ADELAIDE MEDICAL STUDENTS' SOCIETY
EST 1889

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Friday 3rd June 2022

Ms Brooke Pearson
Accreditation Officer, Medical School Accreditation
Australian Medical Council

Dear Ms Pearson,

On the 12th of November 2021, the Adelaide Medical Students' Society (AMSS) received an invitation from the Australian Medical Council (AMC) to submit a student report on the University of Adelaide Medical School's performance in accordance with the AMC standards for accreditation.

The Adelaide Medical Students' Society (AMSS) is the peak representative body for medical students at the Adelaide Medical School. The AMSS recognises the importance of the Australian Medical Council (AMC) accreditation process and is grateful for the opportunity to contribute student opinion. The AMSS appreciates the fact that the Australian Medical Council (AMC) has once again requested a student submission.

As with previous student submissions, the AMSS has invested significant energy in developing an evidence-based report which focuses on the core AMC accreditation standards. The survey guiding this document is of similar scope to previous surveys, collecting responses from 393 students (an overall 38% response rate of the total medical student cohort at the Adelaide Medical School). We believe that our methods, response rate and informed view of student opinions allows this document to be taken as a sufficiently accurate reflection of student opinion. However, this student submission should be interpreted within the context of its limitations.

This document aims to convey student opinion on matters associated with the AMC accreditation standards. Overall, student opinion does not unreservedly endorse the medical program, and this document raises some concerns regarding staffing of the medical program (particularly with regards to pastoral care), continuing development of the MBBS Course, transition to clinical placements, participation in interprofessional learning and meaningful engagement of clinical supervisors. The strengths of the University of Adelaide medical program that we have identified include student representation and engagement with student feedback, access to rural placements, communication of assessment requirements and clinical skills teaching in Years 1 and 2.

Lastly, we acknowledge the efforts of all the other students who were consulted in the creation of this report, including the AMSS Executive and student representatives in AMSS Team Education. We also thank those involved in the analysis of data and documentation of the findings, as listed below:

- Kelly Hou – Preclinical Education Officer
- Kashyapchandra Avadhani – Second Year Education Representative

The AMSS calls on the AMC to carefully consider this submission and to act accordingly, given that this is a crucial time with the commencement of the BMD medical program. We

sincerely thank the AMC for the opportunity to submit this document and would be very happy to provide any additional information.

We thank you for your time and consideration of this letter. Please do not hesitate to contact us for further information.

Kind regards,

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Acronyms

Common Phrases

AMC means the Australian Medical Council
AMSS means the Adelaide Medical Students' Society
AMS means the Adelaide Medical School
Medical Program means Bachelor of Medicine Bachelor of Surgery (MBBS) degree
BMD means Bachelor of Medical Students/Doctor of Medicine degree
Clinical mean Years 4-6 of the medical program
Preclinical means Years 1-3 of the medical program

Teaching components

SBL means Scenario Based Learning (BMD)
P&L means Professionalism and Leadership (BMD)
S&S means Science and Scholarship (BMD)
H&S means Health and Society (BMD)
CBL means Case Based Learning (MBBS)
MPPD means Medical Professional and Personal Development (MBBS)
MMI means Medical Microbiology and Immunology
SMTS means School of Medicine Teaching Series (MBBS)
TTIP means Transition to Internship Program (MBBS)

Clinical Courses

SHU means Core Surgery Placement (Surgical Home Unit)
MHU means Core Medicine Placement (Medical Home Unit)
MSK means Musculoskeletal Medicine Placement
Psych means Psychiatry
HRH Means Human Reproductive Health (Obstetrics and Gynaecology) Placement
Paeds means Paediatrics Placement
Geris means Geriatrics Placement
GP means General Practice Placement
APIC means Anaesthesia, Pain and Intensive Care Placement

Buildings

AHMS means the Adelaide Health and Medical Sciences building

Clinical Sites

NALHN means the Northern Adelaide Local Health Network
CALHN means the Central Adelaide Local Health Network
WCHN means the Women's and Children's Hospital Network

QEH means the Queen Elizabeth Hospital (part of CALHN)
RAH means the Royal Adelaide Hospital (part of CALHN)
LMH means the Lyell McEwin Hospital (part of NALHN)
WCH means the Women's and Children's Hospital (part of WCHN)

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Methods

Survey design

The survey used to collect data for this student submission contained questions tailored to each year level. The questions were reviewed and approved by a panel of student representatives prior to distribution. The standards assessed in the surveys were also chosen by this group with the intention to capture the main strengths and weaknesses of the program. Respondents submitted opinions regarding the year level they expect to complete in 2022. The specific formats of the survey questions are described in the body of this report. At the end of the questions, respondents were asked to explain their answers via an optional free-text field. Participation was entirely voluntary and promoted to all students enrolled in the Adelaide Medical School medical program in 2022. Six prizes of $50 gift cards were funded by the AMSS and randomly provided to respondents to encourage participation. Respondents were asked to submit their student number and email to mitigate the potential for multiple responses from a single student.

Demographics

The data presented in this report describes the responses of the 393 students who completed the survey. This equates to 38% of the 1021 medical students at the Adelaide Medical School. The number of respondents per year level is demonstrated in the figure below:

- 111 respondents of 166 Year 1 students
- 60 respondents of 159 Year 2 students
- 61 respondents of 178 Year 3 students
- 69 respondents of 181 Year 4 students
- 39 respondents of 169 Year 5 students
- 53 respondents of 168 Year 6 students

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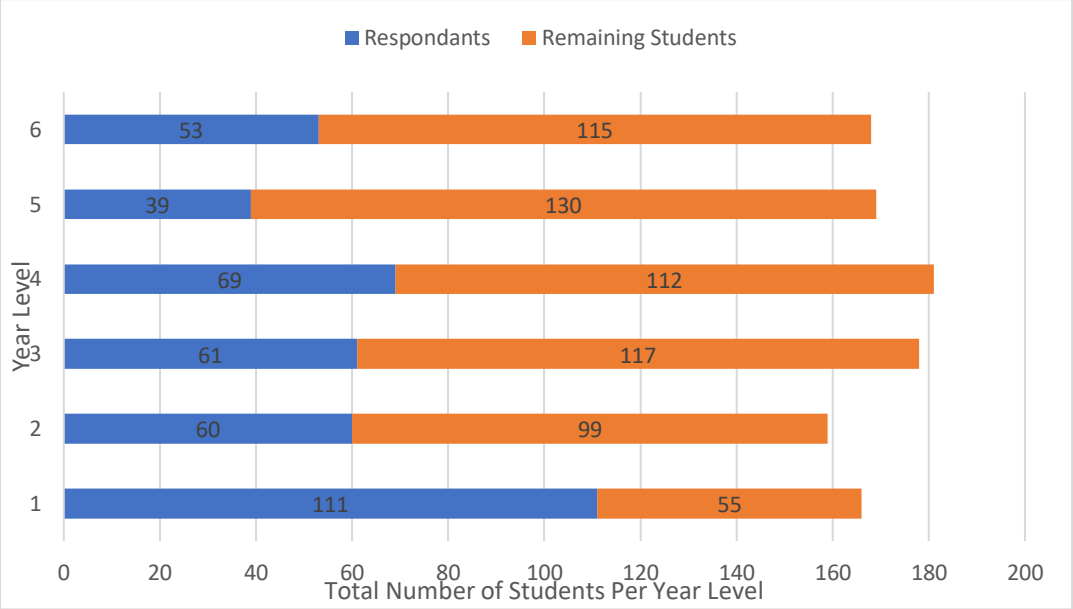
Figure 1: Respondents by year level



Data interpretation

Data from incomplete responses were included in this analysis. We considered both mode and mean values in the analysis of Likert scale data. The following criteria were applied when categorising data from the Likert scales, which ranged from 1 to 5 with a mid-point.

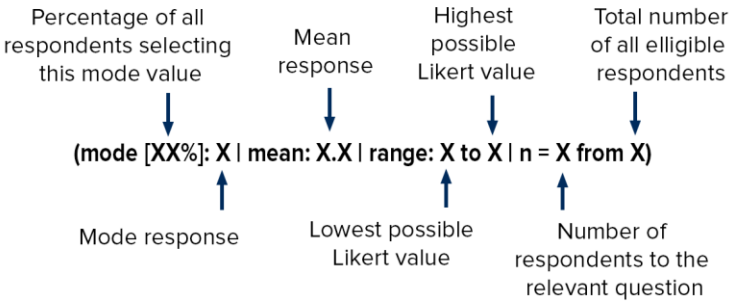
- Positive response = mode > 3 AND mean > 3.5
- Negative response = mode < 3 AND mean < 2.5
- Equivocal response = mode = 3 OR 2.5 ≤ mean ≤ 3.5

Data from all areas of the survey have been included here, including those where student opinion was positive, negative, or equivocal. The quantitative data is often elaborated further by qualitative data from free text comments. Positive opinions have been included to illustrate the excellent areas of the medical program and the areas that have improved in response to changes stemming from feedback in previous years.

Data presentation

Throughout this survey, various year level groups are reported in varying combinations when the data is appropriately similar. However, they are often grouped into preclinical (students in years 1-3) or clinical (students in years 4-6). However, given the introduction of the BMD this year, the groups may have also been represented as BMD students only, MBBS Only, preclinical MBBS (students in Year 2-3) or clinical MBBS (students in Year 4-6).

Responses to the Likert scales were presented in graphs and as follows:



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Limitations

Student Opinion

It is important to acknowledge that the survey, and therefore this student submission, seeks to represent majority student opinion on various issues within the medical program. Student opinion is inherently subjective, based on student expectations and perceptions of what is satisfactory and appropriate.

Survey Timing

Due to the timing of this surveys release, students were unable to provide feedback in relation to course content from semester 2 of 2022. Students were also unable to comment on the end of semester 1 examinations and had an incomplete experience of the semester 1 courses. The timing may also mean that student responses are reflective of elements of the program from semester 2 of 2021 and where this is relevant it has been commented on. In addition, due to the Covid-19 Pandemic, students in Year 3 had a delayed start to their clinical placement so their responses relating to this course are from a shorter experience than expected and this has been commented on where relevant.

Response Rate

The adequacy of 393 responses (overall 38% response rate) is open to discussion and a higher response rate is always desirable to address the problem of selection bias. It is our view that obtaining a higher complete response rate to a survey that comprehensively covers the many facets of the medical program is difficult. There were also more responses recorded from preclinical students (Year 1, Year 2, and Year 3) which has the potential to confound accurate representation of general student opinion. We have attempted to mitigate the impact of this by breaking down our findings into preclinical and clinical groups and reporting them as such. If data was reported 'overall', it can be assumed that there were no obvious differences between the responses of the different cohorts.

Selection Bias

There is an obvious potential for selection bias to affect the results of student surveys. Students who feel passionately about the medical program are more likely to complete the survey, whereas those that are apathetic or generally satisfied with the medical program would be less likely to do so. The main strategy used to mitigate the impact of selection bias was the overall response rate. Another element of selection bias that comes into

question is standard choice. Due to time and engagement limitations, it was not possible to explore every AMC standard and only certain standards were selected for comment. This process could have failed to identify some key strengths and weaknesses of the program.

Central Tendency Bias

The use of Likert scales, which was extensive in the survey used to inform this document, is unavoidably associated with central tendency bias. This may contribute to the under-reporting of significant positive and negative results, and the over-reporting of 'equivocal' responses.

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Executive Summary

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

The survey found that preclinical students generally agreed that there was appropriate staffing, however, the clinical students were more equivocal. The areas identified as lacking in appropriate staff or resources included: reusing old content (especially in Year 2 and 3), understaffing of those involved with timetabling/rostering clinical activities, lack of pastoral care support for clinical students, and lack of engagement with clinical year level supervisors.

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 survey results for those in years 3-6 of the program were overall equivocal regarding students' opinion on the consistency of teaching and learning at the various placement sites. However, free text comments identified Psychiatry and HRH as specific placement sites of concern.

3.4 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.

Overall, students in most year levels were satisfied by the provision of learning objectives across the medical program. There were a few courses that were poorly perceived by students such as MMI and MPPD in the preclinical space and MHU, SHU and Psych in the clinical years.

3.5 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 broad student opinion is that the curriculum covers a range of content related to Indigenous health, but there is a lack of Indigenous staff to teach this. Students feel most content is delivered in preclinical years, with limited coverage in the clinical years. Furthermore, the assessments for the content were felt to be of limited usefulness in developing skills for cultural competence.

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

Students feel that the medical school does, to a reasonable standard, prepare students to be competent in taking histories and performing physical examinations on real patients. However, students feel the school falls short on its teaching of procedural skills, as the course relies heavily on clinical placement for students to practice and perform skills on patients for the first time.

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

The design of the BMD program has a more rigorous interest in engaging students with interprofessional learning. However, responses from MBBS students (in years 2-6) indicate a severe lack of interprofessional experiences. Hence, there is a clear need to improve this so that when the MBBS students graduate, they are more familiar with the roles and responsibilities of their allied health colleagues. This is imperative so that they can work together fluidly within clinical medicine.

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

Overall, students in most year levels of the program were satisfied about the balance of assessment tasks. Notable outliers from this include Year 1 S&S, Year 4 SHU and the MHU courses. Students felt that these courses could benefit from more formative assessment opportunities.

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

Preclinical students are satisfied with the provision of feedback in most areas but have identified their data analysis assessment as an area for further improvement. Clinical students have identified quality and timeliness of feedback as an issue, which has been prevalent for many years and creates a substantial barrier to their learning. This has been raised again with the Medical Programs Assessment Committee and will hopefully see some improvement in 2022.

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

Students broadly agreed that the scope of practice is upheld over all clinical sites. However, individual variation exists among various clinical supervisors who may not be aware of this. Similarly, assessments are felt to be generally consistent although individual variation by clinicians still exists. This issue predominantly affects those in Year 4 and 5 who have more generic assessment forms.

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.

In general, the student opinion is that the support provided is substantial for those in preclinical years, who overall agree that the above standard is met. However, clinical

students have identified that counselling, pastoral care, and academic advisory supports are limited. This is exacerbated by a perceived lack of engagement from year level advisors, which is a issue that has been raised to the school.

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

Similar to standard 7.3.1, there is a clear disparity between the student support provided in preclinical and clinical years. There is currently no dedicated pastoral care support person for students in clinical years and therefore concerns are directed to either the course coordinators, year level advisors or the year 4-6 coordinator who are all involved in academic decision making.

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 goes to great lengths to include student representation on various academic committees and to create avenues for seeking student feedback. However, students feel that while this feedback is sought, it is not always acted upon appropriately. With respect to program design, the opinion is held that student input is better accommodated in the new BMD than the outgoing MBBS.

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

The learning opportunities to interact and develop skills with simulated patients during Years 1-2 is excellent, but they are not carried over into Year 3 teaching. The general theme of Year 3 student responses suggested that there was inadequate teaching conducted through simulation to make up for the lack of real clinical exposure. With respect to clinical students, those in Year 6 agree the standard is currently being met with adequate patient exposure and learning activities. However, those in Year 4 and 5 rate more equivocally and note concerns such as individual unit variability, short duration of specific rotations (e.g., paediatrics) and the impact of Covid-19.

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

As discussed under standard 3.5, the broad student opinion is that the theoretical knowledge provided has been sufficient. However, there is a limitation in the practicing of these skills as well as insufficient opportunities for patient interaction and involvement in healthcare delivery.

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

Overall, the student opinion was that clinical supervisors are partly aware of reasonable expectations of student's attendance and knowledge, but are not being monitored or followed up by the school. This has led to the impression that there is still marked variability between different supervisors regarding assessment and expectations of student skills, which could be improved with better communication from the school.

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

Students identified that in general, clinical teaching onsite is conducted by junior doctors and there is a lack of engagement from senior clinical staff. Some senior clinicians do go to great lengths to allocate time for teaching students, but most of the teaching delivered by senior staff is done through lectures/tutorials run specifically by the school.

Placement hours

Most clinical units excel in allowing students time to study, while some perform poorly. However, students have expressed that more direct communication to supervisors is needed to highlight that total contact hours (which includes placement, teaching, and private study) should not exceed 38 hours per week.

Standard 1

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

Methods

All students were asked to consider the staffing of the medical program and evaluate its appropriateness by rating their level of agreement with a series of statements. The statements had the common stem of "The Medical School has sufficient staff to [blank]." The three subsets of this question that students considered were "respond to student concerns," "deliver teaching content" and "arrange timetables". All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were asked to explain their answers via an optional free text field.

Preclinical

Students in Year 1 and 2 of the program overall agreed that there was sufficient staffing to respond to student concerns (mode 4 [50.3%] | mean: 4.06 | range: 1 to 5 | n= 171 from 171), deliver teaching content (mode 4 [45.6%] | mean: 4.51 | range: 1 to 5 | n= 171 from 171) and arrange timetables (mode 4 [46.2%] | mean: 4.14 | range: 1 to 5 | n= 171 from 171). This was supported by 27 comments from Year 1 students that praised the efforts of the course coordinators and staff involved in the Year 1 BMD. As one comment put it "all my issues have been met with urgency, respect, and precision," and another that "there is a huge team working closely with the students and behind the scenes to make sure everything runs smoothly, and we are supported." Comments also noted there is a good range of lecturers to deliver content and timetables are posting regularly in advance. Students in the Year 2 program were more guarded in their replies, attesting that there are some staff members (such as the year level advisor) who do an excellent job of coordinating content delivery and responding to concerns. 8 comments noted this, and it was nicely summarised by the statement "Any concerns I have ever had have always been addressed in an efficient and considerate manner". However, a common theme noticed in 5 of the comments is that many resources are re-used lecture materials from several years ago, raising the concern of sufficient resource management to allow updated content to be created. A student in Year 2

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detailed this concern clearly as "There is also an obvious lack of recent lecture material in the lectures that are presented online - many of the lectures provided are more than 3 or 4 years old and present information that seems to no longer be relevant to our learning. This would also be aided through greater staff availability to be able to record and provide newer lecture materials".

Students in Year 3 responded equivocally about the sufficiency of staff to respond to concerns (mode 4 [34.4%] | mean: 2.93 | range: 1 to 5 | n= 61 from 61), deliver teaching content (mode 4 [34.4%] | mean: 2.93 | range: 1 to 5 | n= 61 from 61) and arrange timetables (mode 2 [29.5%] | mean: 2.7 | range: 1 to 5 | n= 61 from 61). Of note, the data regarding timetable management had a slightly more negative trend with a mode of 2. 11 free text comments identified the Clinical Practice course as a major source of concern. Students reported disorganisation with timetabling and difficulty contacting the lead coordinator for course concerns. For example, one comment identified that their impression of the course was that "It feels like one person organising the entire course which led to it being messy, poorly structured, and confusing", Furthermore, 7 free text comments specifically painted a negative light on the quality of lectures delivered online to the cohort, citing that many lectures are from greater than 4 years ago and that there is a low amount of new content prepared. A common theme represented was that students in Year 3 feel left behind as the staff focused their efforts on the BMD. Both these viewpoints can be highlighted from the concerns that the staff are "too busy making the BMD to care about the MBBS students. Lectures are often 5+ years outdated".

Clinical

Overall, students in the clinical years were equivocal about the staffing required to respond to concerns (mode 3 [38.5%] | mean: 2.85| range: 1 to 5 | n=161 from 161), deliver teaching content (mode 3 [31.7%] | mean: 2.81| range: 1 to 5 | n=161 from 161) and arrange timetables (mode 3 [40.4%] | mean: 2.95| range: 1 to 5 | n=161 from 161). Free text comments from those in all years represented a more negative picture, with 12 comments addressing the theme of precinct office understaffing (particularly at the Women's and Children's Hospital), which has led to delays in students receiving timetables, despite the notably hard work put in by staff as identified by one comment: "The core staff who are employed are doing a fantastic job, but a huge load is stretched across very few people (i.e.. Carrie is looking after both HRH and Paeds)". A further 10 comments across all clinical years specifically requested more didactic content rather than self-directed learning. Furthermore, there were explicit concerns raised around the adequacy of pre-recorded online resources in comparison to updated content delivery, as comments raised concerns regarding the datedness of several resources provided. For example, one comment stated, "The fact that entire lectures are being recycled throughout the years to suggests that perhaps the staff do not have enough time to update content" and another noted that "some of our resources can be very outdated and with broken links to resources."

Summary

Across the board, students in the later years of the MBBS program responded more equivocally in quantitative data, and more critically in the qualitative data about the sufficiency of resourcing and staffing within the medical school. Major concerns flagged include the reusing of old content and understaffing of those involved with

timetabling/rostering clinical activities. Of particular concern is the perceived disparity of resources directed towards the MBBS and BMD programs.

It should also be noted that all comments from the clinical years which made mention of responding to student concerns specifically highlighted that the hospital precinct staff have been very helpful in responding to concerns. However, no students identified their course coordinator or year level advisor as a person to seek assistance from, and it is the view of the student representatives that this is because these staff members have a scant physical presence for students and thus are not seen as a source of support. The interactions students have with these individuals tends to only be through email when escalated by the precinct staff, or via the student channel of our education representatives. This does not represent an issue of staffing the position, rather finding the appropriate staff who are able to have a more visible presence for students.

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Standard 2

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.

Methodology

Students in years 3-6 of the program (those with clinical exposure) were asked to evaluate the efficacy of the Adelaide Medical School to provide comparable clinical placement experience and assessments. For those in years 4-6 of the program, this was achieved by rating level of agreement based on the following statement "Learning and clinical experiences feel comparable between hospital sites for the same rotation". Those in Year 3 were asked to rate their level of agreement with the statement "The following feel comparable between all hospital sites" which had the three subsections of "teaching and learning", "assessments", and "clinical experience". It was the opinion of the student representatives that the students in Year 3 would be able to evaluate their limited clinical experience more appropriately with more specific guidance. However, as assessments are covered elsewhere, those in clinical years were able to appropriately evaluate learning and clinical experiences together in the aforementioned statement. We also specifically asked the Year 5 rural cohort to evaluate their experience based on the following statement to better draw out any nuance of rural compared to metropolitan clinical placement experiences: "The rural 5th year program provides learning at least equivalent to the metropolitan 5th year program". All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were asked to explain their answers via an optional free text field.

Preclinical

Students in Year 3 were equivocal about the consistency of teaching and learning experiences at the different hospital sites (mode 3 [38.6%] | mean: 2.84 | range: 1 to 5 | n= 44 from 61) and equivocal about the consistency of the clinical experience (mode 3 [39.1%] | mean: 3.07 | range: 1 to 5 | n= 46 from 61). However, they overall agreed that assessments

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were comparable over the different clinical sites (mode 4 [41.3%] | mean: 3.5 | range: 1 to 5 | n= 46 from 61).

The tendency to pick an equivocal answer was most likely related to the fact that students In Year 3 had a delayed entry into the clinical environment this year. Thus, at the time of completing the survey, the majority had only spent 1-2 weeks in the clinical space and did not feel well placed to make an opinion. Furthermore, 12 comments confirmed this limitation in their responses. The main theme otherwise demonstrated by 4 comments was that the CALHN tends to have poorer engagement with students due to busier staffing whereas students placed at the NAHLN sites tend to be better engaged with the senior clinical staff.

Clinical
Clinical students were overall equivocal in their responses to the consistency of teaching and learning at the various placement sites (mode 3 [35.4%] | mean: 2.89 | range: 1 to 5 | n = 161 from 161). However, there were a variety of opinions expressed in the free text comments that shed light on specific elements of the program. With respect to learning, many comments identified that the online teaching program helped to bridge the gaps of poorer engagement at clinical sites. From the Year 4 cohort, 6 comments identified that Psychiatry rotations in the community setting "feel lacking in regard to activities compared to hospital experiences" and are significantly less engaging for students, due to lower frequency patient interactions and the differing acuity of illness. In addition, from the Year 5 cohort, there was 5 free text comments comparing the experience of Human Reproductive Health (HRH) placements at the Lyell McEwin Hospital (LMH) vs WCH. These comments identified issues with LMH site pertaining to LMH having "A much poorer teaching experience with more cancelations and less scheduled clinical times then at the WCH for HRH."

Standard 3

3.4 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.

Methodology
Students in all year levels were asked to evaluate the provision of clear learning objectives throughout the program by rating a level of agreement based on the following statement "the learning objectives are clear and useful." This statement was separated for every course student had undertaken (or were in the process of completing) in Semester 1 2022.

For BMD students, this was asked of the following courses: Science and Scholarship (S&S), Professionalism and Leadership (P&L), Medical Practice and Health and Society (H&S). For those in the preclinical MBBS program, the same format was asked for their corresponding courses: Clinical Practice, Scientific Basis of Medicine (SBM), Medical Professional and Personal Development (MPPD) and Research & Critical Appraisal (RCA) (Year 3 only) or Medical Microbiology and Immunology (MMI) (Year 2 only).

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For clinical students, the same methodology was applied. For Year 4, this included Medical Home Unit (MHU, Surgical Home Unit (SHU), Psychiatry and Musculoskeletal Medicine (MSK). For Year 5, this included Paediatrics, Human Reproductive Health (HRH), Anaesthesia Pain & Intensive Care (APIC), Geriatrics & General Practice (GGP) and the rural program. For Year 6, this included Transition to Internship Placement (TTIP) which is the only core teaching component in the Year 6 program.

The answers were obtained using a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were also asked to explain their answers via an optional free text field.

Preclinical

Students overall agreed that the provision of learning objectives in the preclinical BMD and MBBS program was clear and useful: (mode 4 [33.1%] | mean: 3.78 | range: 1 to 5 | n= 232 from 232). This was generally supported by free text comments which found that the objectives are clearly communicated to students across the program, but at times can be "quite broad and don't always pertain to the online lecture content provided." This was particularly evident in the S&S and SBM courses, with 36 comments indicating this opinion. For example, this comment encapsulated the view of most respondents that "The learning objectives are very helpful as a checklist to ensure all topics have been covered, however it is unclear how much depth is required/should be known for each objective."

The MMI course in Year 2 was more equivocal with a slight negative skew (mode 1 [23.3%] | mean: 2.92 | range: 1 to 5 | n = 60 from 60). The free text comments for MMI confirmed their highly negative opinion with 11 comments suggesting that the learning objectives are not clearly communicated and that students are expected to be guided largely by the lectures alone. One comment summarised this sentiment as "Don't know if there are learning objectives for MMI? Not sure where to find them" It should be noted that this course is in its final year at the time of writing due to the transition to the BMD program.

In both Year 2 and 3, the MPPD course received more equivocal responses. A similar pattern was noted for both Year 2 (mode 4 [33.3%] | mean: 3.48 | range: 1 to 5 | n = 60 from 60) and Year 3 (mode 4 [32.8%] | mean: 3.49 | range: 1 to 5 | n = 61 from 61). The free text comments suggested that the learning objectives, while communicated to students during teaching, are not easily available in a written format.

Clinical

Students in Year 5 and 6 overall agreed that the provision of learning objectives in the clinical MBBS program was clear and useful: (mode 4 [41.8%] | mean: 3.72 | range: 1 to 5 | n = 84 from 92). The comments identified a strength in that all courses had learning objectives. However, at times they were vague, which was particularly reflected in APIC by 2 comments and GGP by 3 comments.

In combining all courses, Students in Year 4 had an overall equivocal response towards whether the provision of learning objectives was clear and useful: (mode 3 [29.1%] | mean: 3.28 | range: 1 to 5 | n = 69 from 69). However, when broken down into individual courses,

we noted that MSK course was overall agreed to have met this standard (mode 4 [35.1%] | mean: 3.62 | range: 1 to 5 | n = 37 from 37). We would also note that 3 comments specifically referred to the psychiatry course having unclear learning objectives, however it was still overall rated equivocally (mode 3 [27.3%] | mean: 3.21 | range: 1 to 5 | n = 33 from 33).

Summary

Overall, students in most year levels of the program were satisfied by the provision of learning objectives across the medical program. There were a few notable exceptions which were felt to have vague learning objectives. In the preclinical years this was S&S, SBM and MMI and in the clinical years this was APIC, GGP and Psychiatry.

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3.5 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)

Methodology

Students were asked to evaluate the teaching proficiency of Indigenous Health within the medical program by rating a level of agreement with the following two statements: "The medical school has provided sufficient education about the greater context that contributes to the health outcome disparity between Indigenous and non-Indigenous Australians" and "The medical school has provided sufficient education to allow me to deliver culturally competent care to Aboriginal and Torres Strait Islander people." Answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were asked to explain their answers via an optional free text field.

Results

Students in all year levels agreed with the statement that sufficient education was provided regarding the greater context of Indigenous Health (mode 5 [37.2%] | mean: 3.95 | range: 1 to 5 | n= 339 from 393). Furthermore, students also agreed that the education felt sufficient so that they could deliver culturally competent care when the opportunity may arise (mode 4 [36.4%] | mean: 3.67 | range: 1 to 5 | n = 324 from 393).

Free text comments from preclinical students were congruent with the quantitative data, however, 8 comments expressed a common theme of desiring more Indigenous staff to deliver this content. 3 comments also raised a concern that while the education provided is extensive, the tasks and assessments associated are "a tokenistic approach to teaching about Indigenous health" and "more tactile and interactive sessions would be more effective, with more representation from Indigenous peoples". In addition, 8 free text comments from clinical years expressed concerns that most of the teaching was provided in preclinical years and that there is limited content in the clinical years. This was well put by one comment, "the majority of teaching was through a written assignment that was self-taught." 5 further comments specifically praised the efforts of the rural school in its ability to deliver engaging content as "the rural school provided the best teaching we have received on this topic".

Standard 4

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

Methodology
Students in all years were asked to evaluate the current teaching of core clinical skills by rating their level of agreement based on the following statements.

All preclinical students were asked to respond to the statement "I feel I have sufficient opportunities to practice histories and physical examinations." In addition, students in Year 1 and 2 were asked to respond to the statement "I receive constructive and timely feedback about my performance in Clinical Practice/Medical Practice sessions". Students in Year 3 were also asked to respond to the following two statements "I feel that the clinical teaching provided so far throughout medical school has adequately prepared me to assess real patients in the hospital environment" and "I feel that I have adequate direction and support during hospital days", which better reflects the current clinical program for their year level.

All clinical students were asked to rate a level of agreement with the more specific statement: "I feel I have adequate opportunities to practice core procedural skills (e.g., NG tube, catheters, IV cannulation) in a simulated environment before performing them in the hospital setting".

All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were asked to explain their answers via an optional free text field.

Preclinical
In response to being asked to rate a level of agreement in the context of opportunities to practice histories & physical examinations, students in Year 1 (mode 5 [43.2%] | mean 4.0 | range: 1 to 5 | n = 111 from 111) and Year 2 (mode 5 [62%] | mean 4.38 | range: 1 to 5 | n = 60 from 60) overall agreed. Similarly, both Year 1 (mode 5 [71.2%] | mean 4.6 | range: 1 to 5 | n = 111 from 111) and Year 2 (mode 5 [62%] | mean 4.32 | range: 1 to 5 | n = 60 from 60) agreed that they received timely and constructive feedback. Free text comments from students in year 1 (12 comments) and year 2 (4 comments) expressed that they valued the small group tutorials and opportunity to practice skills and receive immediate feedback. However, 6 comments from year 1 raised the concern that they felt limited opportunities for practice before being marked as a competency, and 4 comments raised concerns regarding consistency of marking. For example, one comment drew on both of these aspects and stated: "It would be great if all tutors gave the same in-depth responses as it was very helpful to look back on and improve before the next session. It would be good to have an opportunity to practice taking a history/examination prior to it being marked (either formative or summative), as it can be a bit stressful to be assessed on something we haven't practiced with tutors before". This was similarly reflected in 4 comments from students in Year 2 which conveyed concerns regarding marking and feedback consistency.

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Students in Year 3 were equivocal regarding opportunities to practice their clinical skills (mode 3 [32.8%] | mean 3.36 | range: 1 to 5 | n = 61 from 61). They were also equivocal towards the statement that Year 1 and 2 had prepared them adequately for hospital (mode 4 [36.1%] | mean 3.31 | range: 1 to 5 | n = 61 from 61) and disagreed that they are being provided enough direction and support in the clinical space (mode 2 [35.09%] | mean 2.16 | range: 1 to 5 | n = 61 from 61). The free text comments from Year 3 students drew on 2 major themes. The first was that all expressed that they felt the hospital days lacked substance and direction (22 comments). Many of these comments also expressed that they felt unsupported and unguided. For example, "the only support we receive is from our peers on the wards that feel sorry for us" or "It is extremely hard to understand exactly what we are meant to be doing at hospital and not much guidance is given at all because often our hospitals supervisors don't know what we are doing either." Concerningly one comment also highlighted that "staff on the ward don't even know we are coming and because of that, we are not warned of patients not to visit e.g., patients with MRSA and thus we end up visiting them without putting on PPE." The second major theme expressed was that the self-directed nature of the 3rd year program meant some students had vastly different experiences, in that some had more opportunities to practice histories and exams than others, for example one comment reported "I performed a singular examination so far this year and nil history taking and other skills" while another noted "I've seen infective endocarditis, valvular heart disease on the first day straight away". It should be noted however 5 comments expressed that they felt adequately prepared for hospital due previous years of the program, for example "The SBM teaching has translated really well so far".

Clinical

Students in Year 4 of the program had an equivocal response to the statement with a slight negative skew (mode 2 [34.8%] | mean 2.55| range: 1 to 5 | n = 69 from 69). There were 29 free text comments which shared the similar view that only a very limited range of skills are taught in simulation (IV cannulation, scrubbing technique and joint aspiration/injection) before entering the clinical space. However as one commenter noted "I felt a one-off session of cannulation over 6 months prior to placement for example was not adequate". The comments also reflected those students were severely lacking in the opportunity to practice core clinical skills such as NGT insertion, urinary catheter insertion, nasal swabs, and arterial blood gases. The concern was highlighted they "attempt them in hospital with little experience," on real patients for the first time.

Students in Year 5 disagreed that they had significant opportunities to practice core clinical skills (mode 2 [33.3%] | mean 2.21| range: 1 to 5 | n = 39 from 39). Of the free text responses, 22 comments identified that the only procedural skills training they had received was in Year 4 of the program, as mentioned above. 2 comments reflected that there was airway device training as part of the APIC course, which all students do receive, but as the timing of the survey was part way through the year, many students are yet to receive this training.

Students in Year 6 were overall equivocal in their responses to this statement, with a slight negative skew (mode 2 [30.19%] | mean 2.9 | range: 1 to 5 | n = 53 from 53). This was reflected in the free text comments which expressed also equivocal opinion. Of the 24

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comments, 9 identified excellent teaching of clinical skills within the simulation block of TTIP. The remaining 15 students (who may not have undertaken this simulation course yet) all left comments which expressed a similar sentiment of "simulation teaching for practical skills is severely lacking - why is it that we have a tutorial for a joint aspiration (in MSK) but not for catheterisation or NG tube insertion?".

Summary

Students feel that the medical school does to a reasonable standard prepare students to be competent in taking histories and performing physical examinations on patients in a hospital environment. However, students feel the school falls short on its teaching of procedural skills and relies heavily on the students being on clinical placement, where they often feel ill-equipped to practice on real patients for their first instance of performing a procedure. Notably, the core procedural skills taught did include an IV cannulation workshop in Year 4, joint injection in Year 4, birthing simulation in Year 5 and a variety of skills in Year 6 TTIP. In the opinion of the student representatives involved in authoring this paper, these simulations fall short in giving students the opportunity to practice other simple skills that they are expected to perform as a common task in a clinical environment.

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

Methodology

Students in all year levels were asked to evaluate the efficacy of current interprofessional learning by rating a level of agreement based on the following statements: "There is sufficient teaching in the medical program about the roles and responsibilities of other healthcare professionals", "The medical school fosters interprofessional learning and collaboration with other healthcare professionals" and "There is sufficient exposure to working with other healthcare professionals (e.g. nursing, physiotherapy) in a simulated environment". Answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were asked to explain their answers via an optional free text field.

Results

Students in Year 1 (BMD) of the program strongly agreed that there is sufficient coverage of the roles and responsibilities of other healthcare professionals within the program (mode 5 [55%] | mean: 4.45 | range: 1 to 5 | n= 111 from 111). By comparison, students in Year 2-6 (MBBS) of the program felt more equivocal about the teaching, with a slight skew towards positive (mode 4 [33%] | mean: 3.47 | range: 1 to 5 | n = 282 from 282). With respect to the fostering of interprofessional learning and collaboration, the BMD students overall agreed that sufficient effort is being made by the school (mode 5 [46%] | mean: 4.15 | range: 1 to 5 | n = 111 from 111). In contrast, the students in the MBBS program were overall equivocal to this (mode 4 [30.5%] | mean: 3.23 | range: 1 to 5 | n= 282 from 282). For the final question regarding exposure to allied health professionals, results were split into BMD, preclinical MBBS and clinical MBBS. Students in the BMD were overall equivocal in their response (mode 3 [30.6%] | mean: 2.92 | range: 1 to 5 | n = 111 from 111). This was supported by 12 free text comments that identified the program has strengths in receiving

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teaching from allied health professionals, but they are yet to implement any collaborative work with other students e.g., in a simulated environment. In opposition to this, the preclinical MBBS students overall disagreed with the aforementioned (mode 1 [28.9%] | mean: 2.43 | range: 1 to 5 | n = 121 from 121) and the clinical MBBS students were overall equivocal with a slight negative skew (mode 2 [20.6%] | mean: 2.69 | range: 1 to 5 | n= 161 from 161).

The opinions of the MBBS students were similarly reflected in comments from each year level. 13 comments from Year 2 students and 20 comments from Year 3 students all identified that there has been limited teaching from allied health professionals and an absolute lack of collaborative learning through simulation. One comment encapsulated this sentiment as "we've never been exposed to working with other healthcare professionals in a simulated environment, Most of our teaching around other healthcare professionals is simply who we can refer patients to in specific scenarios." 16 comments from Year 4 and 11 comments from Year 5 all similarly identified the lack of simulated IPL or engagement with other professionals in tutorials/lectures. 12 comments from those in Year 6 identified a useful amount of IPL in the first year of their program (in 2017) but noted there has been none since then. The sentiment from the clinical students was captured in the following comment from a student in Year 6: "Throughout more than five years in medical school, we have had no more than three sessions with nursing students in interprofessional learning (mostly during our pre-clinical years) and no contact with other healthcare students. All knowledge about the roles and responsibilities of other healthcare professionals has been through exposure in the hospital, not through teaching by the medical school."

Summary
The design of the BMD program clearly has a more rigorous interest in engaging students with interprofessional learning. However, this is severely lacking for the students still undertaking the MBBS program. There is a clear need to improve this so that when the MBBS students graduate, they are more familiar with the roles and responsibilities of their allied health colleagues, and so they can work together fluidly within clinical medicine.

Standard 5

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

Methodology
Students in all year levels were asked to evaluate the balance of formative and summative assessment tasks by rating a level of agreement based on the following statement "In this course there is a useful amount of formative assessment / knowledge checking activities before the summative assessments." This statement was separated for each course students had undertaken (or were in the process of completing) in semester 1 2022.

For BMD students, this was asked of the following courses: S&S, P&L, Medical Practice and H&S. For those in the preclinical MBBS program, the same statement was asked for their

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corresponding courses, which included Clinical Practice, SBM, MPPD, RCA (Year 3 only) and MMI (Year 2 only).

For clinical students, the same methodology was undertaken. For Year 4, this included MHU, SHU, Psych and MSK. For Year 5, this included Paeds, HRH, APIC, GGP (and the rural program). For Year 6, this included TTIP, ED Internship, Surgery Internship, Primary Care Selective and Psychiatry Selective.

In addition, students in years 2 and 3 of the MBBS program were also asked to respond to the following statement "The amount of summative assessment is balanced with the content delivered", with respect to the aforementioned courses.

All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were also asked to explain their answers via an optional free text field.

Preclinical

Students overall agreed that there was a useful amount of formative assessment opportunities in the MBBS and BMD programs (mode 4 [33.3%] | mean: 3.74| range: 1 to 5 | n = 232 from 232). In addition, the students in Year 2 and 3 found that the summative assessments were appropriately balanced to the content delivered (mode 4 [38.92%] | mean: 4.03| range: 1 to 5 | n = 121 from 121). This was generally supported by the free text comments, which indicated there was a useful number of opportunities to undertake formative assessment, particularly in the clinical/Medical practice courses. However, in relation to SBM/S&S, the student comments expressed an interest in wanting more content related formative assessment such as practice quizzes. This was reflected in 10 comments in Year 1, 3 comments in Year 2, and 3 comments in Year 3.

The second statement, "The amount of summative assessment is balanced with the content delivered," was not asked of the BMD cohort. Given the timing of the survey, it was thought that they did not have enough exposure to summative assessments to answer this question appropriately. However, the free text comments from various other questions throughout the survey (with 5 identified in relation to the learning objectives within S&S) suggested that students felt the summative tasks did not reflect the content delivered and were beyond the scope of their teaching.

Clinical

Students in Year 5 and 6 overall agreed that there was a useful amount of formative assessment opportunities (mode 4 [33.3%] | mean: 3.66| range: 1 to 5 | n = 92 from 92). However, this was not as clear in Year 4, where responses were overall equivocal (mode 3 [26.17%] | mean: 3.11| range: 1 to 5 | n = 69 from 69). The overall negative opinion about formative assessment opportunities in the SHU course may have skewed this data (mode 1 [23.18%] | mean: 2.83 | range: 1 to 5 | n = 42 from 42).This was supported by 8 free text comments which expressed the view that formative assessment in SHU was limited, and when present it was a poor reflection of the content assessed in their summative tasks as noted by one comment that "quizzes are not accurately representative of the final quiz.". Importantly, another comment also noted that that due to the lack of relevant formative

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assessments "many people I have spoken to have adopted a defeatist attitude and are happy to accept a bad grade and scrape by."

While Year 4 students were equivocal about formative assessment opportunities in MHU (mode 3 [28.95%] | mean: 2.74 | range: 1 to 5 | n = 38 from 38), students agreed that the assessments were better balanced for the MSK (mode 4 [32.43%] | mean: 3.43 | range: 1 to 5 | n = 37 from 37) and Psych courses (mode 4 [37.5%] | mean: 3.53 | range: 1 to 5 | n = 33 from 33).

Students from the Year 5 rural program responded positively regarding assessment balance, though there was a small sample size (mode 5 [57.14%] | mean: 4.2 | range: 1 to 5 | n = 14 from 14). However, it should be noted that a strong range of opinions were expressed within the free text comments, which stated that opportunities for assessment were impacted by the location of placement.

Summary
Overall students in most year levels of the program were satisfied about the balance of assessment tasks. The courses that were perceived by students to have best met this standard are the preclinical Medical/Clinical Practice courses, Year 4 MSK and the Year 5 Rural program. Notable outliers from this include Year 1 S&S (identified through qualitative data), Year 4 SHU and the MHU courses (identified through both qualitative and quantitative data). Students felt that these courses could benefit from more formative assessment opportunities, and that these should better reflect the content assessed in the summative tasks.

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

Methodology
Students in all year levels were asked to evaluate the provision of feedback following the completion of assessment activities. They were asked to analyse this in relation to the major examination items of the medical program, including written exams and OSCEs. Assessment tasks conducted last year, which were not included in the 2021 AMC report, were included in this report, due to last year's submission date. Similarly, this year's examination feedback can only be included in the 2023 report. Choosing to highlight feedback in response to examinations was deemed necessary, particularly for clinical students, as that form of assessment and ensuing feedback is entirely in the control of the medical school. Other assessment items are generally ward or medical unit based, and the opportunity to receive feedback comes from individual clinical staff, not necessarily associated with the Adelaide Medical School.

Students were invited to respond to the following three statements for both their written exams and their OSCE: "The medical school facilitates feedback on written examination performance that is timely," "The medical school facilitates feedback on written examination performance that is appropriate" and "The medical school facilitates feedback on written examination performance that is of sufficient detail to be useful for learning". Students in the Year 1 BMD program and Year 2 MBBS were only asked about feedback for written

examination, as they are yet to take an OSCE. All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were also asked to explain their answers via an optional free text field.

Preclinical

With regards to the written examinations, preclinical students overall agreed that the feedback was timely (mode 4 [46.9%] | mean: 3.63 | range: 1 to 5 | n = 228 from 232), were equivocal about its appropriateness (mode 4 [47.5%] | mean: 3.42 | range: 1 to 5 | n = 227 from 232) and equivocal about its usefulness (mode 4 [37.4%] | mean: 3.12 | range: 1 to 5 | n = 227 from 232). The free text comments predominantly expressed themes of wanting more feedback in relation to short answer question assessments. Another concern raised was that "only if you do badly do they provide good feedback" as further feedback is only offered for those deemed at a borderline competency or below.

With regards to the OSCE feedback, students in Year 3 of the MBBS program were overall equivocal about its timeliness (mode 4 [52.46%] | mean: 3.48 | range: 1 to 5 | n = 61 from 61) and appropriateness (mode 4 [45.9%] | mean: 3.31 | range: 1 to 5 | n = 61 from 61). They were equivocal with a negative skew that the feedback was of sufficient detail to be useful (mode 2 [27.87%] | mean: 2.61 | range: 1 to 5 | n = 61 from 61). The main concerns raised about OSCE feedback, as noted in 5 comments, was the incomplete level of detail which did not allow students to identify what areas of weakness were present to improve on for next year. An example comment which exemplifies this shared concern stated "It can be demoralising to get a bad score and get the feedback of "well done" or "ok" on your OSCE feedback. The stations that did write detailed feedback last year, I genuinely still remember and use now!"

Clinical

Students in the clinical years of the MBBS program were much more critical of the feedback following major assessment items. Overall students disagreed that the current systems achieve a sufficient level of feedback following assessment.

With regards to written examination, students strongly disagreed that feedback was timely (mode 1 [34.2%] | mean: 1.89 | range: 1 to 5 | n = 161 from 161). The responses were equivocal about its appropriateness (mode 3 [37.3%] | mean: 2.2 | range: 1 to 5 | n = 161 from 161) and disagreed it was of sufficient detail to be useful for learning (mode 2 [35.4%] | mean: 1.77 | range: 1 to 5 | n = 161 from 161). With regards to the OSCE examination, students disagreed that feedback was timely (mode 1 [48.5%] | mean: 2.33 | range: 1 to 5 | n = 161 from 161), disagreed that feedback was appropriate (mode 1 [31.7%] | mean: 2.7 | range: 1 to 5 | n = 161 from 161) and again disagreed it was of a useful level of detail (mode 1 [47.8%] | mean: 2.19 | range: 1 to 5 | n = 161 from 161).

There were 13 comments from Year 6, 16 comments from Year 5 and 24 comments from Year 4 in relation to the feedback following written and OSCE examinations. Almost all these comments expressed two significant issues with the feedback. Firstly, they reported that there has been exceedingly lengthy delays between completing assessments and receiving grades/feedback – often months. With reference to semester 2 2021 exams, one comment identified that "It is very disappointing that over 6 months following the written

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exams in 2021, we do not have a breakdown of our results". This predominantly affects written exams, but some comments identified this in relation to OSCEs as well. The other major concern raised relates particularly to qualitative or free text feedback for OSCEs. The students repeatedly identify a lack of feedback within the examiner comments for each station, even when they had achieved a grade aligning with borderline competency. Some examples of these concern were highlighted by the following comments: "OSCE responses seem wildly inconsistent with feedback provided. Many stations would receive one-line responses with no clear indication of methods to improve" or "multiple OSCE stations provided just a mark last year with no feedback" and "OSCE examiner reports would be helpful if comments were taken more seriously by the examiners."

This is an issue that student representatives have raised multiple times to the Medical Programs Assessment Committee in early 2022. The current status is that OSCE examiners are not required to leave free text feedback on a student's performance, therefore many examiners only provide numerical ratings. The quantitative data distributed to students is of great detail and highly valued but is often not timely. However, the student body has again through this survey, voiced its concerns that the qualitative data provided by a free text comment is pivotal to their learning. The response of the staff to this date has been that it is too difficult for examiners to type in comments, as there is limited time, and many examiners are either not trained in giving feedback or are not adequately proficient with the technology to do so. It is the opinion of the student representatives that this is not an appropriate justification, and this has been raised to the Medical Programs Assessment Committee.

Summary

In the preclinical space, students are satisfied with the level of feedback following major assessment items but have identified some areas they would like to see further improvement in. This relates to the provision of more specific feedback for short answer assessment tasks. In the clinical space, there is significant dissatisfaction with the quality and timeliness of assessment feedback despite repeated requests for improvement. The student representatives have been assured by the staff that it is a goal to continue to improve upon feedback provided following assessments. By the time of the AMC visit in 2022, the first semester exams will have been completed, and an inquiry into the provision of feedback for that semester would be of value.

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

Methodology

Students in years 3-6 of the program were asked to evaluate the consistency of the Scope of Practice and assessments across the various clinical placement sites by rating a level of agreement to the statement "The scope of practice is consistently upheld across different clinical sites and my supervisors are aware of its breadth". In addition to this, clinical students were asked to further evaluate the following statement "clinical assessment activities are consistent and similar across teaching sites." Answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were asked to explain their answers via an optional free text field.

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Results
When evaluating whether the scope of practice was upheld over all clinical sites, students were overall equivocal (mode 3 [36.49%] | mean 3.25 | range: 1 to 5 | n = 222 from 222). In the free text comments, there was a small number of individual comments stating that certain staff members at clinical sites would ask students to act outside the scope of practice, suggesting that not all clinical staff are aware of this. However, there was also an equal number of comments supporting that the Scope of Practice was being well maintained.

In evaluating the consistency of clinical assessment activities, the results were broken down by each year level. Students in Year 4 (mode 3 [33.3%] | mean 2.86 | range: 1 to 5 | n = 69 from 69) and Year 5 (mode 3 [33.3%] | mean 2.86 | range: 1 to 5 | n = 39 from 39) were overall equivocal about this statement. However, students in Year 6 overall agreed that the assessment was consistent (mode 4 [47.2%] | mean 3.62 | range: 1 to 5 | n = 53 from 53). There were 14 free text comments that further elaborated on these results. The predominant theme was that while standardised assessment forms do exist, there is significant variation in the way individual assessors grade assessments conducted on clinical sites. Students indicated that any assessment completed by the school staff (such as MCQs or written assignments) tend to be more consistent in marking than assessment conducted at clinical placements. Students in Year 6 reported individual assessor variability less frequently. One possible explanation for this may be because Year 6 placement-based assessment forms have detailed and less ambiguous marking rubric than those present for years 4 and 5.

Standard 7

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.

Methodology
All students were asked to evaluate the school's provision of student support services by rating their level of agreement with a series of statements. The statements had the common stem of "The medical school meets my personal, physical, and cultural needs by providing sufficient[blank]." The three subsets of this question that students considered were "pastoral care," "academic support" and "counselling." All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). Students were given an optional cannot respond option should they not be familiar with any of these services. At the end of the question, students were asked to explain their answers via an optional free text field.

Preclinical
For this question, the preclinical results are separated into those from years 1 and 2 of the program and those in Year 3, given the difference in results. Overall, students in years 1 and 2 agreed that there was sufficient access to pastoral care (mode 4 [45.95%] | mean 3.75 | range: 1 to 5 | n = 148 from 171), academic support (mode 4 [50.93%] | mean: 3.9 | range: 1 to 5 | n = 161 from 171) and to counselling services (mode 4 [44.6%] | mean: 3.87 |

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range: 1 to 5 | n = 139 from 171). There were 41 free text comments from Year 1 that expressed satisfaction with the services and the availability of access. Several also highlighted that while they had not yet used any of the services, they were aware of how to access them. From Year 2, there were 14 comments addressing similar themes as demonstrated by the comment "Approachable teachers and tutors for both academic and personal support. Easily accessible help from pastoral care coordinator and counsellor", there were numerous positive comments regarding the efforts of the preclinical pastoral care coordinator.

For students in Year 3, there was a more equivocal response to their perception of the supports on offer in relation to pastoral care (mode 3 [38.6%] | mean: 3.4| range: 1 to 5 | n = 57 from 61) and counselling (mode 3 [49.12%] | mean: 3.33 | range: 1 to 5 | n = 57 from 61). However, students agreed that there is a sufficient level of academic support available (mode 4 [37.29%] | mean: 3.39| range: 1 to 5 | n = 59 from 61). The 15 free text comments from this year level suggested that students have not attempted to engage with such supports, which may explain why there was a skew towards a more equivocal response.

Clinical

In contrast to the preclinical space, the students in clinical years had overall equivocal responses with a negative skew in relation to pastoral care (mode 3 [37.1%] | mean: 2.66 | range: 1 to 5 | n = 132 from 161), academic support (mode 3 [37.5%] | mean: 2.96| range: 1 to 5 | n = 144 from 161) and counselling (mode 3 [37.2%] | mean: 3.1 | range: 1 to 5 | n = 129 from 161). 20 free text comments suggested a more negative view. For example, "I have not used any pastoral care, academic support, or counselling from the medical school. It is not made obvious where to find these avenues" or "Despite a focus on wellbeing in the preclinical years and easy access to support staff, I do not feel there is the equivalent for clinical years". These comments touch on the main themes seen in the free text that students are unaware of how to access these supports, do not feel that pastoral care exists and are disconnected from their year level advisors. This was again exampled by another comment which stated "I wouldn't know who to go to. I am unaware of who our year level advisor is". One commenter also identified an underlying issue which has been strongly advocated on by the AMSS that "There is no counselling specific for medical students and the regular university counsellors often cannot provide advice / support specific to dealing with in-hospital bullying and/or sexual harassment ". Further to these comments, another 4 respondents specified that they felt they received most of their support from peers, such as the AMSS, in lieu of official avenues through the staff. Several comments also raised that the school fails to meet their cultural needs as there is no accommodation of religious cultural days, such as Eid, and that the only 'days off' were related to those of Western cultural importance.

Summary

The survey results above corroborate with the views held by the majority of the student education representatives and the AMSS committee: that student support is much more prevalent and accessible to those in the preclinical atmosphere. Unfortunately, many students in the clinical half of their degree feel disconnected from their year level advisors and stated that they have never met them. In addition, the clinical students feel as though the lack of a dedicated pastoral care person (of which exists in the Year 1-3 space) is of great

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detriment to their personal needs. This is an issue which has been raised to the staff multiple times over the past years, and unfortunately, the major barrier appears to be financial resourcing. The provision of a Pastoral Care Coordinator for Years 4-6 is actively being followed up by the AMSS with key members of staff involved in program coordination. We hope to see further steps taken to meet students' needs over the rest of this year and those to come.

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

Methodology
Students in all year levels were asked to evaluate how well the Adelaide Medical School separates decision making for academic progression from student support. They rated their level of agreement on the following statement "I am able to get support and accurate advice on issues arising from Medical School (including clinical Placement) from a staff member that I trust." Answers were obtained via a Likert scale with 1 (representing strongly disagree) to 5 (representing strongly agree). There was also a cannot respond option. At the end of the question, students were asked to explain their answers via an optional free text field.

Students in Year 1 and 2 agreed that the Adelaide Medical School has been separating student support from academic progression decision making: (mode 5 [32.1%] | mean 3.82 | range: 1 to 5 | n = 159 from 171). 20 free text responses from Year 1 and 2 also suggested a positive opinion, with 17 students stating that they knew who to go to for support. For example, one student commented that the "staff are always very kind and approachable, and I know I can go to them for advice should I need it." In addition, 3 students stated that they were confident they knew who they could reach out to if needed but they have not had to contact them yet. However, it should be noted that 8 students expressed more negative opinions of this process, sharing a common theme was that they did not know who to receive advice from. This may reflect a need for ongoing promotion of support services available for some students who are unaware of the processes.

Years 3, 4, 5 and 6 students were grouped together as theyla had an equivocal response regarding the separation of student support from academic progression decision making, (mode 3 [40.2%] | mean 3.2 | range: 1 to 5 | n = 189 from 222)

In Year 3, the 12 free text responses suggested a more positive opinion, with 6 comments stating that various tutors and course coordinators have been extremely helpful. However, 4 comments stated that barriers to receiving helpful advice (although they knew where to receive support) were difficulties in communication with the staff and not knowing the staff members well enough. Only 2 comments expressed a wholly negative experience with receiving student support, with one student saying that "staff members are too confronting & hard to contact".

In Years 4-6, the 28 free text responses suggested a more negative opinion with 20 comments specifically listing barriers to receiving student support from staff. 7 comments stated that they did not have a close enough connection with the staff, making them feel unable to contact them. This was due to the students never meeting the staff in real life and

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because the staff rarely ever reached out to the students. 14 comments expressed that it was difficult for their issues to be resolved due to scarce support provided and ambiguous replies. The above concerns can be summarised by a comment left by a Year 4 student who stated "I get my support from fellow students. There are no staff members that I feel comfortable asking for support from. I'm not even sure who the person to go to is. If their name was written down somewhere, I would not feel comfortable contacting them because I would have never met them." Only 6 comments stated that they have had a positive experience when contacting staff for support, while 2 comments stated they had never had an issue so have not experienced the need to contact staff yet.

Summary
There is a clear disparity between the student support provided in Years 1-3 and Years 4-6. Most Year 1-3 students feel that they know who to contact, are comfortable with speaking to staff and feel a strong connection with their tutors, course coordinators or year level advisors. However, most Year 4-6 students feel that their course coordinators and year level advisors are disconnected from their course, they don't receive positive support and that it is difficult to resolve personal and educational matters due to miscommunication, uncertain responses, and little compassion. One difference that may be a cause for this disparity is the absence of a dedicated pastoral care role in the clinical Years in comparison to the preclinical years. This is a long-standing issue and further detail has been provided under Standard 7.3.1.

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

Methodology
All students were asked to consider adequacy of student representation within the medical program by rating a level of agreement with a series of statements. The statements had the common stem of "The Medical School facilitates and supports [blank]." The three subsets of this question for students to respond to were "student-led feedback," "student representation on academic committees" and "student input on program design". All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were asked to explain their answers via an optional free text field.

Results
With respect to student representation on academic committees, all students overall agreed that this was adequately met (mode 4 [41%] | mean 3.97 | range: 1 to 5 | n = 376 from 393). Free text comments did not particularly address this statement. It is the view of the student representatives that this is a key strength of the medical school, and this is enhanced and encouraged by those in the current leadership positions. To date, there is student representation on Year level Subcommittees, the Medical Program Assessment Committee, and the Program's Board. There are also various other positions within the larger Faculty/Central University that students from the course have the opportunity to sit on.

For student-led feedback, results were divided into preclinical and clinical students. Students in the preclinical cohort agreed that student feedback is facilitated and encouraged by the

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staff (mode 4 [40.3%] | mean 4 | range: 1 to 5 | n = 226 from 232). In contrast, those in the clinical cohort were overall equivocal in response to the same statement (mode 4 [30.8%] | mean 3.07 | range: 1 to 5 | n = 159 from 161). 31 comments from those in Year 1 were supportive of the staff's efforts to actively seek and act on student feedback. This theme was also expressed in 10 comments from Year 2 and 9 comments from those in Year 3. However, comments from those in clinical years highlighted some dissatisfaction. 13 comments identified a similar experience where they felt their feedback was not acted upon when provided or as one comment identified "it often feels that student feedback is more for show than for any other purpose, and when student feedback is ignored, it is often done so without any explanation". In contrast there were 6 positive comments across all Clinical years that expressed satisfaction with how the current leadership of the program was actively seeking feedback, for example one commenter noted that "it's been great to see the medical school generally very responsive to student feedback and suggestions over the past year or so". In contrast, there were 6 positive comments across all clinical years that expressed satisfaction with how the current leadership of the program was actively seeking feedback, for example one commenter noted that "it's been great to see medical school generally very responsive to student feedback and suggestions over the past year or so".

Results for the statements regarding student input on program design were separated into Years 1 and 2, compared to those in years 3-6 of the program. This grouping of data was based on the similarities of the responses both quantitatively and qualitatively.

Students in Year 1 and 2 tended to agree that student input on program design was facilitated by the staff (mode 4 [40.5%] | mean 3.78 | range: 1 to 5 | n = 158 from 171). In the free text comments from this cohort, there were 20 which highlighted a similar theme that was described in one comment as: "The medical school actively seeks input from students and have already implemented changes". 3 comments from those in Year 2 highlighted their enthusiasm about their invitation to join a staff led focus group regarding the BMD, which they felt led to significant improvements in the course. However, it should be noted that negative comments were still present. 5 negative comments from the Year 2 students expressed that they felt that "a lot more effort has been put into the BMD program" and not towards improving the MBBS.

Students in years 3-6 were overall equivocal on whether the staff supports student input on program design (mode 3 [39%] | mean 3.34 | range: 1 to 5 | n = 213 from 222). However, there were no positive opinions expressed in the free text comments in relation to program design. There was a range of comments (5 from Year 3, 7 from Year 4, 3 from Year 5 and 5 from Year 6) which conveyed the theme that students have a limited impact on program design as one student expressed that "students get some input, but if not championed by a member of staff they won't be listened to."

Summary

The medical school, under its current leadership, goes to great lengths to include student representation on various academic committees and to create avenues for seeking student feedback. However, it should be noted that a reasonably common theme amongst student comments is that student feedback may be sought but is not always felt to be acted upon appropriately. In addition, student input on program design is felt to be of a higher standard

for the BMD program than the outgoing MBBS program, as shown by the difference of opinion from those in years 1-2 compared to years 3-6.

Standard 8

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

Methodology
All students were asked to consider the adequacy of patient contact (including simulated encounters) in meeting the larger objectives of the course. Students in Year 1 and Year 2 rated their level of agreement on the following statement "There is sufficient exposure to simulated patients in the relevant teaching activities of Clinical Practice to meet the objectives of the course" while Year 3 students responded to the statement "There is sufficient exposure to simulated patients in the relevant teaching activities (clinical placement, simulation sessions etc.) to meet the objectives of the course".

Clinical students based in metropolitan hospitals were asked to rate their level of agreement with the following statements in reference to the courses they had completed (or were in the process of completing) in 2022. The statements were: "There is sufficient exposure to patients to meet the objectives of the course" and "there is sufficient exposure to the relevant learning activities of the unit (clinics, operating theatres etc.) to meet the objectives of the course."

In addition to this, students enrolled in the Year 5 Rural Medicine program were asked to rate their level of agreement with a series of statements. The statements had the common stem of "I have adequate exposure to [blank] patients to meet the objectives of the course." The three subsets of this question that students considered were "Indigenous patients," "Obstetric patients" and "Paediatric patients."

All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were asked to explain their answers via an optional free text field.

Preclinical
Students in Year 1 and 2 agreed that the Adelaide Medical School's simulated patient scenarios provided sufficient exposure to meet the objectives of the course: (mode 5 [67.57%] | mean 4.58 | range: 1 to 5 | n= 111 from 111) and (mode 5 [71.7%] | mean 4.5 | range: 1 to 5 | n= 60 from 60) from Years 1 and 2, respectively.

Additionally, of the 18 free text responses from Year 1 and 2 students, 16 suggested they had sufficient and helpful exposure to simulated patients during Clinical Practice teaching sessions. However, a few of the responses mentioned that the simulated learning environment with simulated patients can be stressful, as students are expected to perform skills immediately after seeing a demonstration. For example, referring to SPs, one student

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commented that students are not afforded the opportunity to "practice with them in a non-stressful environment"

Students in Year 3 had an equivocal response to the statement (mode 3 [39.3%] | mean 3.38 | range: 1 to 5 | n = 61 from 61). Of the 10 free text responses from Year 3 students, 5 mentioned that the exposure to simulated patients was less than in the previous years and that this had the potential of not sufficiently preparing them for real hospital placement. However, 3 responses mentioned that when provided with a simulation experience such as the Vascular Workshop, students found the teaching helpful and relevant to achieving their learning outcomes. Lastly, a minor theme expressed through free text responses from years 1-3 centred around the significant impact that Covid-19-related absences had on missed opportunities in simulated scenarios. These absences could not be made up for at times, decreasing the quality of student education. For example, a detailed comment highlighted that they "have struggled this semester to meet requirements for case presentations and case writeups due to difficulties with introduction to placement, additional offsite activities, struggles in finding appropriate patients to examine."

Clinical

Students in Year 4 were overall equivocal regarding exposure to patients (mode 3 [26%] | mean 3.18 | range: 1 to 5 | n = 69 from 69) and again equivocal regarding exposure to the unit learning activities (mode 4 [30%] | mean 3.4 | range: 1 to 5 | n = 69 from 69). The free text comments explored a range of opinions from students, with 15 comments noting that deciding factor on meeting the standard "really depends on the ward you are placed on". Particular placements noted included surgical specialities which were regarding by one student to be "not as useful as general surgery, which is majority of exam content" and community psychiatry placements which are viewed to have "insufficient patient exposure compared to placement at a larger hospital site." In addition, the experience of clinical placements during the pandemic has also affected those in Year 4 with 9 comments specifically identifying Covid-19 related disruptions to placement. Examples of these disruptions included outpatient clinic/theatre cancellations or being placed on Covid-19 teams and being unable to interact with patients.

Students in the Year 5 metropolitan program agreed that patient exposure was sufficient (mode 4 [31.17%] | mean 4.32 | range: 1 to 5 | n = 39 from 39) and were equivocal (with a positive skew) regarding exposure to learning activities of the unit (mode 4 [40.26%] | mean 3.45 | range: 1 to 5 | n = 39 from 39). One outlier from this data was the paediatrics course, which was rated equivocally, with a negative skew (mode 2 [36.84%] | mean 2.6 | range: 1 to 5 | n = 19 from 19). However, there were 7 free text comments which noted that the paediatric course has very short rotation lengths (2 weeks medical, 2 weeks surgical, 2 weeks simulation) and students felt "it's just not enough" and "depending on what your rotation is it could be difficult to meet the objectives of the course". Students in the Year 5 Rural program rated their agreement as equivocal for indigenous patients (mode 3 [28.57%] | mean 3.21 | range: 1 to 5 | n = 14 from 14, obstetric patients (mode 4 [28.57%] | mean 2.86 | range: 1 to 5 | n = 14 from 14) and paediatric patients (mode 3 [35.71%] | mean 2.42 | range: 1 to 5 | n = 14 from 14). However, 4 comments echoed the concerns of the metropolitan cohort. For example, one student commented that "we only get 2 weeks of

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Paeds and HRH, so you have to be lucky to see enough". Covid-19 related disruptions was also similarly identified in 3 comments.

The students in Year 6 overall agreed that there was sufficient exposure to patients (mode 4 [46.2%] | mean 4.09 | range: 1 to 5 | n = 53 from 53) and to the relevant learning activities (mode 4 [50%] | mean 4.04 | range: 1 to 5 | n = 53 from 53). There were 15 free text comments that supported the quantitative data. Examples included comments praising the learning in the TTIP course as "excellent and useful" or the primary care selective which excelled in "practical hands on things, parallel consulting, paeds - geris patients" However 7 comments highlighted concerns such as "clinical exposures can be quite limited if you are placed on a niche ward/unit" or specific to the ED/ICU placement that "it was much more difficult to see all the cases required to pass the course".

Summary
Preclinical students feel that the Medical School provides sufficient learning opportunities to interact and develop skills with simulated patients during Years 1-2 but does not carry this level of opportunity into Year 3 teaching. Students in Years 1-2 repeatedly expressed appreciation for the weekly interactions with simulated patients in their clinical practice course and felt that working alongside tutors was generally helpful in building their competency to perform clinical skills. While acknowledging the impact of the Covid-19 pandemic on limiting Year 3 student exposure to real clinical practice, the general theme student responses suggested that there was inadequate teaching conducted through simulation to make up for the lack of real clinical exposure.

Clinical students, especially in year 4 and 5, are more equivocal about the sufficiency of the exposures in the current clinical learning environment. A common concern noted is that differences in clinical units they are allocated to appear to have significant impact on the opportunities they are afforded, and this is exacerbated by short placement lengths such as the paediatric rotations. This is all further added to by Covid-19 related disruptions, which featured less in comments from those in Year 6 who are still able to interact with these patients due to their wider scope of practice. The reduced impact of Covid-19 on patient interactions for those in year 6, longer placement durations and increased simulation time in TTIP may explain why they tended to overall agree this standard has been met unlike those in Year 4 and 5.

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

Methodology
Students in all year levels were asked to consider the usefulness of Indigenous Health related teaching in their curriculum by rating a level of agreement with the following statements: "The Indigenous Health teaching has equipped me well with practical skills for treating Indigenous Patients in a culturally sensitive manner within my future practice", "I have sufficient opportunities to be exposed to the delivery of health care to Aboriginal and Torres Strait Islander peoples" and in a slightly reworded format for those in the clinical year levels "I have sufficient opportunities to be involved with delivery of health care to Aboriginal and

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Torres Strait Islander peoples." All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were asked to explain their answers via an optional free text field.

Preclinical

Overall, the preclinical students agreed that the current level of teaching has equipped them with practical skills to deliver culturally competent care (mode 4 [38.9%] | mean 3.74 | range: 1 to 5 | n = 221 from 232). This was also reflected under standard 3.5, however, the questions relating to this standard focuses more upon the opportunities afforded to students to practice these skills. They were equivocal about having sufficient opportunities to being exposed to the delivery of healthcare (mode 3 [29.3%] | mean 3.39 | range: 1 to 5 | n = 232 from 232). 20 comments from those in Year 1, 8 comments from those in Year 2 and 17 comments from those in Year 3 all reflected a shared theme that the theoretical knowledge provided has been sufficient, yet there is a limitation in the practicing of these skills and insufficient opportunities for live patient interactions. It is acknowledged that the observation of clinical care is not a focus of the preclinical years. Nevertheless, the free text comments do express the students' desire to have a more active involvement in Indigenous healthcare as one commenter noted the consequence is that "we research a lot and learn about healthcare to Aboriginal and Torres Strait Islander Peoples, but it's hard to put this into context/practice." This could be improved by having more Indigenous simulated patients for simulated clinical encounters to practice the skills learnt (in addition to the other scripted stations), to improve student learning.

Clinical

Clinical students responded equivocally regarding whether their teaching has sufficiently equipped them with the practical skills to deliver culturally competent care (mode 3 [34.4%] | mean 3.13 | range: 1 to 5 | n = 139 from 161) and were also equivocal towards having sufficient involvement in the delivery of healthcare to Aboriginal and Torres Strait Islander peoples (mode 3 [29.2%] | mean 3.04 | range: 1 to 5 | n = 161 from 161). However, the free text comments indicated a more negative response. 7 comments from those in Year 4 stated that they felt unprepared during the transition from Year 3 and are yet to have significant opportunities for involvement. For example, one comment stated that "there have been no formal opportunities to actually provide care as part of this course." Another commenter noted that "I have participated in teaching specific to treating Indigenous patients but still don't feel it is up to scratch for use in real placements" further demonstrating the need for practical involvement. 5 comments from those in Year 5 echoed similar concerns that Indigenous Health related placement opportunities are minimal, unless specifically sought out by students via their own means. This was further shown by 9 comments from those in Year 6 that identified a clear gap between the provision of theoretical knowledge compared to relevant placement opportunities. For example, one comment stated that "I've encountered very few Indigenous patients and the Indigenous Health teaching does not impart communication skills that can be applied to real-life conversations with actual human beings outside of the theoretical academic setting."

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

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Methodology

Students in years 3-6 were asked to evaluate the school's ability to engage with clinical supervisors and monitor their performance with respect to their ability to assess students. Students were asked to evaluate this by rating a level of agreement in accordance with the following statements "clinical supervisors are well informed on reasonable expectations of student knowledge and skills" and clinical supervisors are well informed on reasonable expectations of student attendance." All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were also asked to explain their answers via an optional free text field.

Results

On average, all year levels felt that supervisors are well informed on reasonable expectations of student attendance (mode 4 [42.9%] | mean 3.59 | range: 1 to 5 | n = 161 from 161). There was, however, a range of opinions expressed in the free text comments which suggested that this was site/clinical unit dependant with some rotations expecting a greater level of attendance, and that some supervisors were not aware of the existing fair hours policy of 38 hours per week including preserved study periods. This was expressed in 24 comments across the clinical years which included things such as "Many supervisors are not aware of the student clinical placement hours policy (e.g., not exceeding 38 hours of placement per week)" or "the fact that studying is also required outside of placement hours are not adequately considered" and "Some supervisors expect 8+ hour long days 5 days a week - this leaves minimal time for study."

Students in years 3 and 4 were equivocal that their clinical supervisors are informed to a reasonable degree about appropriate student knowledge and skills (mode 3 [35.1%] | mean 3.21 | range: 1 to 5 | n = 57 from 61) and (mode 3 [34.8%] | mean 3.12 | range: 1 to 5 | n = 69 from 69) respectively. In contrast, students in Year 5 (mode 4 [41%] | mean 3.69 | range: 1 to 5 | n = 39 from 39) and Year 6 (mode 4 [58.5%] | mean 3.74 | range: 1 to 5 | n = 53 from 53) tended to agree that supervisors are informed of the appropriate level of knowledge and skills. However, we note one specific comment referencing this standard which highlighted that "many clinicians get confused about what we are expected to know from exams and regularly ask us whether if we have been taught something". This standard was discussed by a focus group of the Year 3 and Year 4 student representatives. The major theme arising from the discussion was that the Year 3 students are not well integrated into the hospital environment during their clinical practice course. Thus, when commencing full-time clinical placement in Year 4, they are unaware what knowledge and skills they should be focusing on, and this was felt to be exacerbated by the fact that there is minimal guidance on the transition provided by the school. It was felt that the clinical supervisors are also unaware of this, which means the most junior students are being expected to perform at the level of someone familiar with the hospital system and mechanics of a unit.

In response to the statement that supervisors assess students in line with reasonable expectations of knowledge and skills, there was a greater disparity among the year levels. Students in years 3 and 4 were overall equivocal (mode 3 [39.3%] | mean 3.48 | range: 1 to 5 | n = 56 from 61) and (mode 3 [43.5%] | mean 3.38 | range: 1 to 5 | n = 69 from 69) respectively. However, students in Years 5 and 6 agreed that assessment was reasonably in line with expectations of knowledge and skills, (mode 4 [46.2%] | mean 3.79 | range: 1 to 5

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| n = 39 from 39) and (mode 4 [67.92%] | mean 3.81 | range: 1 to 5 | n = 53 from 53) respectively. 28 Free text comments from all year levels expressed the opinion that there is marked variability depending on the assessor, indicating that some are more well informed than others about the expectations of each year level. 1 comment from year 5 and 2 comments from year 6 identified that the more detailed the assessment rubric, the more likely a supervisor was to assess a student in a fair manner. However, similar to those in year 3 and year 4, there was 5 comments which identified that this was still supervisor dependant and that junior doctors tended to be fairer assessors than senior clinicians. It is also noted that some students expressed that they only met supervisors on their final day for assessment. One student in particular commented that "I never met my clinical supervisor for the entire 6 weeks. I got one of the Fellows from the unit to complete my supervisors report instead."

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

Methodology
Students in Year 3-6 of the program were asked to evaluate the sufficiency of clinical teaching provided to students on placement. This was done by rating a level of agreement with the following statement "Sufficient teaching is provided during hospital by senior clinicians." All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were also asked to explain their answers via an optional free text field.

Results
Overall, Year 3 to 6 students responded equivocally regarding the amount of teaching provided by senior clinicians (mode 3 [30.6%] | mean 3.06 | range: 1 to 5 | n = 222 from 222). However, the comments from each year level represented a range of more negative viewpoints.

From Year 3, there were 12 comments indicating dissatisfaction with the current standard of teaching, citing that "tutors are hard to contact and sometimes they just don't reply". There were an additional 3 comments that addressed the fact that it may be too early in the year to fairly judge this given their delayed entry into hospital.

31 comments from Year 4 students, 15 comments from Year 5 students and 28 comments from Year 6 students all addressed a similar theme: that unless there was scheduled teaching arranged through the school (e.g., via zoom tutorial), they received limited to no teaching from their clinical supervisors. More than half of these comments indicated that "senior clinicians are very busy, most teaching is done by the junior doctors, which is still very helpful," as the senior staff members were too busy or disinterested in providing formal education for medical students. Some examples of comments referencing this included: "Unless the university has assigned specific tutorials by senior clinicians, tutorials are never given by senior clinicians, and they have an extremely low passion for teaching students" and "teaching from consultants is highly variable and generally not done in any meaningful way." However, four respondents did indicate that certain supervisors go to great lengths to impart teaching on their students, indicating that some are more engaged than others. 5

students in Year 6 also indicated that the only teaching from clinical supervisors they received was while in the Emergency Department.

Finally, while the numerical data was equivocal, the comments seem to suggest students chose this option as they do receive teaching on site, but from those in a junior position, not a senior clinician or clinical supervisor. This is congruent with other findings in this report: that there is often significant disengagement from those holding the title of supervisor and that they have often have little involvement in the education of the students assigned to their units.

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Placement Fair Hours

While not aligning to a specific AMC standard, the position of AMSS is that students should be at placement for a maximum of 38 hours per week, which includes a 4-hour block of protected study time. The AMSS and staff have collaborated to produce a fair hour's policy which stipulates this, among other guidance regarding student placement hours. This policy has been in effect since 2020, however the consistency of its application is uncertain.

Methodology
Students in the clinical years were asked if their placements, in general, fall in line with the fair hours policy. This was achieved by asking them to rate a level of agreement with the following three statements: "My placement hours are aligned with the medical school fair hours policy of a maximum of 38 hours per week", "I am regularly able to undertake the preserved study block of at least 4 hours during the Monday-Friday placement hours" and "I am given appropriate time off placement surrounding nights, late covers or weekend shifts in accordance to the school fair hours policy". All answers were obtained via a Likert scale from 1 (representing strongly disagree) to 5 (representing strongly agree). At the end of the question, students were also asked to explain their answers via an optional free text field.

Results
Students in Year 4 overall agreed that, in general, they undertake placement hours to a maximum of 38 hours per week (mode 5 [47.83%] | mean 4.13 | range: 1 to 5 | n = 69 from 69). They were equivocal that they could have a 4-hour preserved block of private study time (mode 5 [27.54%] | mean 3.17 | range: 1 to 5 | n = 69 from 69) and overall agreed they would get appropriate time off around out of hours shifts (mode 5 [40.91%] | mean 3.9 | range: 1 to 5 | n = 69 from 69). However, the free text comments indicated a lack of awareness of both students and supervisors about the existence of this policy, and 4 comments specifically indicated they were unaware of the policies guidance around time off surrounding out of hours shifts and a result. For example, one student commented: "I covered after hours shifts and night shifts without any additional time off." A further 4 comments identified specific units as troublesome for student hours, as they worked more than 38 hours with no preserved study time. This was particularly directed at surgical units, where one comment identified "My registrar on one rotation expected me to stay 8-6 all 5 days which accounts for more than 50 hours- I didn't get lunch sometimes", and rural surgical placements where another student commented that "rural hospital had no concept of 38-hour weeks. We usually did 10-hour days (7am-5pm)"

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Students in Year 5 overall agreed that, in general, they undertake placement hours to a maximum of 38 hours per week (mode 5 [41%] | mean 4.03 | range: 1 to 5 | n = 39 from 39). They also overall agreed that they can have a 4-hour preserved block of private study time (mode 4 [35.9%] | mean 3.54 | range: 1 to 5 | n = 39 from 39) and overall agreed they would get appropriate time off around out of hours shifts (mode 4 [38.46%] | mean 3.92 | range: 1 to 5 | n = 39 from 39). However, the free text comments echoed similar themes to those in Year 4. 6 of the comments again identified a general lack of knowledge from both the students and supervisors about the policy, particularly with respect to preserved study time and rostering around out-of-hours shifts. For example, one comment identified that "I've never been given 4-hour study blocks during the week when on rotation with 8-5 hours. Study blocks should be emphasised more to the course coordinators and the rest of the hospital staff".

Students in Year 6 overall agreed that, in general, they undertake placement hours to a maximum of 38 hours per week (mode 5 [47.83%] | mean 4.13 | range: 1 to 5 | n = 69 from 69). They were overall equivocal about their ability to have a 4-hour preserved block of private study time (mode 2 [39.6%] | mean 2.5 | range: 1 to 5 | n = 53 from 53) and overall agreed that they would get appropriate time off around out of hours shifts (mode 4 [36.5%] | mean 3.6 | range: 1 to 5 | n = 53 from 53). However, the free text comments again echoed similar themes of unit variability, but in general, that supervisors are not aware of the policy and view students as 'slacking off' if they attempt to leave for their preserved study time. Issues around preserved study time were highlighted in 8 comments and Issues surrounding rostering around out of hours shifts were reflected in 7 comments, for example "some do not allow the next day to be off if you have had a night shift or do not protect study time". We do note that issues surrounding rostering and fair hours were mainly made in reference to Emergency Department placements

Summary

There is a disconnect between clinical supervisors, students, and the medical school when considering what constitutes appropriate clinical time on placement. In the current ecosystem, students are expected to advocate for themselves based on the fair hours policy and there is no consistent message from the course coordinators to tell clinical supervisors about fair placement hours. Most units excel in allowing students time to study, while others perform poorly. When issues are raised appropriately to staff's attention, interventions are usually made. While students are generally comfortable with most rostered hours, the common theme from the numerous free text comments is that they wished for more action from the school to communicate guidance around hours, including preserved study time to clinical supervisors.