathways for education focused promotion.

Recognition of educational and health services scholarship and complex educational roles as vital academic contributions within the School is important. Ensuring that appointment and promotion policies balance teaching, research and service functions is required to maintain adequate program delivery across the sites.

The dissolution of the previous Medical Education Unit has led to efforts to better distribute medical education expertise across the School and training sessions have been provided for academic staff in medical education and assessment to improve educational literacy. There was evidence of professional development of staff in curriculum design, assessment, standard setting and the option to undertake a Graduate Certificate in University Learning and Teaching. Optional training also available included 'Teaching on the run' module and a Faculty peer-assisted teaching support program. Staff at the clinical sites reported awareness of training opportunities available with variable uptake.

2 The outcomes of the medical program

2.1 Purpose

2.1.1 The medical education provider has defined its purpose, which includes learning, teaching, research, societal and community responsibilities.

2.1.2 The medical education provider's purpose addresses Aboriginal and Torres Strait Islander peoples and/or Maori and their health.

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

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

The University of Tasmania, Faculty of Health has a broad vision which includes working with communities to obtain global recognition for the quality of health professional education, transformative health and medical research. The specific medical research themes are: biomedicine, dementia, translational neurosciences, prevention and management of chronic disease, and healthcare and support services.

The School of Medicine mission statement acknowledges the goal to improve the health outcomes of the local community as well as national and global health outcomes:

Medical staff and students of this University are guided by a common goal: to transform healthcare as we know it, and to improve the health of Tasmanians, Australians, and the world. Society today demands better health outcomes and expects more of healthcare professionals. Studying Medicine at the University of Tasmania will ensure you are receiving the best possible healthcare and health science skills required to provide the highest quality healthcare support.

This mission statement was under review at the time of assessment. It would benefit from being broader as it appears to predominantly relate to the recruitment of students.

The Faculty Plan 2015-2020 lists one of its key initiatives as:

Ensure Aboriginal history, culture and knowledge inform our learning and teaching through an on-going engagement and partnership with Aboriginal peoples.

The recently modified mission statement of the medical program adopted in October 2015 also includes reference to Aboriginal peoples:

The Tasmanian Medicine Program seeks to be a socially accountable medical program producing excellent medical graduates who deliver compassionate, competent and safe care to the urban and rural communities from which they learned, including Aboriginal and Torres Strait Islander peoples.

The University of Tasmania vision statement is provided in the Year 1 outline but the revised mission of the medical program described in the School's AMC submission is not found on the School's website or in the unit outlines. The lack of wide dissemination of the higher level purpose or goals of the School and program may result in a lack of clarity in the educational philosophy and pedagogical principles for staff and students. This may cause difficulties in guiding and prioritising changes and improvements to the program. Communication of the program's purpose in program materials is required, such as an over-arching program outline or course guidebook which provides the students and staff with the purpose and philosophy of the program and an overall view of the curriculum. This will also assist in describing the assessment philosophy, the methods for vertical integration, longitudinal structures within the curriculum such as the portfolio, and can sign-post learning for the students.

A consultative framework and group, *Partners in Health*, existed from 2005 to 2011 and a new framework is planned. However, it is unclear how this previous partnership assisted to develop or inform the program, as it is described more as an operational agreement with the Department of Health and Human Services for staffing and resources rather than a collaborative group assisting to advise on strategic and pedagogical matters.

The School is developing a new consultative framework with its Medicine Stakeholder Engagement Advisory Group, though the membership and terms of reference of this group were not finalised. This consultative group is necessary to inform the School's purpose, goals and expected graduate outcomes, and evidence of its formation, function and effect will be necessary (as required at Standard 1.1).

It is recommended that the stakeholder group includes community members, Indigenous community representation, patient representatives, health department representatives, students, clinicians and researchers. Having a widely understood and agreed purpose and strategy may then inform and guide future changes to the School and program to better suit the needs, aspirations and resources of the local context. This is particularly relevant considering the 40 to 45% retention rates of graduates in the Tasmanian health system. Improvement in graduate retention will require multi-organisational collaboration and engagement.

The 2012 University strategic plan, *Open to Talent*, outlines that the activities of the University will relate to the local community:

Our position as the sole university in Tasmania brings exceptional potential for engagement with the economic, social, cultural and intellectual life of the island and for connecting with national and international networks.

The Faculty of Health Plan 2015-2020 outlines teaching, research and service related strategies to transform the local community. The activities of the School of Medicine align with the Faculty and University strategies. In particular, the School relates its teaching to its local communities. This is evident in the clinical schools where the teaching activities

are strongly supported by the local hospitals, clinicians and patients. The team commends the clinicians' enthusiasm for medical student education which emphasises the goal to attract graduates back to their local areas to enhance the local health services. The School advised that the Tasmanian Government has guaranteed intern positions for all future domestic graduates who wish to remain in Tasmania. It was encouraging to see evidence of local recruitment and retention of graduates in rural areas and areas of need. Numerous anecdotal reports from staff indicate that graduates of the program are well equipped for internship and highly regarded in terms of preparedness in the local areas in which they trained.

2.2 Medical program outcomes

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

- 1 Science and Scholarship: the medical graduate as scientist and scholar*
- 2 Clinical Practice: the medical graduate as practitioner*
- 3 Health and Society: the medical graduate as a health advocate*
- 4 Professionalism and Leadership: the medical graduate as a professional and leader*

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

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

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

The School had recently modified the outcome statements and structure from five themes to the four AMC domains and associated outcomes. This was done to improve horizontal and vertical integration and remove duplication. The four domain model was introduced in 2015 across all five years of the program.

The AMC acknowledges that each provider will have graduate attribute statements that are relevant to the vision and purpose of the medical program. The School is encouraged to identify local strengths, needs and priorities through consultation with stakeholders and reflect these in the program's outcome statements.

The School provided a document that mapped the old and new outcome structure in its accreditation submission. In this mapping document, AMC Graduate Outcome Statement

4.1 *Provide care to all patients according to “Good Medical Practice: A Code of Conduct for Doctors in Australia” and “Good Medical Practice: A Guide for Doctors” in New Zealand*, had not been mapped to the new outcome structure. The team was provided with reassurances that this outcome applies within the program. Evidence that AMC Graduate Outcome Statement 4.1 applies within the program should be provided.

The outcomes are appropriate for the program in terms of developing junior doctors who are work-ready, and also able to continue their medical education and training. The graduates are highly regarded in terms of work-readiness and ability to continue further training. The School advised that all graduates, both domestic and international, have found employment as interns.

The academic staff within the core curriculum committees have an excellent understanding of the domain structure and associated outcomes, and engagement with how the structure can be used to afford vertical integration and appropriate curriculum change and control. It was unclear if students and clinicians who provide the majority of the teaching and supervision have a similar level of understanding. The School is encouraged to improve the description and dissemination of the outcomes and domain structure for students and staff. The previously recommended program guidebook and curriculum map may assist in this regard. Enhanced knowledge of the domain structure and outcomes may encourage staff to provide integrated learning opportunities for all domains through the five years of the curriculum, rather than the current focus on the Science and Clinical Practice domains (see also Standards 3.3 and 3.4).

In Years 4 and 5, students are allocated across three clinical schools: Hobart, Launceston and Rural, each offering a variety of clinical experiences. Students consistently raised concern regarding their perception of differences between learning and assessment at the three clinical schools. The School commissioned the 2015 Burgess Review of Clinical Schools which found that curricular alignment and discipline exposure was varied. Burgess made a range of recommendations to harmonise processes, schedules, curriculum, and program delivery at the three sites. Regarding given disciplines, Burgess recommended that discipline leads should be identified at each clinical school, and the overall discipline chairs should clarify relationships with discipline site leads and with the discipline in the pre-clinical program to ensure integration.

The School formed the state-wide Clinical Disciplines Group in 2016 in an effort to clarify and strengthen discipline delivery across the program at all sites. It also formed the state-wide Clinical Training Committee. At the time of the visit, these Groups were new. Demonstration of the plans and progress to align the delivery of discipline specific education and assessment across the clinical sites is required.

Results from student surveys do not provide evidence that any of the clinical schools are substantially better or worse than their counterparts despite differences. The School indicated that students achieve similar overall pass/fail rates across sites. However, data are not available for achievement of outcomes in individual clinical disciplines. Evidence

is required of comparable achievement of outcomes across sites in the major clinical disciplines, by comparing results in clinical, written and portfolio assessments. This will be particularly relevant once the recommendations from the Burgess Review are enacted and the harmonisation process of the clinical schools is completed. This process commenced in 2016 and is expected to be completed by the commencement of the 2017 academic year.

3 The medical curriculum

3.1 Duration of the medical program

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

The medical program is of sufficient duration to ensure that the defined graduate outcomes can be achieved. In 2006 the program was modified from six to five years in duration. The five-year program comprises 169 weeks of teaching, distributed across the years as two traditional 13-week semesters in Years 1 and 2 and extended to two, 18-week semesters in Years 3 to 5.

In Years 1 and 2 each semester comprises one unit of study. In Year 3 there are two parallel units one of which is clinical rotations. Years 4 and 5 are structured as semester-long units each with multiple rotations in clinical specialties.

The units of study are:

Year 1: CAM101 - Cells, tissues, organs and systems, concepts and basic pathological processes and the integumentary system.

CAM102 - Musculoskeletal and organisation of the nervous system.

Year 2: CAM201 - Cardiovascular and respiratory systems.

CAM202 - Gastrointestinal, hepatobiliary and genitourinary systems.

Year 3: CAM304 - Nervous and endocrine systems.

CAM305 - Multisystem disease. Introductory rotations in clinical practice.

Year 4: Clinical rotations in obstetrics and gynaecology, paediatrics, psychiatry, specialist medicine and specialist surgery, with a therapeutic focus.

Year 5: Clinical rotations in adult medicine, adult surgery, emergency medicine, general practice, selectives and a clinical elective, with a management focus.

Although there are differences in the scheduling and delivery model for Years 4 and 5 across the three clinical schools, the program structure provides students with the opportunity to achieve the graduate outcomes. As noted elsewhere in the report, the Burgess Review made a number of recommendations regarding Years 4 and 5, one of which is a common scheduling framework with the use of standardised teaching blocks and clinical rotations across all the sites. The School indicated that steps had been taken towards schedule alignment. Updates will be required.

3.2 The content of the curriculum

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

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

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

3.2.2 Clinical Practice: The medical graduate as practitioner.

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

3.2.3 Health and Society: The medical graduate as a health advocate.

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

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

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

The curriculum has been extensively reviewed since the AMC's last major change assessments in 2005 and 2007. These developments have been reported to the AMC in progress reports.

Years 1 to 3 have a strong focus on the medical science base and introductory clinical skills necessary for the clinical rotations in Years 4 to 5. From Semester 1, content is integrated within semesters in a fairly traditional model in which clinical skills teaching mirrors the systems being addressed.

The early years are organised by human body systems and in the first five semesters students learn normal structure and function, pathophysiology, history taking and physical examination skills relevant to the body system they are studying. This commences with a focus on principles and basic functions/skills and spirals through to deeper systemic pathology and more specific history taking and physical examination in later semesters. In Semester 6, the focus is on integration of pathology and the clinical communication and information management skills necessary for Year 4 rotations.

Throughout Years 1 to 3 these studies are complemented by those in public and population health, health services, Aboriginal and Torres Strait Islander health, interpretation of literature, research skills, evidence-based medicine, professionalism, ethics and medico-legal studies. Years 4 and 5 are pitched at deeper knowledge and skills relevant to major generalist specialties with Year 5 including selectives and electives. These major content areas are distributed across four domains as described below.

The Science and Scholarship domain integrates the disciplines of anatomy, histology, biochemistry, physiology, genetics, pathology, microbiology and pharmacology. Students apply their knowledge of these disciplines to abnormal structure and function as a result of disease and its clinical presentation. This domain also addresses the topics of scientific methods and research skills and the ability to access, appraise and interpret medical and scientific literature in order to practice evidence-based medicine. Staff indicated they emphasise scholarship and research to students, and expect the planned change to the MD will provide opportunity to embed this. Current research content includes the Year 3 medical research program run between rotations and a unit in primary care where students design a project and have a mentor.

The Clinical Practice domain focuses on knowledge, skills and attitudes for practice as an effective clinician. This includes effective communication, teamwork and collaborative skills. history taking and clinical examination techniques, and skills in clinical reasoning involving problem solving, development of differential diagnoses and formulation of appropriate investigation and management plans. Intensive clinical exposure commences in Year 3 in Hobart hospital settings and general practices state-wide, in conjunction with a focus on teaching core clinical skills.

In Years 4 and 5, the clinical practice curriculum is structured as year blocks specific to each clinical school, though content and discipline input in clinical placements may differ. The Years 4 and 5 courses are integrated and comprise clinical attachments, development of a portfolio, core CBL sessions, and a range of learning sessions. Year 4 clinical attachments include medical and surgical specialties, paediatrics, obstetrics and gynaecology, psychiatry, general practice and emergency medicine (at the Rural Clinical School). However at different sites, length and type of placement varies. For example at Hobart, Year 4 students do nine weeks in Women's Health and nine weeks in Child and Adolescent Health, and Launceston Clinical School (LCS) and Rural Clinical School (RCS) students do five weeks in each. LCS and RCS in Year 4 do three more weeks in both Primary Care and Mental Health than Hobart Clinical School. In Year 5 there are also differences.

The 2015 Burgess Review of Clinical Schools found that the different rotation requirements meant the curriculum was not aligned and led to students' perceived inequity in relation to some disciplines and in equitable assessment. Student transferability among clinical schools for selectives or core rotations is restricted as a result. The School is working to improve consistency across the sites in line with the Burgess Review which the new Clinical Training Committee will consider. The new Year 4 and Year 5 Committees will also work with the new Clinical Practice Domain Group and the new Clinical Discipline Group in this clinical practice space. As at Standard 2.2, the School is required to demonstrate progress in the alignment of discipline specific curriculum content and assessment across the clinical sites.

The Health and Society domain includes public and population health, health services, Aboriginal and Torres Strait Islander and rural health. An emphasis is placed on

understanding the patient's social and cultural context and the importance of disease prevention. This domain includes the Kids and Families Program from Year 1 that requires students to follow a family over two and a half years. The required minimum exposure to rural placement is achieved through a rural week in each of Years 1 and 2 and a two week rural placement in Year 3 during the Primary Care rotation. The domain staff indicated that quality and safety is included in two lectures and a Year 3 clinical audit, though it could be more explicit. Staff also indicated the domain has a skeleton plan for content in Years 4 and 5 however needs to first resolve the resources available to them. The School has identified that it can improve the Aboriginal and Torres Strait Islander health content (refer to Standard 3.5).

The Professionalism and Leadership domain includes professionalism, ethics, law and self as applied to students and future practicing doctors. This domain introduces the importance of self-care and personal health. It also supports professionalism through the concepts of reflective practice and reflective writing. The School has strengthened this domain by reviewing the curriculum and mapping it against the AMC Graduate Outcomes and the curriculum of another medical school. It has strengthened leadership and the delivery team. Domain staff indicated they have identified the curriculum requires additional professionalism and patient safety content and plan to address this. Consistency of the assessment of professionalism in Years 3 to 5 was raised as an issue in the Burgess Review. The new domain committee structure should provide a mechanism to improve professionalism content and the consistency of assessment.

The School plans to change to a Level 9 extended Masters level medical program with only minor program changes. In Years 1 and 2, it plans to improve delivery of research themes with additional lectures and workshops on research methods. Year 3 will slightly increase in duration to match Years 4 and 5, and students will be selected into one of three groups: clinical research, educational scholarship and community service development, with tailored research training for each group. Students will complete a project in Years 4 and 5, and the learning portfolio will have an additional research theme outcomes component. The School advised that approximately one-third of existing students participate in a research project in their own time. It will add opportunities for students to link with PhD and Professional Doctorate programs (both Level 10). As noted at Standard 1.7, the School is active in research and there were reports of ample research opportunities available at each clinical school. The MD proposal was not available during the assessment, and the School will be required to notify the AMC of change once confirmed.

3.3 Curriculum design

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

The curriculum is organised both horizontally and vertically. Horizontal integration is achieved through the year based structure and is effectively managed in Years 1 to 3 by unit coordinators and in Years 4 and 5 via the clinical disciplines. Assessment is similarly integrated within semesters and rotations (see Standard 5). Graduate outcomes have been aligned with the AMC Graduate Outcome Statements.

Vertical integration was described as being structured around the framework of students' first gathering, then synthesising and finally applying knowledge and skills. Vertical integration is addressed through the domain structure which has been revised from five themes to the four domain structure of the AMC (see Standard 3.2). Staff reported that this revision had been only a minor realignment from the previous five theme structure. The work had not required changing any outcomes but only their remapping to the appropriate domain.

The four domains are represented throughout the curriculum by an overlapping wedge model described as follows:

	Science and Scholarship	Clinical Practice	Health and Society	Professionalism and Leadership
Year 5	10%	60%	10%	20%
Year 4	20%	60%	10%	10%
Year 3	40%	40%	10%	10%
Year 2	70%	10%	10%	10%
Year 1	70%	10%	10%	10%

Within each domain there was potential to improve vertical integration. For example, in the clinical years, integration of science and scholarship content was not always documented although staff indicated confidence that it was present. In the domains of Health and Society, and Professionalism and Leadership, staff recognised that additional content could be integrated in the clinical years. In the Clinical Practice domain, the Brazil Review identified poor vertical development of clinical skills which should be strengthened.

To improve integration, the program's new advisory domain committees will aim to ensure vertical integration of the domain outcomes, learning opportunities and assessment through the curriculum. There had not been time for the domain committees to have established their roles at the time of the assessment. Evidence of improved vertical integration of domain content in the curriculum will be required, and consistent associated unit-level outcomes (see also Standard 3.4). Mapping curriculum content is a

core area to improve and demonstrate vertical and horizontal integration. This work can accompany and be assisted by the curriculum database that is in development (see Standard 3.4).

An important element of the curriculum design is the case-based learning (CBL) sessions. In Years 1 to 3, these cases are linked to the human body system being covered and in Years 4 to 5 they form a default option when a genuine patient with the relevant condition is not available. While the curriculum is described in terms of the content areas addressed by the domains, it was unclear whether the curriculum philosophy is defined by the structured CBL. Development of a framework that defines the place of CBL within the curriculum, whether it is organised around the CBL content (or other organisational principle) and whether that content is consistently applied across sites to assist with greater transparency of the curriculum is required.

Staff acknowledged that despite the domain structure and plans for strengthening the impact of domain committees, linkage of Years 1 to 3 to Years 4 to 5 remains difficult. Many of those involved with Years 1 to 3 at Hobart had little or no contact with the clinicians involved in Years 4 to 5, especially those based at the Launceston Clinical School (LCS) or the Rural Clinical School (RCS). Similarly those based at LCS or RCS stated they have accrued knowledge of Years 1 to 3 through their general expectations of medical students entering the clinical years based on prior experience; discussion with students and individual discussions with Hobart-based staff, rather than formalised dissemination strategies. As is often the case, while some expressed a desire for formalised communication, others indicated that time and workload would limit their engagement with formalised efforts to inform them of the Years 1 to 3 curriculum. Availability of a curriculum database may assist in this regard, providing a consistent platform for accessing curriculum information. A common site for all years in the *MyLO* Learning Management System (see Standard 8.2) may also assist, although similarly relies on clinicians exploring the information of their own volition.

Articulation from Year 5 to internship is assisted by pre-internship programs that had been developed at each site to suit their particular contexts. At Hobart, the Intern's 'day in surgery' simulation was awarded the Vice Chancellor's Citation for Outstanding Contribution to Student Learning and the team congratulates those involved on this achievement. The LCS runs a week-long pre-internship program that is well regarded by recent graduates and staff for the preparation it provides.

Articulation into junior doctor roles is further assisted by the knowledge brought to the program by those staff who hold dual roles of honorary appointment to the program and Chair and Deputy Chair of the Postgraduate Medical Council of Tasmania (PMCT). The Directors of Clinical Training at Launceston General Hospital and North West Rural Hospital are also clinical title holders within the program and play active roles in teaching further enabling communication about expectations and requirements,

Clinicians supervising interns consistently spoke of the relatively smooth transition of Tasmanian medical graduates in comparison with interns from other programs.

3.4 Curriculum description

The medical education provider has developed and effectively communicated specific learning outcomes or objectives describing what is expected of students at each stage of the medical program.

The learning outcomes for each stage of the program are defined and communicated via unit guides. Learning outcomes and unit guides are promoted to students and are readily accessible via the *MyLO* platform. Hard copies are also distributed. Academic staff and clinical teachers can also access *MyLO*.

The unit outlines had been adjusted in Years 4 and 5 to reflect the new outcome structure. In Years 1 to 3, the unit outlines did not list the graduate outcomes though students are referred to the AMC site in order to obtain the graduate outcomes. Although the domain structure was mentioned, the unit-level outcomes were inconsistently listed in domain groups. With the importance of the domains in the curriculum structure, this may diminish the student appreciation of the vertical integration of content, and decrease the visibility of the domains as a core curriculum structure. This may be more problematic with the domains less frequently taught such as Health and Society, and Professionalism and Leadership. The School is required to demonstrate consistent listing of unit-level outcomes in the unit information aligned to domain outcomes (see Standard 3.3). The development of an outcome map across the curriculum would assist.

Clinical staff outside Hobart indicated that they were not involved in teaching in the preclinical years and while some were unaware of what students had learned in these years, there was an assumed level of student knowledge. Clinicians reported that clinical school staff ensured they were informed of curriculum requirements.

The School did not have a curriculum database at the time of the assessment, although one was under development. When available, the planned database is expected to provide a needed resource for dissemination of curriculum content to stakeholders, it will reduce duplication or gaps in content, and will assist with integration. The School hoped it could serve as a database for timetabling, as a repository for teaching materials, and assist assessment blueprinting. Communication about graduate and course outcomes would be assisted through a curriculum database that could provide a resource for mapping the curriculum by sessions, outcomes and assessment.

Development of the database was in its early stages; however work on the database did not seem to be strongly linked to a clear plan. Liaison with Information Technology Services (ITS) was beginning and further development was planned to occur in conjunction with ITS so that awareness of the database's ability to interface with

enterprise level systems can inform ongoing work. It is recommended that the School confirm the purpose, feasibility and resourcing of the proposed curriculum database, together with the timeline for availability of a curriculum database to staff and students.

No matter how outcomes are presented, students also need assistance in interpretation and contextualisation so they understand the limits of learning in each year. This support is largely delivered through the Case-Based Learning (CBL) sessions. These evolve throughout the program and in Year 1 include discussion of expectations for learning which progresses to greater application of anatomy and physiology to clinical scenarios in Year 2 and application in primary care and medicine in Year 3. In Years 4 and 5, the complexity of CBL scenarios increases further to include broader applications in Year 4 and a stronger focus on management in Year 5. As noted at Standard 3.3, a framework that defines the place of CBL cases within the curriculum is needed to strengthen the use of CBL.

Overall, the School is encouraged to improve formal communications to staff, students and supervising clinicians regarding what is expected of students at each stage of the program. A strong communication strategy will be imperative during this time of change and harmonisation across clinical sites.

3.5 Indigenous health

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

The School takes its responsibilities to teaching Indigenous health seriously and in the last few years had worked to improve the content of this area within the curriculum. The topic is well championed by the leader for the Health and Society Domain and work is ongoing to embed major topics across all years of the curriculum. The curriculum has been mapped against the Leaders in Indigenous Medical Education framework which indicated that while there is a solid foundation of content coverage in Years 1 to 3, there are opportunities to strengthen the topic across the program.

Students are first introduced to the issues through a cultural awareness session, *Come Walk with Us*, in Year 1 that is held in-country and facilitated by the Tasmanian Aboriginal Centre (TAC). This is followed by case-based learning (CBL) in Years 1 and 2, a lecture series on population health including Indigenous health in Year 2 and a newly developed CBL that was first delivered to Year 3 and Year 4 in 2015 and will be delivered to Year 5 in 2016. Staff intend to develop more CBLs so that each of Years 3 to 5 will contain one each. In addition to these sessions, the Health and Society Domain lead co-teaches a session with the Tasmanian Aboriginal Health Service at each Clinical School in Year 5.

Student placements are available to interested students upon application. In Years 1 to 3 students may visit the Hobart TAC for one of their community placements and there is a

week-long placement at the Launceston TAC Health Service. In Years 4 and 5, a small number of students may elect to complete a two-week placement at the Hobart or Launceston TAC Health Service, and some may undertake a selective in Aboriginal and Torres Strait Islander clinical placements on the mainland.

Students reported variably on their experiences saying that the cultural awareness session was challenging but valuable, and that the CBL sessions were more valuable to their understanding than the lectures, which they reported were often poorly attended. Some students reported valuable additional learning, such as the general practice requirement at Launceston to complete the RACGP cultural awareness module.

A framework for the Indigenous health curriculum is required to ensure students receive a cohesive experience in Indigenous health across the curriculum. This framework would benefit from taking account of well-regarded national curriculum frameworks, adopting strategies to enhance integration of content, particularly in Years 1 to 3 and increasing integrated learning experiences, and assessment of Indigenous health content. The School will need to ensure adequate resourcing for this development.

3.6 Opportunities for choice to promote breadth and diversity

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

There are multiple opportunities for students to pursue studies of choice.

At the broadest level, interested students can choose to take the Master of Public Health which is offered largely online and can be sequenced flexibly to fit with their commitments within the medical program. Those interested in maximising their knowledge of research and gain skills in executing research can take the Bachelor of Medical Research program which is offered as a one-year option between Years 3 and 4.

Smaller scale options are available at all levels of the program. In Years 1 and 2 there is a choice of community health placements from a list of approved sites and in Year 3 there is choice in selection of the Medical Research Opportunity, Research Project and the two-week Medicine Selective. In Year 5, the availability of clinical selectives provides students with an opportunity to achieve greater immersion in a clinical or non-clinical area of their choice. As mentioned at Standard 3.5, students interested in Aboriginal health can choose to be placed within the Aboriginal Health Service, or other opportunities such as cardiac rehabilitation at Launceston Clinical School.

Of particular note is the availability and program support for international opportunities. In Year 5, students may elect to take their selective as a two to four week placement with partner universities in Sweden, Denmark, France, Indonesia and the Netherlands. Furthermore the School of Medicine Internationalisation and Elective Program (SMILE) provides elective opportunities for an international elective of four to six weeks duration

between the conclusion of Year 4 and commencement of Year 5. The program is overseen by a 0.5 FTE clinical academic, the Director of Electives. On average over the last five years, 73% of students have taken an elective overseas. Students and staff were consistently positive about the success and impact of this elective opportunity and the reciprocal exchange program that brings international students to the program (particularly from Lund University, Sweden).

There are numerous extracurricular opportunities for students particularly with respect to community engagement and service. Many of these incorporate aspects of interprofessional learning for students (see Standard 4.7). These include initiatives such as young refugee mentorship, high school visits, a wellness program at the local *AgFest* event and the Teddy Bear Hospital initiative. These were consistently mentioned by students as strengths of the program and are valued and enthusiastically supported by staff members.

The team commends the opportunities and support for international placements, electives and extracurricular activities and the leadership of these activities within the program.

4 Learning and teaching

4.1 Learning and teaching methods

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

The School is commended for the diversity of learning and teaching methods employed to engage and facilitate students' learning. Methods are selected to align with the intended learning outcomes and to the stage of learning. Methods range from lectures, seminars, tutorials, laboratory, and skills lab sessions to use of on-line resources delivered through the learning management system *MyLO* and small group sessions in clinical settings including bedside teaching, chart audits, clinical case discussions and apprenticeship-style teaching.

As discussed at Standard 1.4 and 3, reviews of the curriculum have occurred across 2014 - 2015 which have also driven change in the use of learning and teaching methods. For example, the 2014 Hays Curriculum Review found Years 1 to 3 to have up to 17 lectures a week, and since, lectures have decreased by 20% by reducing repetition and improving horizontal integration.

Case-Based Learning (CBL) is an important component of delivering enquiry-based learning. In Years 1 and 2, CBL group sizes are 10 to 12, with Year 1 comprising two, one-hour sessions per week, and Year 2 being a 90-minute session per week. Sessions are delivered to groups of up to 20 students in Years 3 to 5. Trained CBL tutors who are often general practitioners lead the CBL sessions. Despite its importance, the use of CBL across the curriculum appeared variable ranging from highly interactive sessions to those that are more didactic in nature. The School was working to address this variability and had made progress in CBL alignment across clinical sites. Refresher tutor training in the expected delivery of CBL would be of benefit, and monitoring of the effectiveness of this via student and staff feedback is encouraged.

Anatomy practical sessions were reviewed in 2015 following a 20% cut to contact hours. Staff reported that gross anatomy includes practical sessions with the use of imaging and dissection in parallel. Students are rotated through the dissections doing one in three. More complex sessions that were difficult for students have been removed. The School has a body donation program and uses a range of whole cadavers and prosected specimens.

Some members of staff have enthusiastically adopted innovative technology-enhanced learning (TEL) including developing the Digital Slidebox for teaching histology, and using podcasts and e-learning resources. Virtualisation of the pathology museum has included development of an interface with added notes for the specimens. Despite individual examples, systematic embedding of TEL within the curriculum has been hampered by the lack of an overarching strategy and dedicated support. Leadership to provide development and advocacy for technology-enhanced learning, and clarification of the

roles of the Faculty Technology Enhanced Learning and Teaching Committee and Information Technology Services are recommended (relates also to Standard 1.8 regarding ensuring appropriate staff and resourcing to support planned initiatives).

The well-supported longitudinal Kids and Families Program that partners students with a family that has a new-born or is due to have a baby commences in Year 1 and concludes in Year 3. This provides an effective mechanism for students to integrate content across all four domains of the curriculum and in general, is well received by students.

In the clinical years, the Patient Partner Program (P3) promotes student integration of learning. In P3, clinicians facilitate sessions in which students engage with volunteer patients and community members in a patient-centred approach to healthcare. P3 began at Launceston Clinical School in 2005 where it is strongly supported by staff and welcomed by students. Across 2014 and 2015 the program has been adapted and contextualised for use in Hobart and at the Rural Clinical School to develop a consistent approach while being sensitive to the different contexts. The Kids and Families and P3 programs are commended.

Direct Observed Consultation and Examination Skills (DOCES) have been introduced in Year 4 as an alternate group teaching method and Objective Structured Clinical Examination (OSCE) preparation. Cases are written by staff and represent a compendium of OSCEs. The tutor roleplays the patient, and in a group of around ten, individual students perform structured clinical examinations with other students observing. Delivery of DOCES reportedly varied across sites, with some groups being 40 in size. Students indicated that DOCES had been introduced to replace OSCEs, though the School presented a sound rationale for the DOCES. While many students were positive, feedback was mixed and appeared tutor/delivery dependent. As with CBL delivery, refresher tutor training and additional communication to tutors and students regarding the objectives of DOCES is encouraged to make this a comparable and valuable experience.

The School has a long-standing Clinical Associates program in women's and men's health providing opportunity for students to develop skills required for sensitive examination of intimate areas. Simulation is used at all three clinical sites with high fidelity simulation available at all three although the difficulty of continuing funding for staff at the facility at Hobart is noted. The dedication of staff involved in simulation at the LCS and RCS was clear to the team although the person-dependency of the program, especially at Launceston requires consideration.

4.2 Self-directed and lifelong learning

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

The CBL sessions, particularly in Years 1 and 2 encourage students to identify and achieve their own learning goals. As noted at Standard 4.1, ensuring consistency in CBL delivery is important, and will facilitate students taking responsibility for their learning. The School advised it has increased formative assessment opportunities for students to promote student engagement and responsibility for achievement.

Library staff conduct specific sessions to help students learn how to find, access and reference original research literature, developing skills for lifelong learning through their professional careers.

To reinforce student self-evaluation, the School requires each student to compile a learning portfolio from Year 1 documenting their activities and achievements throughout the program, to be submitted at the end of Year 5. As is the case elsewhere, achieving these goals has been challenging. Some students in the early years stated they were not aware of the portfolio and those in the later years acknowledged that many compile the portfolio specifically for its submission rather than as an ongoing learning activity. It is recommended that the School improve the communication strategies used to inform Years 1 to 3 students about the requirements of the portfolio and the benefits of early engagement for their development as reflective learners.

4.3 Clinical skill development

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

Clinical skills teaching begins in Semester 1 and continues in a scaffolded manner throughout the program. The focus in Years 1 to 3 is on developing basic, practical skills which is extended in Years 4 to 5 to a focus on interpretation and application.

In Years 4 and 5, each clinical school follows its own model for curriculum delivery. All sites include skills facilities in which students receive structured teaching of clinical skills. Simulation is included as part of the curriculum with high and low fidelity simulation facilities being available for skills training.

The 'student tutors' program involves selected Year 4 and 5 students (five students in 2016) conducting peer learning in clinical skills sessions for early years students is a positive initiative that increases tutor student ratios and fosters a teaching culture.

Clinical skills development and teaching was the focus of the internal Errey review in 2013, and the external Brazil 2015 Clinical Practice domain review. The School recognised that clinical skill development in Years 1 to 3 requires clarity and consistency

of teaching. Further, Brazil recommended that throughout the program, underpinning principles for delivery of skills and expected outcomes for development of clinical skills would assist.

The strengthening of the domain structure and leadership (see Standard 3.3), and the formation of the Clinical Training Group will provide the impetus through which the major Brazil recommendations of improved timing, sequencing, depth of knowledge and skill development will be realised. Future reporting in developments in clinical skills teaching and learning will be required.

These issues aside, the team found that the program offers students good hands-on clinical experience. Clinicians supervising students at all sites in Years 4 and 5 consistently reported that the majority of students were generally well-prepared, with poorly prepared students being the exception.

4.4 Increasing degree of independence

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

In Years 1 to 3, students are taught using a combination of small group practice sessions including using their peers for practice, simulated patients and exposure to real clinical settings and patients, with introductory concepts addressed in lectures prior to the skills sessions.

The School's Errey review identified a need to increase student exposure in the program's early years to real patients, and it was apparent that the School is considering and developing this area. Students see patients in Year 1 as part of the clinical skills program. In Year 2, there are two sessions per semester involving history taking and examination on real patients in small groups. For example, staff may roleplay the patient, then later real patients are involved in a 'goldfish bowl' setting. Students visit the Emergency Department or other clinical settings to see patients based on the content being covered at that time.

Students also each experience a rural week in Years 1 and 2, and Year 3 has a two-week rural placement, providing exposure to patients in rural settings.

In the clinical years, the Patient Partner Program (P3) which commenced at Launceston as a small group working for half-a-day with a community-based patient has received excellent student feedback and is delivered at Hobart and Rural in varied ways. There were concerns raised by staff and students regarding funding of P3. Updates should be included in future progress reports.

The therapeutic focus of Year 4 transitions to a management focus in Year 5, representing a graded level in expectation of student participation in patient care as part of the clinical team. Students reported adequate supervision in clinical placements by committed clinical supervisors, and also commented that the informal peer mentoring of Year 4 students by Year 5 students was valuable for both years.

4.5 Role modelling

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

Students receive exposure to clinical tutors in their CBL sessions from Year 1, which provides guidance in professional behaviours, clinical and ethical reasoning. This continues throughout the program via the extensive network of active clinicians engaged with teaching the students.

Research development is also supported by clinical tutors and clinicians, as many are research active. This is further emphasised in Year 3 when students spend a week with a clinician researcher observing and learning about the research process. Students reported positively to the team about opportunities to undertake research throughout the program. This was particularly apparent at Launceston Clinical School where research activities are actively promoted and supported by the Clifford Craig Medical Research Trust.

The School reported that since 2015 it has actively encouraged students to raise any concerns about negative role modelling of teachers, and it introduced a session on whistleblowing. Students are encouraged to raise issues with student support, and if required make a complaint to the Head, Division of Medicine. The School has investigated a number of cases as a result and in some cases, staff members have ceased teaching / supervision of students. The School is commended on its positive professional role modelling in this area.

4.6 Patient centred care and collaborative engagement

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

Patient centred care and collaborative engagement are evident throughout the five years of the program. In the early years, CBL cases and other sessions are designed with these themes as a central focus and the experiential learning in Years 4 and 5 continues the emphasis. Specific examples are the simulation experiences which are designed from a patient centred care perspective, the P3 program which is a strong element of curriculum delivery at LCS, and the Teaching Aged Care Facilities program in which students are

placed in an aged care facility for two to four weeks. Students generally reported positively on these initiatives and they are well supported by enthusiastic and dedicated staff.

4.7 Interprofessional learning

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

Staff reported that there have been difficulties in embedding interprofessionalism within the early years of the program largely due to timetabling constraints across the health professional programs offered in Hobart (medicine, pharmacy and paramedicine). Despite this, there are several opportunities for students to observe and/or participate in interprofessional teams particularly in Years 4 and 5 when students are immersed in the clinical schools.

The Teaching Aged Care Facilities program described in Standard 4.6 provides opportunity for students to be placed with nursing or paramedicine students when possible. Students also participate in emergency simulation scenarios with paramedicine students in their final year, and in Year 4, have an opportunity to go away for a 'Wilderness weekend' with paramedical students, medical school staff, along with State Emergency Service and Antarctic Division representatives. Simulation activities are often conducted together with students from other disciplines, such as with nursing and midwifery students in Launceston. Many of the extracurricular activities described in Standard 3.6 provide excellent examples of interprofessional learning (IPL) opportunities however their voluntary nature means that student exposure is not scaffolded or assured within the program.

The School recognised that to date, ILP had been well-intended though ad hoc, and that the new Tasmanian Medical Program Committee in the new governance structure should be able to capture IPL activities, pilot correctly and implement if valid.

Enthusiasm for IPL was evident among many staff in the program, and approaches to this important issue would be strengthened by including IPL in a curriculum framework across the program. The School is required to embed IPL within the curriculum for all students and allocate appropriate resources to ensure its sustainability.

5 The curriculum – assessment of student learning

5.1 Assessment approach

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

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

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

The University of Tasmania *Assessment Policy* provides an appropriate description of assessment philosophy and principles. In 2008, following a review of assessment processes, the School defined nine principles governing assessment in the medical program. It subsequently developed the *Assessment Accountability Matrix* which defines the role and responsibilities of academic and professional staff in assessment, and the 2011 Medical Education Unit guide *Assessment in the MBBS*.

The governance of assessment has changed in the program since 2011, and the Medical Education Unit (MEU) was no longer operational. Assessment was previously the responsibility of the year committees with input from the MEU. The new Assessment Committee was formed in January 2016 and its terms of reference include responsibility for assessment policies, practices and quality assurance throughout the program. The Committee is chaired by the recently appointed academic lead in assessment, whose role will include oversight, monitoring, advising and reporting. The committee members include year and domain leads that will have operational roles in assessment in the various years.

At the time of the visit, the Assessment Committee had not had sufficient time to form an action plan to review the program's assessment processes and effectiveness. The year committees indicated they were awaiting clarification regarding how each will work with the Assessment Committee in setting assessments. Additionally, the Assessment Committee will consider the 2015 Wilkinson Review of Assessment (see Standard 5.4) which includes options for improvements in assessment. Changes in assessment will require approval of the Tasmanian Medical Program Committee and/or the School Learning and Teaching Committee. The new Assessment Committee is an important mechanism to oversee the program's assessment philosophy and processes. In the short term, it is necessary that the Committee's priorities include confirming the responsibilities of committees and staff for assessment activities, and review of the program's assessment processes, in particular acting on the Wilkinson review. The School is required to provide evidence that the Wilkinson Review recommendations have been addressed, and provide details regarding any changes to the program's assessment philosophy and processes.

At a year and unit level, the assessment mechanisms, practice and rules were well described in the individual unit outlines of the medical program. These are available to students enrolled in the respective units. Within each unit, the assessment appeared to align with the learning outcomes although there was no formal mapping of specific outcomes to their assessments. The academic staff in the year committees demonstrated clarity and commitment in explaining their existing process to align assessment to outcomes, and it is required that the formal process used to align learning outcomes to assessment be documented for the benefit of students and tutors.

Academic progression in the medical program is in accordance with University policy, and the Faculty of Health has *Supplementary Assessment Guidelines* which the program abides with. In the program, assessment and progression requirements in terms of unit assessment items and barriers are well-described in each unit outline, but the School process for discussing and deciding on progression in the program is not clear. The Wilkinson review identified that some of the progression rules may allow students to pass who should not have, for instance where there is compensation across different competencies, or where progression is determined by passing disciplines, rather than passing attributes. The team agreed there are areas of ambiguity in the progression rules and this should be addressed.

Progression decisions for medical students have previously been prepared by the year committee, then year leads present student assessment results to a School of Medicine group that ratifies results before submitting to the Faculty Dean. There is not a student advocate at the School progression group, though staff explained student advocacy in the progression process occurs at the year committee level. The Division of Medicine has formed a new Academic Progress Review Committee, which was due to have its inaugural meeting in June 2016. The team supports the formation of this committee as it will provide a whole-of-program view for consistency of progression rules and decisions, and the opportunity for student advocate input into decisions. At the time of the visit, information regarding the terms of reference, membership, relationships and functions of the Academic Progress Review Committee was not available, and this is required, including any criteria and progression rules used in its decision-making process.

There is a balance of formative assessment and feedback prior to most summative assessments, and a broad range of assessment modalities are used for both formative and summative assessments. The detail in feedback varies between assessments, with some providing basic summary data about the individual and class performance, and others providing detailed individual performance feedback.

Some students raised concerns regarding the loss of the Year 4 formative OSCEs and perceived there was less formative assessment. This decision was taken by the School as it stated formative OSCEs did not reflect summative results. The School indicated that formative assessment had increased and was consistent across sites, though it appeared student concerns related to the varied delivery of formative assessment across sites. The School agreed that this is an area for the Clinical Training Committee to consider in its

work to harmonise clinical sites. Overall, the team found that students obtain sufficient feedback following their formative and summative assessments to guide their learning.

5.2 Assessment methods

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

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

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

Students are assessed in all units with appropriate assessments for the intended learning outcomes. Assessment methods used in Years 1 to 3 include end of semester written exams utilising SAQ (short answer questions), MCQ (multiple choice questions) and EMQ (extended matching questions), and in-course essays, assignments, case studies and monitoring. There is a 4 station OSCE in Year 2 and a 12 station OSCE in Year 3. In Year 4, there is an end-of-year MCQ and a 12 station OSCE (objective structured clinical examinations). In Year 5 the 10 station OSCE increased to 12 stations in 2016 and the School indicated the number of stations may increase further in 2017. Workplace-based assessments in the clinical years include mini-CEX (mini clinical examination exercise) and DOPS (direct observation of procedural skills), in line with those used for Tasmanian interns. In both Years 4 and 5, students must complete 10 mini-CEX; and across Years 4 and 5 must complete core competency DOPS first in a simulated setting and then in a clinical setting. The longitudinal portfolio in the clinical years is used for specific graduate outcome assessments in the final year and has thorough guides and checklists to inform and guide the assessors and optimise reliability.

The 2015 Brazil Review found that procedural skills assessment was mostly absent in Years 1 to 3. In the clinical years, students are required to be signed off for clinical skills competencies specific to each placement and must complete a prescribed set of basic competencies overall. The issue of consistency across clinical sites and disciplines applies likewise to delivery of clinical skills curriculum and assessment.

Blueprinting, particularly in the early years, occurs according to volume of teaching for a domain or topic. In Years 4 and 5, MCQs and OSCEs are blueprinted according to the learning outcomes for the unit. Although each year had a clearly defined assessment mechanism for each unit, there was no overarching assessment blueprint mapped to learning opportunities and outcomes for each year, or for the program in full. The School participated in the Medical Deans blueprinting project based on the AMC Graduate Outcomes, and is considering whether to use this model for its blueprinting. Assessment

blueprints are required for each year or phase of the program. The role of the new Assessment Committee will be key in defining a blueprinting policy for the program.

There are validated standard setting methods for most assessments in the clinical years but not in Years 1 to 3. The University pass standard of 50% is used for written assessments and MCQ in Years 1 to 3. The School trialled the Hofstee method for MCQ in 2015 but at the time of the assessment this had not been implemented. The Hofstee method is used for the Year 4 MCQ, and the borderline regression method is used for OSCE standard setting (Year 2 excluded). There is no standard setting for the portfolio. Implementation of standard setting models for Years 1 to 3, and evaluation of the standard setting methods in Years 4 and 5, is required.

Staff indicated that support was required for item review and archiving, as they recognised the need to archive items better. IMS is starting to be used as an archiving database which will allow staff to bank items. Updates on the ongoing adequacy of resources to manage the program's assessment will be required in future progress reports.

5.3 Assessment feedback

5.3.1 The medical education provider has processes for timely identification of underperforming students and implementing remediation.

5.3.2 The medical education provider facilitates regular feedback to students following assessments to guide their learning.

5.3.3 The medical education provider gives feedback to supervisors and teachers on student cohort performance.

The School has effective processes to identify underperforming students. Formative and summative assessment mechanisms include early formative exams in Years 1 and 2 and a Year 2 mid-semester summative exam. The unit coordinators are responsible for monitoring student performance and speaking with students who are underperforming. The process was well understood by the academic staff involved, where students in difficulty are notified to the relevant unit coordinator who then involves the student support team, the safe practice team, or the program director. This can then trigger appropriate further investigation and diagnosis and development of a remediation or management plan.

Additionally, all students receive formal teaching about well-being and recognising one's own difficulties, and are informed about access to the student support team. The School requires students to be signed off annually on *Safety to Practice*. All approaches combined, the School provides commendable mechanisms for identification of students in difficulty and thereby implementing remediation which is well coordinated and offers a multipronged approach.

Students obtain sufficient feedback following their formative and summative assessments to guide their learning. However, in Years 4 and 5, the Wilkinson Review reported that the amount of feedback provided varies widely across clinical school sites, and recommended that the School consider a policy that states students should not be expected to submit assessments unless they are returned with feedback. The team recommends that a consistent feedback policy for summative and formative assessments be considered by the Assessment Committee.

Supervisors and teachers do not have consistent information about student performance, despite having a student marks database available for use. Evidence is required that information regarding student cohort performance is formally provided for discussion at the performance and is available for consideration by the relevant year committees and the Tasmanian Medical Program Committee, and that student cohort feedback is disseminated to supervisors and teachers.

5.4 Assessment quality

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

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

As noted at Standard 5.3, the School has a student marks database using IQ DREAMS software for MCQ and EMQ examinations and for clinical assessment data. The School has capacity to analyse results and report to staff and students. MCQ items are stored in the IDEAL database.

The School is a member of ACCLAIM which benchmarks OSCEs against a large number of Australian medical schools. The School found it had comparable pass marks but significant differences in reading time, scoring systems and failure rates on stations. It has subsequently standardised reading times, and implemented new scoring systems and feedback systems. The School is encouraged in this quality improvement work and updates in future reports will be of interest.

The School also participates in the Medical Deans Benchmarking project, and its results based on 50 MCQ items inserted in its Year 4 exam suggest the students are of a similar standard to other participating schools.

The School has taken efforts to review its assessment processes, and in 2015 commissioned the Wilkinson review of assessment, which provides an excellent resource to guide the development of an assessment quality framework. The options for improvement described in the review include:

- Consideration of assessment by domain rather than discipline
- Investigation of different blueprinting methods, for example by domain, cases or level of knowledge rather than discipline
- Evaluating and/or implementing standard setting procedures
- Considering use of the term “conditional pass” rather than “borderline”
- Reviewing the consistency and harmonisation of assessments across sites
- Ensuring consistency of quality feedback given to students for all assessments
- Reviewing OSCE stations and consideration of a patient mark component in some stations, blueprinting of all domains, providing opportunities for examiners to discuss their understanding of the stations as a group in order to improve reliability
- Considering the use of progress tests
- Improving the clarity of the portfolio purpose and use in the early years
- Reviewing assessment item quality (written exam questions and OSCE stations) to ensure questions appropriately assess at the relevant levels of Bloom’s taxonomy
- Development of an assessment quality improvement system with evaluation of the various assessment tools and processes in place to improve

The new Assessment Committee affirmed it intended to review the recommendations. The School should develop an assessment quality framework and implementation plan that also addresses the Wilkinson review options. This plan should include practices related to item development, moderation, standard setting, blueprinting, psychometric evaluation, and progression/attrition rates. Psychometric expertise will be required as noted at Standard 1.8. The AMC will require evidence that an action plan has been developed to address the issues above (also noted at Standard 5.1), and evaluation is planned for any changes.

There is evidence that there were inconsistencies in the volume and methods of assessment across the clinical schools. Examples cited in the Wilkinson Review included varied in-course assessments, markedly varied examiner quality in the clinical year OSCEs and differences in workplace-based assessment in each clinical school. There was variable delivery of the formative DOCES in Year 4 (see Standard 4.1). The School’s Burgess Review also recommended that there be an improvement in the consistency of assessment of student professionalism in Years 3 to 5.

Staff at the three clinical schools indicated that the clinical schools were examining the same core skills and students were meeting the required outcomes, albeit in different ways.

The Clinical Training Committee is focused in 2016 on harmonising the clinical training process. Once this has been implemented, the AMC will require evidence of standardised processes to ensure consistency of summative and formative clinical assessments across clinical sites. This includes the process for assessment, calibration across sites, and ongoing quality assurance and review of assessment across sites.

6 The curriculum – monitoring

6.1 Monitoring

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

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

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

Monitoring of the program occurs in accordance with the University Evaluation Policy, which includes use of eVALUate to monitor subjects and teachers, the Course Experience Questionnaire, and the Professional Experience Placement survey. There are multiple points at which students provide evaluation data, including these standard university evaluation forms, unit specific approaches and evaluation officer led initiatives, such as state-wide student focus groups. At a school level, more qualitative review occurs in response to specific issues raised. There was evidence of timely responses to feedback in reaction to specific units or year groups. The use of ad hoc opportunities to gather data when concerns have been highlighted is valuable.

In the last two years there have been several external reviews, including the Hays curriculum review, the Brazil review of the clinical practice domain, the Wilkinson assessment review, the Sen Gupta rural medical education review, and the internal Burgess clinical schools review and Errey clinical skills review. It will be important to consider the review recommendations, the extent to which they need to be part of ongoing monitoring, and who will be accountable for specific recommendations.

Although there is a range of evaluation activities being undertaken, there was not a process for regular systematic review of the program. The School was developing an evaluation framework for the medical program. It has an evaluation officer and was considering establishing an evaluation committee. The access to a dedicated evaluation officer will be a key resource to ensure more systematic evaluation across the program and outcomes. This is important given the amount of change the program is implementing through new governance structures. The plans for a systematic approach to evaluation that will monitor the considerable efforts that are going into program and governance development are commended.

A systematic approach aligned with an effective framework with clear governance and adequate resources will be an important element to support the curriculum development

already underway. The School is required to develop and implement a comprehensive program evaluation framework, and show how this links into the governance structure of the medical program. This will include clear objectives around building on the findings from the reviews, evaluating the effectiveness of the new governance structure and making findings available to stakeholders.

A large amount of data are already routinely collected, such as assessment data, and these will be a source of information on how well the curriculum is performing and how responsive the new governance structure can be. It will be important for the new committees to have the review of evaluation data as part of their workplan where appropriate.

Students and supervisors reported a lack of clarity on what impact the evaluation and feedback was having on the curriculum and governance developments. Several initiatives, such as those around interprofessional learning, were reportedly well received. The School is encouraged to incorporate evaluation of these initiatives into the framework to ensure that, where appropriate, such initiatives become part of the mainstream curriculum for all students.

There is good use of national resources to analyse outcomes and benchmark this program against others. The School collaborates with other education providers regarding program outcomes, teaching and learning, and assessment. As noted at Standard 5, the School is a member of IDEAL, ACCLAIM and the Medical Deans Benchmarking project.

The development and communication of the evaluation framework will encourage a more systematic approach to review and monitoring of the program and will drive change appropriately. In particular, the concerns around perceived differences in the delivery of the medical program across the three clinical sites need to be addressed. This can include consideration of assessment data and the preparedness of graduates.

6.2 Outcome evaluation

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

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

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

The School had a number of different approaches underway regarding the analysis of performance of cohorts and graduates, including the evaluations noted at Standard 6.1 with IDEAL and ACCLAIM. It is required that the School formalise a systematic approach

to evaluating the performance of cohorts of students and graduates in relation to the outcomes of the medical program.

The School's collaboration with the Postgraduate Medical Council of Tasmania is important and continued work to share data on graduate outcomes and work readiness at intern level will be a valuable part of the evaluation approach. The draft report compiled on the 2015 Tasmanian interns using the *AMC Intern Training Assessment Form*, found against each intern outcome statement that the great majority of interns are fit for purpose.

Stakeholders perceive there are differences in outcomes, and educational methods and processes across the three clinical schools. Rigorous evaluation needs to include the data on these factors across all schools, and this can form part of the evaluation plan. Given the number of graduates who stay in the state for their first postgraduate year, there are further opportunities to ascertain if the perceived differences across the clinical sites lead to any differences in outcomes at the graduate level.

There are processes in place to provide feedback for committees regarding student characteristics and this can be formalised with the new governance structure. For example, University Admissions feeds data back to schools on applicant profiles and characteristics; and the Admissions Committee is involved in the UMAT Longitudinal study and can analyse data from 2006 to 2016. In addition, the relationship with the relevant student societies and ensuring their input on key committees will be an important part of successful evaluation.

It will be important to ensure committees are clear on their roles in terms of acting on findings and also feeding back to other stakeholders including clinicians who teach into the program. There is an opportunity to clearly delineate the roles of those involved in delivering elements of the program and those capturing and analysing evaluation data. This will ensure streamlining approaches to reduce survey fatigue among students.

6.3 Feedback and reporting

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

6.3.2 The medical education provider makes evaluation results available to stakeholders with an interest in graduate outcomes, and considers their views in continuous renewal of the medical program.

The team found no evidence of significant concerns in feedback and reporting to staff and students, though it was varied and not systematically done or embedded in the governance. It will be part of the role of the new committees to ensure feedback and reporting are effective. As the new governance structure is implemented, it will be important to ensure evaluation has a profile at the relevant points, for example as a

standing agenda item for the Tasmanian Medical Program Committee and domain and year committees. The terms of reference for the new committees will need to include effective consideration of evaluation data and processes.

Feeding back data to a broad range of stakeholders, some of whom may not have a strong affiliation to the program, can be part of the communication strategy in the evaluation framework. Given the challenges in engaging busy clinical staff in curriculum delivery, they will need clear channels of communication to and from the medical program about the effectiveness of their input.

Strong relationships already exist, formally and informally, to provide the foundation for stakeholder involvement in the renewal of the medical program. The formal establishment of the Medicine Stakeholder Engagement Advisory Group is a key group that could have significant input to the priorities in the evaluation workplan.

Formalisation of the process of making evaluation results available to stakeholders and considering their views in renewal of the program is required. This can also form part of the evaluation plan.

7 Implementing the curriculum - students

7.1 Student Intake

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

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

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

The School has defined its intake to the medical program as 120 students per cohort. This comprises 71 Commonwealth supported places, 29 government funded and bonded places, and 20 international student places. There was a slight increase in bonded funding places representing an increase of three students in 2016. Additionally, five International Medical University Malaysia students are admitted into Year 3 each year. Intake has been constant since 2007 when the School transitioned from a six to five year program. Table 1 shows the 2016 intake; Table 2 shows the student numbers for the program by year.

Table 1: 2016 School of Medicine intake

Year	Government supported	Government-funded bonded (Rural/Medical)	Fee-paying domestic	Fee-paying international	IMU	Total
2016	71	29	0	20	4	124

Table 2: Student numbers 2011 - 2015

Year	Government supported	Government-funded bonded (Rural/Medical)	Fee-paying domestic	Fee-paying international	Total
2015	327	134	N/A	111	572
2014	323	127	N/A	112	562
2013	339	128	N/A	103	570
2012	357	130	N/A	98	585
2011	349	123	N/A	113	585

The School reported it has no plans to change intake numbers. Any increase would require state and federal government approval. Allowing for attrition over the five-year program, 93 domestic graduates are produced which aligns with the intern positions offered by the Tasmanian Health Service.

The School has the capacity to adequately resource the program for the cohort size.

Attrition figures representing withdrawals from the program are shown in Table 3. In the last three years, absence rates have been reasonable and related to personal and health reasons.

Table 3: Attrition figures from 2013 - 2015

Year	Year 1	Year 2	Year 3	Year 4	Year 5	Total
2015	3	2	0	3	0	8
2014	1	2	0	0	0	3
2013	2	2	2	2	0	8

The School has a quota of approximately 75% school-leaver students, and 25% students who have commenced or completed tertiary study. The tertiary admissions will change from 2018, when up to 20 tertiary places will come from the School's Bachelor of Medical Research defined MBBS entry scheme and competitive entry scheme.

The School has increased its target for rural students to 50% following the introduction of a rural application process in 2015. The School is using Australian Government rural area ratings RA 2-5 (Modified Monash Model 2-7), with a further aim that 30% of this 50% be from RA 3-5. Students must have lived in a defined rural area for five consecutive or ten cumulative years. In 2016, the School received 71 applications, made 66 offers and 48 students accepted and entered the program.

The rural pathway has been supported with bursaries worth \$5,000 for three years, which were offered to eight students in 2016, and via strengthening of a dedicated academic support person in Hobart. The School indicated it plans to continue the rural admission pathway, bursaries and support in future years with the ongoing assistance of RHMT funding. The team commends the School for its successful initiative to increase the proportion of students entering the program from rural origins.

The School has two places available per year for students identified as Aboriginal or Torres Strait Islander. At the time of the visit, there was one Aboriginal student in the program due to graduate in 2016. The School indicated it had a second prospective Aboriginal student in Year 12 who it hoped will prove eligible for admission. It indicated it wished to increase the target and required student supports as resources and staffing permit.

7.2 Admission policy and selection

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

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

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

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

The School's admission policy and selection processes are well-defined. Admissions administration is centralised with the School providing guidance regarding medical program offers. The School's Admissions Committee is the only program-specific admissions committee in the University, and it is responsible for rural and Aboriginal student processes. While the University acknowledged that medical admissions incur greater overheads, it is supportive of the process to ensure the desired medical cohort is recruited.

All applicants require Year 12 or equivalent Chemistry and English, and if Chemistry is over five years old they must undertake a university bridging course. Applicants require an ATAR of 95 or above, and rural applicants may receive an additional 5 weighted points. Tertiary applicants essentially require a distinction average instead of the ATAR, though there are specific rules regarding various levels of prior study. Ranking will also take into account the UMAT score, both in each section and overall, and must be used the year following UMAT. Interviews are not conducted. International students require a satisfactory ISAT score, IELTSs of 7 and Year 12 A-levels.

The new Bachelor of Medical Research (BMedRes) pathway from 2018 requires the defined entry students to complete the BMedRes in three years with a mid-level credit and no fails, and the competitive entry scheme will offer the top five ranking students a place the year after they complete the BMedRes.

In 2015, the School commenced a new application policy for Aboriginal and Torres Strait Islander students. Admission is based on academic achievement (Year 12 Chemistry and English and a competitive ATAR) and interview. The UMAT is not required. This policy is not an explicit pathway and the School has no plans for formal pathway programs for Indigenous students. It was noted that the online information for the Aboriginal application process for the program does not mention any assistance or supports available to applicants, nor links to this information.

The University's Riawunna Centre for Aboriginal and Torres Strait Islander Higher Education has an explicit role in supporting access to general University programs for

Years 9 to 12 students, which include its *Murina* alternate entry program, a mentor program in which a university student mentors a high school student, and cultural, financial, academic and pastoral supports. Medical applicants are able to access these services.

The School runs a taster day for Aboriginal high school students and invites an Aboriginal doctor to talk to the students. Staff recognised that there was opportunity to work more with local groups and representatives to identify potential Aboriginal students for the medical program, but there was not an identified role to do this. There is further potential for the School and Riawunna to foster school students for medicine and to develop a pipeline for Aboriginal students into medicine and other health courses in the Faculty.

The School should continue to develop its approaches to recruitment and retention of Indigenous students including visibly defining admission requirements and supports available to Aboriginal students. At the time of the visit, the one Aboriginal student received an excellent level of support, including a scholarship and payment of HECS fees. However, as noted at Standard 7.1, if student numbers increase, additional resources will be necessary to ensure student supports. Riawunna provides a welcoming space for Aboriginal and Torres Strait Islander students to meet and harness support, but its location at the Sandy Bay main campus makes it difficult for medical students to access. Tutor support for future Aboriginal students will be necessary, ideally in the medical school precinct not the main campus. Support processes for recruitment and retention are required to be formalised and publicised to guide and encourage future Aboriginal students.

The UTAS *Safe to Practice* policy and the Faculty of Health *Safety in Practice Requirements* include infectious disease requirements and outlines how students must have the medical, physical and psychological capacity to safely undertake the mandatory functional requirements of professional experience placements.

Information about the program's selection process is publically available. Information about the mechanism for appeals if an applicant was unsuccessful is not as easy to find online. It is contained in *Rule 3 Admission and Student Progress* which states that unsuccessful applicants may seek clarification of non-admission of the reasons for the decision from the Executive Director, Student Centre.

7.3 Student support

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

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

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

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

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

The School is commended for the comprehensive set of student supports available, together with a functional and effective set of mechanisms for identifying and managing students at risk. These covered personal, health, mental health, disability, professional behaviour, fitness to practice and academic issues. Appropriate resources were available at School, Faculty and University levels, with escalation pathways well-defined and external resources and supports appropriately engaged as necessary. Mechanisms to identify and support students with disabilities and health related issues are available, and these are outlined at Standard 7.2 and 7.4 in line with *Safe to Practice*.

Within the School, the student advisor facilitates student access to services. Students at the clinical sites indicated awareness of how to seek support. At Launceston and the Rural sites, staff and students indicated strong support mechanisms were available, not least due to all the staff and clinical supervisors knowing all the students.

There was evidence of strong support for international students entering the program and a well-developed and rich set of elective arrangements for students in place. The School had increased its support for rural students at Hobart in Years 1 to 3 with the increase in the rural target. As indicated at Standard 7.2, support for Aboriginal students is available for the current target of two.

The School has deliberately and effectively separated those with student support roles from those with academic progression roles.

7.4 Professionalism and fitness to practise

7.4.1 The medical education provider has policies and procedures for managing medical students whose impairment raises concerns about their fitness to practise medicine.

7.4.2 The medical education provider has policies and procedures for identifying and supporting medical students whose professional behaviour raises concerns about their fitness to practise medicine or ability to interact with patients.

The Faculty of Health has *Safety in Practice* policies and procedures specific to each course, including the medical program, and these are available online. The Faculty has a Professional Experience Placement Office and team to manage these requirements. For example, students with a disability are encouraged to meet a disability advisor to discuss mandatory functional requirements and develop a learning access plan.

Medical students are reminded of the requirements by the Director of Student Support and receive training in Year 1. All students must sign a safety in practice agreement annually and students with health conditions are also required to complete a *Safe to Practice Health Assessment* annually. If students make a disclosure, they give their consent for their treating practitioner to inform the School if they are fit to practice. If a student chooses not to disclose they can be withdrawn from practice.

If concerns arise about a student's clinical practice on a professional placement, the Faculty can remove the student under its risk management procedure. The Head, Division of Medicine is responsible for notification to AHPRA if a student poses a significant safety risk. If serious enough, professional behaviour management may include referral to the University's Academic Misconduct Procedures.

Students can be failed on professionalism and the School has excluded students successfully on professional grounds. If a medical student is unable to meet safe to practice requirements and unable to complete the program as a result, they may be able to articulate into a medical science program.

The team commends the School for the innovations implemented in regard to professionalism and fitness to practice. Not only are the policies and procedures well-constructed conceptually, they are also practical and effective in terms of implementation.

7.5 Student representation

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

The School made clear that student representation is planned for the vast majority of its committees. However, the newness of the committee structures and the fact some had yet to meet meant that student representatives had not yet been identified for all

committees. The School indicated it intends to work with the student body to fill those representative roles. The School is required to confirm student representation on the committees as a priority. Students indicated that students have groups in Year 4 and 5 at their clinical sites and give feedback to their school, though there were no formal structured meetings of students across sites. Student representatives on the Clinical Training Committee from the sites will be a step to improving communication across the clinical sites.

The Tasmanian University Medical Student Society (TUMSS) draws membership from the medical student cohort and has a formal relationship with the School. It receives a budget from the School to support student welfare activities. The School executive regularly meets with the TUMSS president.

There is a rural student society RUSTICA which draws its membership from nursing, medical, pharmacy and paramedic programs with branches at the three sites. IMPACT is the AMSA endorsed global health student society at the medical school.

7.6 Student indemnification and insurance

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

Students are indemnified for relevant activities undertaken as part of program requirements. The University's insurance program provides cover for students while undertaking unpaid Work Integrated Learning Placements approved by the University. It includes cover for personal and professional liability, medical malpractice and personal accident insurance.

8 Implementing the curriculum - learning environment

8.1 Physical facilities

8.1.1 The medical education provider ensures students and staff have access to safe and well-maintained physical facilities in all its teaching and learning sites in order to achieve the outcomes of the medical program.

The University of Tasmania Medical School is situated in the Hobart central business district, approximately five kilometres from the main university campus at Sandy Bay. Students in Years 1 to 3 are based in the Medical Sciences Precinct (MSP) which opened in 2010, including the Menzies Research Complex and Hollidene House, adjacent to the Royal Hobart Hospital. Students in Years 4 and 5 are taught in three clinical schools in Hobart, Launceston and Northwest Tasmania (Burnie and Devonport).

At the MSP, students have access to good facilities in Years 1 to 3, but there is pressure on study space as health faculty student numbers expand. There is a modern facility for teaching the pre-clinical sciences, nearby lecture theatres and tutorial rooms, a clinical skills teaching suite and excellent facilities for teaching anatomy. Teaching space for pathology and simulation is located at the adjacent hospital. There is an excellent library with a large collection of relevant text books, online references and computer stations. University accommodation is available for Hobart students, particularly in Year 1, and for students new to Hobart.

The School acknowledged there was inadequate space to arrange OSCEs in the MSP with sufficient numbers of stations due to the MSP having only seven rooms for this purpose. The Brazil Clinical Practice Domain review also noted that the clinical skills rooms in MSP are inadequate in number, lack AV technology to facilitate remote viewing or recording of performance, and also lack flexibility of layout. The School was awaiting building approval for its plans to convert space to accommodate fourteen station OSCEs, and to acquire co-located property to facilitate growth.

Students at Hobart indicated that there was inadequate study space in the MSP, space was shared with other health students, and the team observed students studying in common foyer areas. The student space at Hollydene House had been cut to develop research space for higher degree research students. Pre-clinical students were worried about the increase in number of other biomedical students and the diminishing common spaces in the MSP. Increasing medical and health student numbers will increase pressure on already constrained space and updates will be required in progress reports on how this will be managed.

In Hobart, the Clinical School facilities are fair. The Royal Hobart Hospital is undergoing a major upgrade to a new major acute care hospital. The Hobart Clinical School remains in the 50 year old F-Block of the Royal Hobart Hospital precinct, which the School acknowledged is old and in need of replacement. There had been refurbishment of the student in-hours common room, and other office and teaching space. At the clinical

school, there have been recent pressures on utilisation of the teaching facilities by other groups, however and there was no clear mechanism for accessing the facilities for medical student teaching. Delineation of a clear mechanism to define space priorities should be clarified.

The excellent physical facilities for students and staff in the Rural Clinical School and Launceston Clinical School are commended. The Launceston Clinical School moved in 2012 from the basement of the Launceston General Hospital, to now comprising a floor of the Launceston Integrated Care Centre in the hospital precinct. There is also a student facility in the St Vincents' Private Hospital in Launceston for all health students. Students suggested a student facility be established at Hobart's Calvary Hospital for medical, nursing and allied health students similar to that at St Vincent's.

Facilities at the Rural Clinical School in the North West are also relatively new and well designed for their purpose. All regional sites have a library, a simulation facility, tutorial rooms, Wi-Fi and, in the Rural Clinical School, subsidised sea-view student accommodation for 57 students. Library resources include textbooks, computer terminals, internet-based reference systems and support staff.

In community care, student facilities in general practice sites have been upgraded over the last five years using HWA, GP North and Commonwealth infrastructure grants with seventeen sites receiving enhanced facilities for student learning. Several Teaching Aged Care Facilities, co-funded by the Commonwealth, have been developed in aged care homes to accommodate medical, nursing and paramedical students training needs.

8.2 Information resources and library services

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

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

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

The School has steadily updated its information communication technology (ICT) infrastructure since the last AMC assessment, upgrading AV technology in lecture and videoconference rooms, introduced cloud computing and Wi-Fi across most campus areas. The Faculty has upgraded its student clinical placement system and the School is upgrading its IDEAL assessment database. The School considers that the ICT resources are adequate for greater use of intranet and online teaching in the program.

Students receive an Office 365 licence, and have good eduroam access to Wi-Fi at all campuses, in the MSP and the libraries. The Information Technology (IT) staff have a new tool to log student IT requests which staff report was receiving good student feedback. At Hobart, the team learned that an extra terminal for students to access hospital records in the library would be valuable as the present terminal gets overloaded when students have assignments pending.

Echo360 is available for recording lectures on an opt-in basis, though not all medicine lectures are recorded as clinician take-up varies. Additional ICT support for academic staff in recording and uploading of lectures would be beneficial.

MyLO, the learning management system, is accessible at all sites to students and staff, although students' access in the clinical years does not extend to units offered at other sites, and practical solutions to these access issues are recommended. As discussed at Standard 4, the School intends to link a new curriculum database to *MyLo*. Discussions are encouraged regarding how the database will be compatible across university systems.

Student and staff library facilities at all sites were satisfactory. Library resources include textbooks, computer terminals, internet-based reference systems and support staff. In Hobart, additional single study desks had been provided in the clinical school library. The School had no plans to expand physical library facilities though web-based services are continually being expanded.

8.3 Clinical learning environment

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

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

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

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

Students have extensive opportunities to experience patient contact and a diverse mix of clinical scenarios at the three sites. Each clinical school is co-located with a major regional hospital: Royal Hobart Hospital has 550 beds, Launceston General Hospital has 300 beds,

and affiliated with the Rural Clinical School, the North West Regional Hospital has 160 beds and Mersey Community Hospital has 100 beds.

In Years 1 and 2, students undertake half-day community visits and primary care placements with a broad range of providers. In Year 3, students are based in Hobart and each student completes four eight-week clinical rotations in surgery, medicine, primary care (includes two weeks in GP placement plus other community providers), and clinical specialties including psychiatry, paediatrics, and obstetrics and gynaecology.

In Years 4 and 5, students are allocated to a clinical school. In Year 4, students undertake clinical attachments in small groups as allocated by the clinical school based on the range of clinical services available. Clinical school allocations are shown:

Table 4: Clinical school allocation, Years 4 and 5

Year	Hobart Clinical School		Launceston Clinical School		Rural Clinical School		Total
	Y4 – 44	Y5 - 40	Y4 – 44	Y5 - 42	Y4 – 27	Y5 - 20	
2015	Y4 – 44	Y5 - 40	Y4 – 44	Y5 - 42	Y4 – 27	Y5 - 20	217
2014	Y4 – 34	Y5 - 43	Y4 – 42	Y5 - 40	Y4 – 24	Y5 - 27	210
2013	Y4 – 38	Y5 - 48	Y4 – 40	Y5 - 44	Y4 – 31	Y5 - 24	225
2012	Y4 – 41	Y5 - 43	Y4 – 43	Y5 - 40	Y4 – 32	Y5 - 30	230
2011	Y4 – 43	Y5 - 34	Y4 – 43	Y5 - 37	Y4 – 32	Y5 - 24	213

The School's *Clinical School Allocation Procedure* manages student preferences, with students reporting that most students get their first preference. The majority of students complete Years 4 and 5 at one clinical school, with only 10 – 15% swapping clinical schools. Changing clinical school sites has been problematic as schedules, rotation lengths and timings have differed. The clinical training harmonisation process underway aims to improve comparability across sites so students can change clinical schools without disadvantage. This is an area for future reporting (see also Standard 2.2 and 3.2).

The School's rural program provides for all students to have a graded experience in rural health. In Year 1, the full cohort attends a rural week at Camp Clayton in the North West, and in Year 2, all students are placed state-wide for a rural week in various communities visiting community stakeholders. In Years 3, 4 and 5, all students do a two-week rural GP placement each year.

Year 4 students at the Rural Clinical School rotate through six four-week acute clinical placements, and in addition complete a longitudinal primary care attachment for 36 weeks on a Tuesday. Students will attend two different practices in the year, and are

generally expected to attend their clinical placement ward round before reporting to the GP before 9am. Students reported great satisfaction with the rural experience, excellent opportunities for patient contact, and superb support from teachers. The rural experiences offered to all students, particularly the opportunity for around 40 Year 4 students to experience a longitudinal healthcare experience at the Rural Clinical School, and the effort made by local tutors to facilitate this, is commended.

There is wide engagement of health care providers in the delivery of education. Private hospitals, private rooms and aged care facilities are used for placements across the program. General practitioners are extensively used as educators in both case-based presentations and on location in individual practices. The team was impressed with the opportunities available for the secondment of students to general practice in remote locations.

Tasmania has five facilities that provide health care for Tasmanian Aboriginal people and given the size of these facilities it is not feasible for all students to directly observe provision of Aboriginal health care in these settings. For example, at the Rural Clinical School, two students at a time are placed in the Aboriginal Health Service, though students interested in Aboriginal health can be placed in general practices with a larger Aboriginal client load, and can also be placed on King Island. Students may undertake Aboriginal and Indigenous health electives on the mainland in Years 4 and 5 with uptake under ten across both years.

The University is the only primary medical and health professional education provider in the state. The Faculty of Health's Professional Experience Placement office has local staff members at each campus to coordinate health professional students.

8.4 Clinical supervision

8.4.1 The medical education provider ensures that there is an effective system of clinical supervision to ensure safe involvement of students in clinical practice.

8.4.2 The medical education provider supports clinical supervisors through orientation and training, and monitors their performance.

8.4.3 The medical education provider works with health care facilities to ensure staff have time allocated for teaching within clinical service requirements.

8.4.4 The medical education provider has defined the responsibilities of hospital and community practitioners who contribute to the delivery of the medical program and the responsibilities of the medical education provider to these practitioners.

Clinical school directors, co-directors and professional staff play a crucial role in supporting and coordinating clinical teachers. Clinical teaching is delivered by a large

cohort of casual clinical educators. New teachers are oriented by the clinical school director and the relevant site discipline lead.

The School's unit handbooks and clinical school handbooks define the curriculum and approaches to teaching. Clinical teachers can access the online learning management system *MyLo* for teaching materials. The Rural Clinical School has an orientation pack for new supervisors, though there did not appear to be a state-wide Tasmania Medical Program guide for supervisors. Consolidation of orientation materials and resources provided to clinical teachers across the clinical sites is recommended.

The activities of general practitioners are coordinated by the clinical sites and are highly integrated into clinical teaching within each clinical school. The level of orientation required may depend on their prior experience as a regional training provider or trainee supervisor. The quality of teaching and supervision is monitored by clinical school management via informal and formal feedback.

While there is considerable pro bono teaching many teachers are able to quarantine time for teaching. Clinical schools are responsible for advising teachers of formal teaching and learning available. Opportunities are provided for educators to undertake modules to enhance their teaching skills including a Graduate Certificate in Education and Teaching on the Run. Teaching on the Run is also offered 'on the run' at GP practices by the Launceston academic coordinator. At Launceston and Hobart Clinical Schools there are monthly clinical teacher meetings, and at the Rural Clinical School up to weekly meetings, for clinical teachers to discuss teaching in the program, and receive updates and advice.

Clinical school directors liaise with health care providers to plan and negotiate clinical placements annually so as not to compromise service delivery. All hospital executives met reported good relationships with the relevant clinical school. Where there was change in roles and responsibilities of management due to the THS restructures, there remained continuity in local relations between the clinical school and health service and commitment to continued delivery of the program.

A strong teaching culture was observed across the clinical sites, which is commended. The team was impressed by the enthusiasm and commitment of clinical teachers whose contributions are valued by the students. Clinicians indicated that they were passionate about tutoring and supervising in the medical program, and motivated by the return of their students as junior doctors. In turn the students felt privileged in their clinical placements and valued by their clinical supervisors.

At a time of significant change in the Tasmanian Health System and increasing service pressures, the team recognises the importance of celebrating these teaching contributions and recommends active consideration of how these might be strengthened and sustained. This may include the School building a 'Tasmania Medical Program' type brand with more centralised recognition of clinical supervisors, in addition to the existing strong bonds that clinicians have with their respective clinical schools.

It was apparent at all sites that the medical program consistently produces graduates who are work-ready interns and the team was pleased to hear accounts of graduates returning to rural locations and other areas of need.

Appendix 1 Membership of the 2016 assessment team

Professor Nicholas Glasgow (Chair) BHB MBChB GradDipFamMed MD FRNZCGP
FRACGP GradCertEdStudies FACHPM

Dean, School of Medicine, Australian National University

Associate Professor Linda Crane (Deputy Chair) BSc PhD Grad Cert in Teaching

Associate Dean, Learning and Teaching, Faculty of Health Sciences and Medicine, Bond
University

Professor Tony Celenza MBBS MClined FACEM FFAEM

Director, Education Centre, Faculty of Medicine, Dentistry and Health Sciences, University
of Western Australia

Clinical Professor Michael Hollands MBBS FRCS FRACS DHM

General Surgeon, Westmead Hospital, Sydney and Western Clinical School, University of
Sydney

Professor Michelle Leech MBBS (Hons) FRACP PhD

Deputy Dean MBBS, Faculty of Medicine, Nursing and Health Sciences, Monash University

Associate Professor Alison Jones PhD BA(Hons)

Manager, South Australia Medical Education and Training, Medical Workforce

Ms Theanne Walters

Deputy Chief Executive Officer, Australian Medical Council

Ms Stephanie Tozer

Manager, Medical School Assessments, Australian Medical Council

Appendix 2 Groups met by the 2016 assessment team

University of Tasmania

Senior Business Partner Finance

Vice Chancellor

Provost

Acting Faculty Dean

School of Medicine Staff

Head of Division of Medicine

Head of School of Medicine

Business Manager

Associate Head Research

Hobart Clinical School Director

Launceston Clinical School Director

Post-graduate programme head

Bachelor of Medicine Research Head

Domain Chair – Clinical Practice

Domain Chair – Health and Society

Domain Chair – Scholarship and Science

Domain Chair – Professionalism and Leadership

Co-Directors Rural Clinical School

School of Medicine Groups and Committees

Admissions Committee

Assessment Committee

CBL Tutors

Clinical Disciplines Committee

Clinical Practice Committee

Clinical Training Committee

Division of Medicine Advisory Group
Division of Medicine Professional Staff
Evaluation group
General Practitioner supervisors
Health and Society domain staff
Indigenous Health staff
Interprofessional learning staff
IT / e-Learning staff
Learning and Teaching Committee
Professionalism and fitness to practice group
Professionalism and Leadership domain staff
Research Committee
Science and Scholarship domain staff
Student support group
Tasmanian Medical Program Committee
Year 1 and 2 Committee
Year 3 Committee
Year 4 and 5 Committee

Students

IMPACT –University of Tasmanian Global Health Society
National Rural Health Student Network
Preclinical and clinical students
Tasmanian University Medical Students Society

Clinical sites

Hobart Clinical School

Clinicians, the Royal Hobart Hospital

Royal Hobart Hospital Executive Directors

School Executive Staff

Students

Launceston Clinical School

Clinicians, Launceston General Hospital

School Executive Staff

Students

Tasmanian Health Services Executive Director of Services, Launceston General Hospital

Newstead Medical Practice

Simulation medical training lead

Burnie Clinical School

Clinicians, Mersey Community Hospital

Clinicians, North West Regional Hospital

Mt St Vincent's Nursing Home, teaching staff

North West Regional Hospital Executive Director, and Director of Medical Services

Patrick Street Clinic, teaching general practitioner

Rural Clinical School Executive Staff

Stakeholders

Clifford Craig Medical Research Trust Foundation – Chief Executive Officer

Department of Health and Human Services - Director, Acute Health Service Planning and Design

Menzies Institute for Medical Research – Deputy Director

Tasmanian Health Service – Chief Executive Officer