



**ADELAIDE MEDICAL  
STUDENTS' SOCIETY**  
— EST 1889 —

# Australian Medical Council

Student Submission

**September 2018**

**Adelaide Medical Students' Society**

# Executive Summary

The Adelaide Medical Students' Society (AMSS) is the peak representative body for medical students at the University of Adelaide. We appreciate the fact that the Australian Medical Council (AMC), as part of its accreditation process, has again requested a student submission from the AMSS.

As with previous similar submissions, the AMSS has conducted a significant survey to inform this document. The survey guiding this document is of similar success to previous surveys, collecting responses from 41% (393 from 955) of eligible respondents in July 2018.

We believe that our methodology, response rate and our informed view of student opinions collectively allow this document to be taken as a sufficiently accurate reflection of student opinion on the Medical Program. It is, however, vital that this submission is interpreted in the context of its limitations; these are elaborated in the 'limitations' section as well as in other relevant areas of the body of the document.

Being a progress report, it is worth noting the key issues identified in last year's submission. These included the communication of learning objectives to students and staff, assessment feedback for Year 4-5 students, the accessibility of student services for those on clinical placement and the teaching of Indigenous Health, histology, genetics and orthopaedics in the Year 4 Musculoskeletal Medicine rotation.

It should be noted that a number of key issues identified by the student body in the 2017 AMSS submission to the AMC have been completely or partially resolved. Most notable are the significant efforts being made to reinvigorate Indigenous Health and pre-clinical anatomy teaching, optimise pre-clinical CBL as well as to take positive action on student health & well-being. Additionally, student-staff collaborations aimed at fixing issues related to clinical year objectives and pre-clinical lectures (in the form of a Year 1-3 Lecture review) are likely to generate more positive feedback in future AMC submissions. These improvements and collaborations are very encouraging and staff should be strongly commended for their enthusiasm for collaborating with the student body in addressing our perceived issues.

There are a number of key strengths of the Medical Program as identified in this submission. The teaching of core skills and the preparedness of Year 6 students for Internship are rated highly by students and are findings that align with that of the 2017 National Survey of Intern Work Readiness regarding University of Adelaide medical graduates. As well, the teaching in the vast majority of medical disciplines in pre-clinical years and clinical rotations, as well as the clinical year lecture series (SMTS and TTIP), have been reviewed positively. Although not a focus in this year's AMC survey, the ever-

increasing use of simulation teaching as well as teaching provided by the Rural Clinical School continue to be praised anecdotally by students.

There are seven areas where student opinion suggests additional attention may be required. The first is the provision of assessment feedback for Year 4-5 students as outlined under standard 5.3. The second is the communication of learning objectives to lecturers, tutors and supervisors discussed in further detail under standard 3.4. The third is the quality of teaching in the Year 4 Musculoskeletal Medicine rotation, outlined under standard 4.1. The fourth is the quality of the Year 3 Clinical Skills Program as discussed under standard 4.3. The fifth is the lack of quiet study space available in the medical school building outlined under standard 8.1. The sixth is the appropriateness of eSELTs as a tool for evaluation of clinical rotations, outlined under standard 6.1. The seventh is the ease of contacting staff regarding common enquiries for clinical students, outlined under Standard 7.3.

Each of these areas has additional commentary after their respective data interpretation.

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# Definitions

<b>AHMS</b>	means the Adelaide Health and Medical Sciences building
<b>ALS</b>	means Advanced Life Support
<b>AMC</b>	means the Australian Medical Council
<b>AMSS</b>	means the Adelaide Medical Students' Society
<b>APIC</b>	means Anaesthetics, Pain and Intensive Care
<b>BLS</b>	means Basic Life Support
<b>CBL</b>	means Case Based Learning
<b>Clinical</b>	mean Years 4-6 of the Medical Program
<b>CRE</b>	means Clinical Reasoning Examination
<b>CPT</b>	means Clinical Placements Team
<b>FHMS</b>	means Faculty of Health and Medical Sciences
<b>IPL</b>	means Interprofessional Learning
<b>LMH</b>	means Lyell McEwin Hospital.
<b>MCQ</b>	means Multiple Choice Question
<b>Medical Program</b>	means the Bachelor of Medicine, Bachelor of Surgery degrees offered by the Faculty of Health and Medical Sciences at the University of Adelaide
<b>MKE</b>	means Medical Knowledge Examination
<b>MLTU</b>	means Medical Learning and Teaching Unit (former administration)
<b>MPH</b>	means Modbury Public Hospital
<b>MPPD</b>	means Medical Professional and Personal Development
<b>Pre-Clinical</b>	means Years 1-3 of the Medical Program
<b>OSCE</b>	means Objective Structured Clinical Examination
<b>RAH</b>	means the Royal Adelaide Hospital
<b>SCAP</b>	means Specialist, Community and Ambulatory Placement, colloquially refers to Year 6 students on their Medical Education selective
<b>SMTS</b>	means School of Medicine Teaching Series
<b>SPSS</b>	means Student Professional and Support Services
<b>TQEH</b>	means The Queen Elizabeth Hospital

# Introduction

The Adelaide Medical Students' Society (AMSS) is the representative body for medical students at the University of Adelaide. We are very grateful for the opportunity to contribute student opinion to this important Australian Medical Council (AMC) accreditation process.

As with previous similar submissions, the AMSS has conducted a significant survey to inform this document. The survey guiding this document is of similar success to previous surveys, collecting responses from 41% (393 from 955) of eligible respondents in July 2018. Therefore, we believe that the comments made in this submission accurately reflect the views of the majority of students.

In the nature of a progress report, in this submission we have focused on providing updated information on areas students considered to be suboptimal and those that were identified as problematic by the AMC in the 2017 comprehensive review. We have also included surveyed student opinion regarding any major changes to the curriculum that took place after the 2017 comprehensive review. Consequently, this submission seeks to convey student opinion on the following standards, as per the updated AMC Accreditation Standards for Primary Medical Education Providers.<sup>1</sup>

<b>Standard 3.4</b>	Curriculum Description	<b>Standard 5.3</b>	Assessment Feedback
<b>Standard 3.5</b>	Indigenous Health	<b>Standard 6.1</b>	Monitoring
<b>Standard 4.1</b>	Learning and Teaching	<b>Standard 7.3</b>	Student Support
<b>Standard 4.3</b>	Learning and Teaching	<b>Standard 8.1</b>	Physical Facilities
<b>Standard 4.7</b>	Interprofessional Learning		

We sincerely thank the AMC for the opportunity to submit this paper and would be very happy to provide any additional information that may be desired.



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## Footnote:

1. Accreditation Standards for Primary Medical Education Providers and their Program of Study and Graduate Outcome Statements. Policy document, Australian Medical Council Limited, viewed 1 October 2017, <http://www.amc.org.au/images/Accreditation/FINAL-Standards-and-Graduate-Outcome-Statements-20-December-2012.pdf>

# Methodology

## Survey design

The survey utilised to collect data for this Submission contained both generic questions and questions tailored to each Year Level. Respondents submitted opinions regarding the Year Level they are about to complete, with students currently in years 4, 5, and 6 completing questions on all of the clinical attachments they have undertaken in 2018. Given the modest response rate in previous surveys, the opinion of interns was not sought in this survey. The specific formats of the survey questions are described in the respective sections of the body of this submission. In general, unless clearly required by the relevant question stem, we utilised Likert scales without neutral midpoints to minimise central tendency bias. All questions included a 'not applicable' or 'cannot respond' response category to ensure respondents were not forced to make a statement that they did not agree with.

## Survey promotion

Participation was promoted to all students enrolled in the University of Adelaide Medical Program in 2018. A cash prize of \$50, as well as 3 merchandise prizes, were funded by the AMSS and randomly provided to respondents to encourage participation. The survey was open from Wednesday 25<sup>th</sup> July to Friday 3<sup>rd</sup> August 2018. Respondents were asked to submit their student number to mitigate the potential for multiple responses from a single student.

## Data Interpretation

Data from incomplete responses are included in our analysis. We considered both mode and mean values in analysing data collected through Likert scales. We include graphic depictions of responses to Likert scales to assist rapid interpretation. In some cases, we note the percentage of individuals responding in the positive or negative spectrum of Likert scales. We applied the following criteria to categorising data from Likert scales from -2 to +2 with no neutral mid-point:

Positive response		mean > +0.4
Negative response		mean < -0.4
Equivocal response		-0.4 ≤ mean ≤ +0.4

We fully acknowledge that this construct for categorising Likert results is notional and open to criticism or replacement with an alternative interpretative framework. However, the ultimate result of such categorisation is merely to identify the areas that student opinion would suggest require additional attention. As is stressed in the ‘limitations’ section of this Submission, this document seeks to convey student opinion for the benefit of the accreditation team and other relevant bodies; it does not claim to determine the actual performance of the Medical Program with respect to the accreditation standards because, although student opinion is important in achieving this, we believe that it is ultimately the role of the accreditation team. We acknowledge that there may be valid reasons as to why areas that attract ‘equivocal’ or ‘negative’ student opinion are in fact not in need of greater attention.

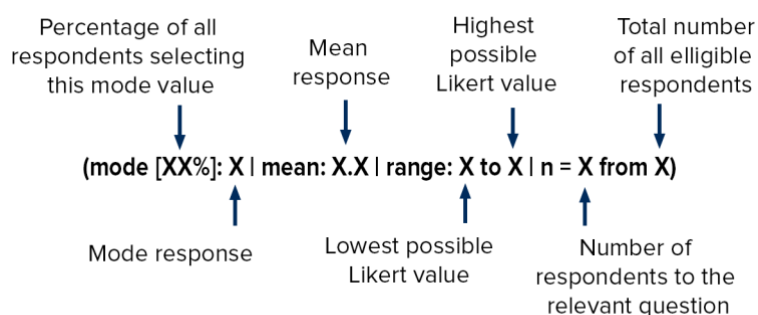
We have attempted to fully describe all data arising from the primary survey informing this document, regardless of whether they are categorised as positive or equivocal or negative. In this submission, data that showed areas where student opinion was clearly positive have been included, rather than just focussing on areas where opinion was negative or equivocal. This is to illustrate the areas of the Medical Program that are well-delivered, and also to provide information about the areas that have be adequately address by the Medical Program in response to previous feedback.

Similarly, with respect to the inclusion of figures, this Submission includes areas where student opinion is clearly positive, rather than focussing on the negative and equivocal areas. We note that we have not included figures for every Likert scale present in the primary survey informing this document, primarily due to concerns regarding the length of the submission and also limited time available for drafting.

The survey and raw results are available upon request.

## Data Presentation

Responses to Likert scales are presented graphically in Figures 1-40 and as follows:

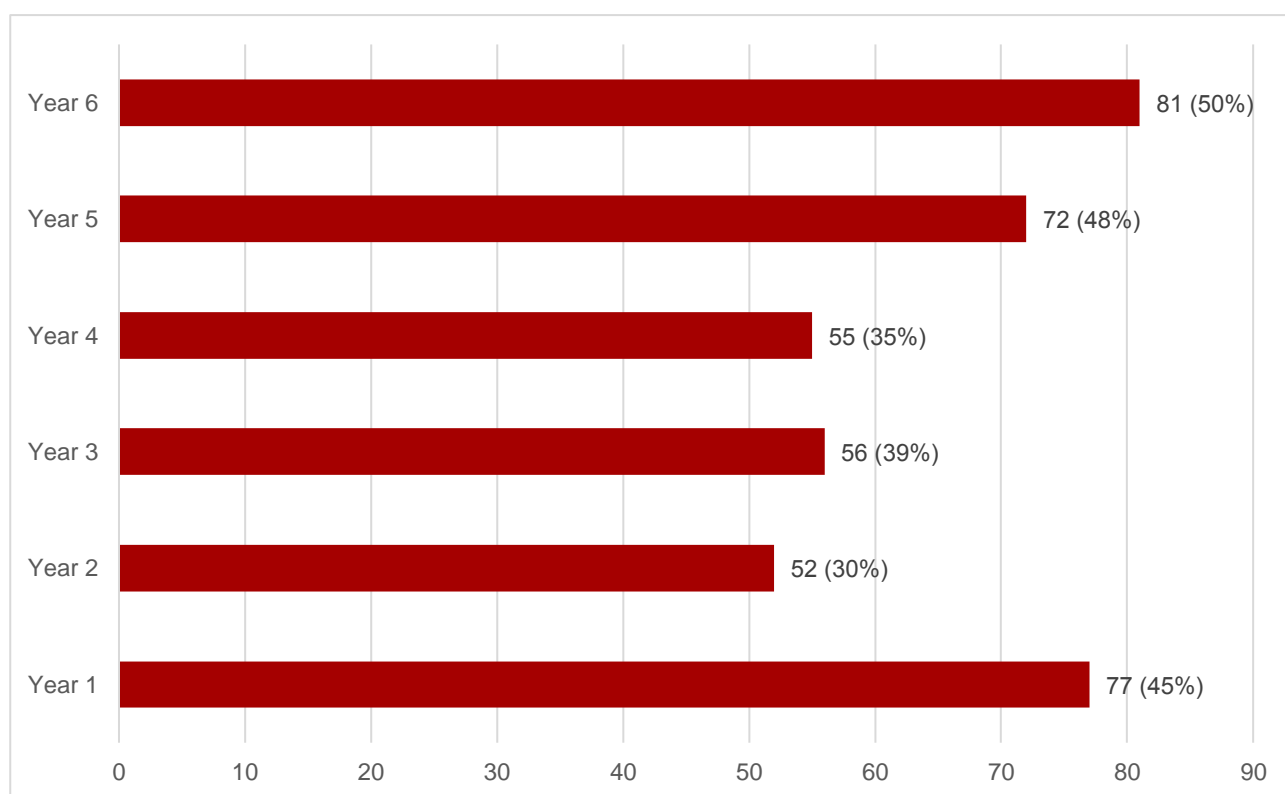


# Demographics

The data presented here represent the submissions of 347 respondents. This equates to a sample of 41% of the 955 medical students at the University of Adelaide.

The distribution of respondents, according to their current Year Levels, is demonstrated graphically in the below image. The data labels indicate the absolute number of responses and then the proportion of eligible respondents from the given Year Level that submitted a response.

**Figure 1: Respondents by Year Level to AMC Survey in 2018**



**\*NB. Of the 72 5<sup>th</sup> Years:**

**42 filled out the Rural 5<sup>th</sup> Year Survey and 30 the 5<sup>th</sup> Year Metropolitan Survey**

# Limitations

Discussion of the limitations of this Submission and the underlying survey has been purposefully placed before the body of the document itself, due to the importance of considering these limitations when interpreting the Submission.

## Student opinion

It is important to acknowledge that the survey and therefore this Submission seek to represent majority student opinion on various issues within the Medical Program. Student opinion is inherently subjective and based on student expectations and perceptions of what is satisfactory / appropriate. In some cases, there may be good evidence or reasoning as to why student opinion is inaccurate, perhaps due to unrealistic expectations or skewed perceptions. This Submission does not purport to determine the actual performance of the Medical Program on the Australian Medical Council accreditation standards, but rather to convey majority student opinion on associated matters in order to assist the accreditation team in their deliberations and for the benefit and / or interest of other relevant parties.

## Clinical Student Bias

A total of 53% of the responses arose from students in the clinical year levels, with the other 47% from pre-clinical year levels. This slight clinical bias has the potential to confound accurate representation of general student opinion. We have attempted to mitigate the impact of this clinical bias by reporting our findings broken down by year level or at least by pre-clinical or clinical status of the respondents. If data are 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 would be 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 to mitigate the impact of selection bias is the overall response rate (discussed immediately below).

## Response Rate

The response rate to this survey was 40% in pre-clinical Year Levels and 45% in clinical Year Levels. Although the response rate from pre-clinical year levels is slightly lower, this should only be considered a limitation to the interpretation of sections of the survey specific to pre-clinical year levels. The adequacy of the overall 41% response rate is open to discussion and, naturally, 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 of any useful length (unless it is a short poll targeted to a specific issue which can therefore be quite brief) would be difficult or impossible without either mandating that students complete the survey or, at the very least, using some form of 'benign entrapment'. Thus if a significantly higher response rate is deemed necessary for student opinion to be considered valid, any attempt at course evaluation which seeks to incorporate student feedback via conventional methods is unlikely to be successful.

## Response Acquiescence Bias

It is possible that the wording of questions may have introduced response acquiescence bias into the data. We have attempted to avoid this as far as possible by utilising neutral wording throughout the survey. The exact wording of all questions can be provided upon request, if there are concerns about response acquiescence bias.

## Central tendency Bias

The use of Likert scales, which was extensive in the survey utilised to inform this document, is unavoidably associated with the central tendency bias. We attempted to mitigate the impact of central tendency bias by avoiding the inclusion of neutral mid-point responses where appropriate. Nonetheless it remains possible that the central tendency bias may contribute to the under-reporting of significant positive and negative results, and the over-reporting of 'equivocal' responses.

## Survey Timing

Due to the timing of release of the survey, students were generally unable to provide feedback in relation to 2018 semester 2 course content. This is particularly relevant to the clinical student respondents, who were unable to provide responses to questions related to clinical rotations that they have yet to complete in 2018, and to genetics teaching, which Year 2 students had yet to undertake at the time of the survey that informed this submission and thus was not surveyed. The former was



accounted for by having a “cannot respond” option available for every question and the impact on the response rate to each question is noted by the method of data presentation (see “Data presentation” in methodology).

# Standard 3 | The Medical Curriculum

## Standard 3.4 | Curriculum Description

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

### Learning Outcomes and Objectives in the MBBS Program

#### Communication of Curriculum Objectives: To Lectures & Tutors

##### Methodology

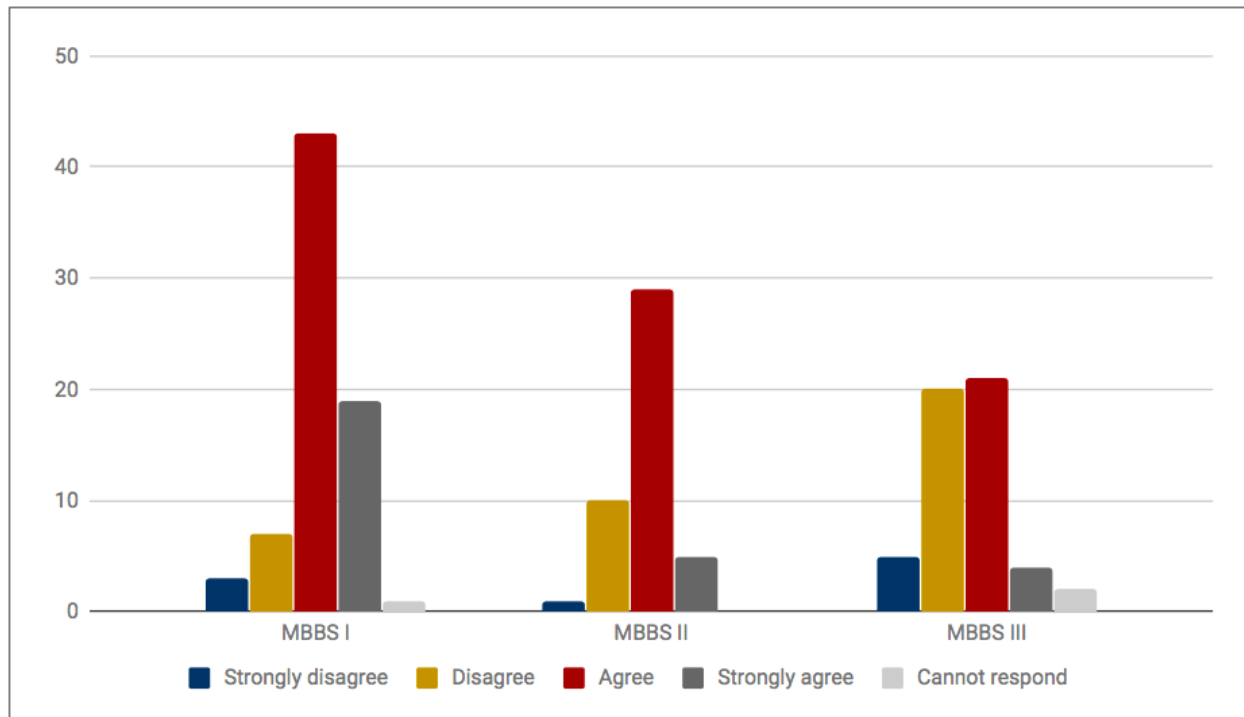
Students in all year levels were asked to evaluate the efficacy of current lecture delivery by rating level of agreement based on the following statement **“Lecturers are well-informed on the depth of students’ prior knowledge, what accompanying lectures are given around their topic and the realm of what their lecture should cover.”** Answers were obtained via Likert scale from -2 (representing Strongly Disagree) to +2 (representing Strongly Agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

##### Preclinical

Preclinical students had an overall positive response in regards to how well-informed lecturers and tutors were on the scope of their lecture content and where their lecture/tutorial fit in within the greater picture of the medical program. (mode [56%] +1 | mean: +0.51 | range: -2 to +2 | n = 167 from 170). However, the Year 3 cohort were equivocal in their response (mean: -0.02) and 35 open text responses from pre-clinical students suggested a more negative opinion. The most common view was that lecturers go too in-depth and expect a level of prior knowledge that students do not have (10 comments). Other predominant themes included that lectures provided as part of the core medical program (Scientific Basis of Medicine) and Fundamentals of Biomedical Sciences courses should be more synergistic (2 comments), and lecture content is often focused on what interests the lecturer

rather than what students should be expected to know (3 comments).

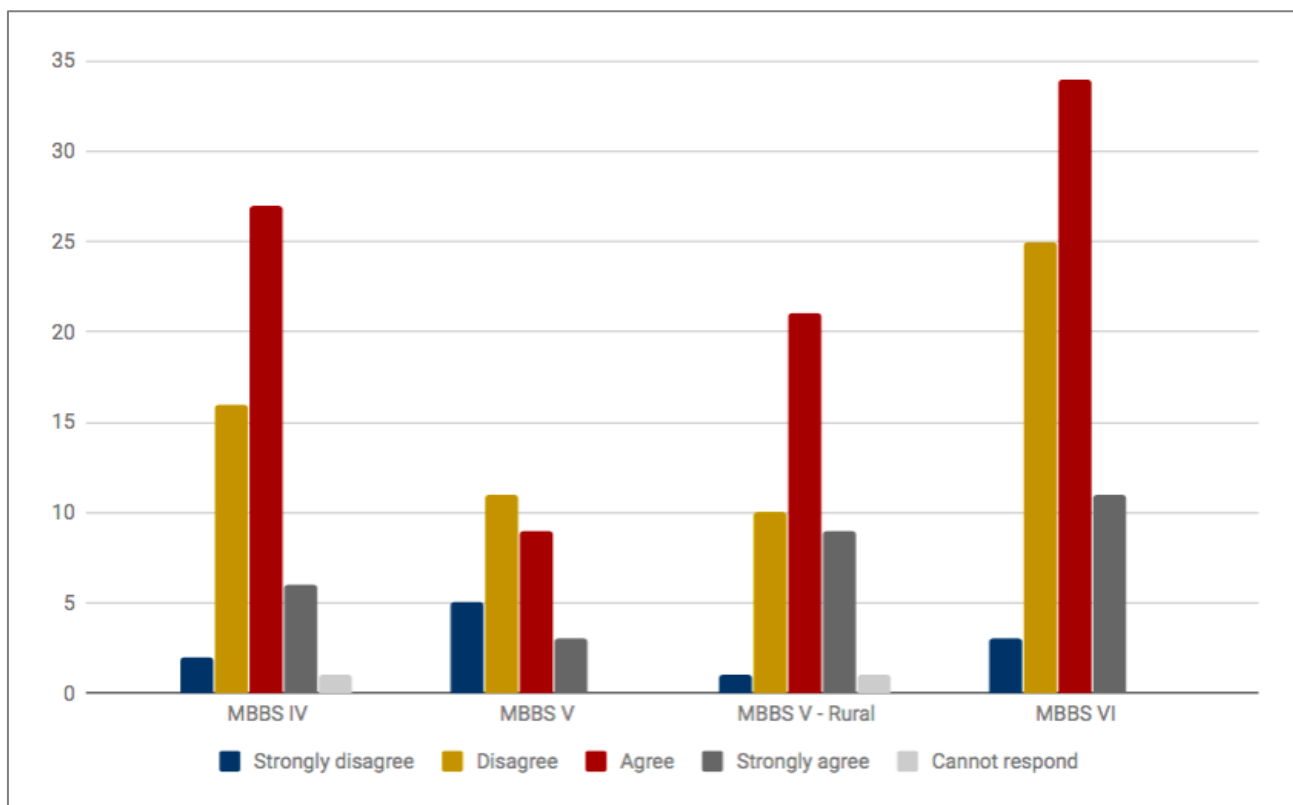
**Figure 2: Preclinical Student opinion of Curriculum: How well informed are Lecturers and Tutors of prior teaching & student knowledge basis**



## Clinical

Clinical students had an overall equivocal response in regards to how well-informed lecturers and tutors were on the scope of their lecture content and where their lecture/tutorial fit in within the greater picture of the medical program (mode [51%] +1 | mean: +0.29 | range: -2 to +2 | n = 192 from 195). The 35 open text responses were congruent with 13 responses indicating a neutral view and 12 responses indicating a negative opinion. The most common negative view was that lecturers are unaware of the level of prior knowledge that students have or what has been covered previously (11 comments). Multiple comments were critical of content being repeated in subsequent sessions (4 comments). Other predominant themes included disparity in the difficulty of content for year level either being too simple or too advanced (3 comments) and lecturers being often tangential rather than focused on specific objectives (3 comments).

**Figure 3: Clinical Student opinion of Curriculum: How well informed are Lecturers and Tutors of prior teaching & student knowledge basis**



## Communication of Curriculum Objectives: To Clinical Supervisors

### Methodology

Students in Years 4-6 were asked to evaluate the efficacy of communication between Faculty and Clinical Supervisors by rating level of agreement with the following statement “Clinical Supervisors and preceptors (e.g. MHU preceptor) are well informed of the learning objectives and required knowledge of students on their rotation.” Answers were obtained via Likert scale from -2 (representing ‘strongly disagree’) to +2 (representing ‘strongly agree’). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

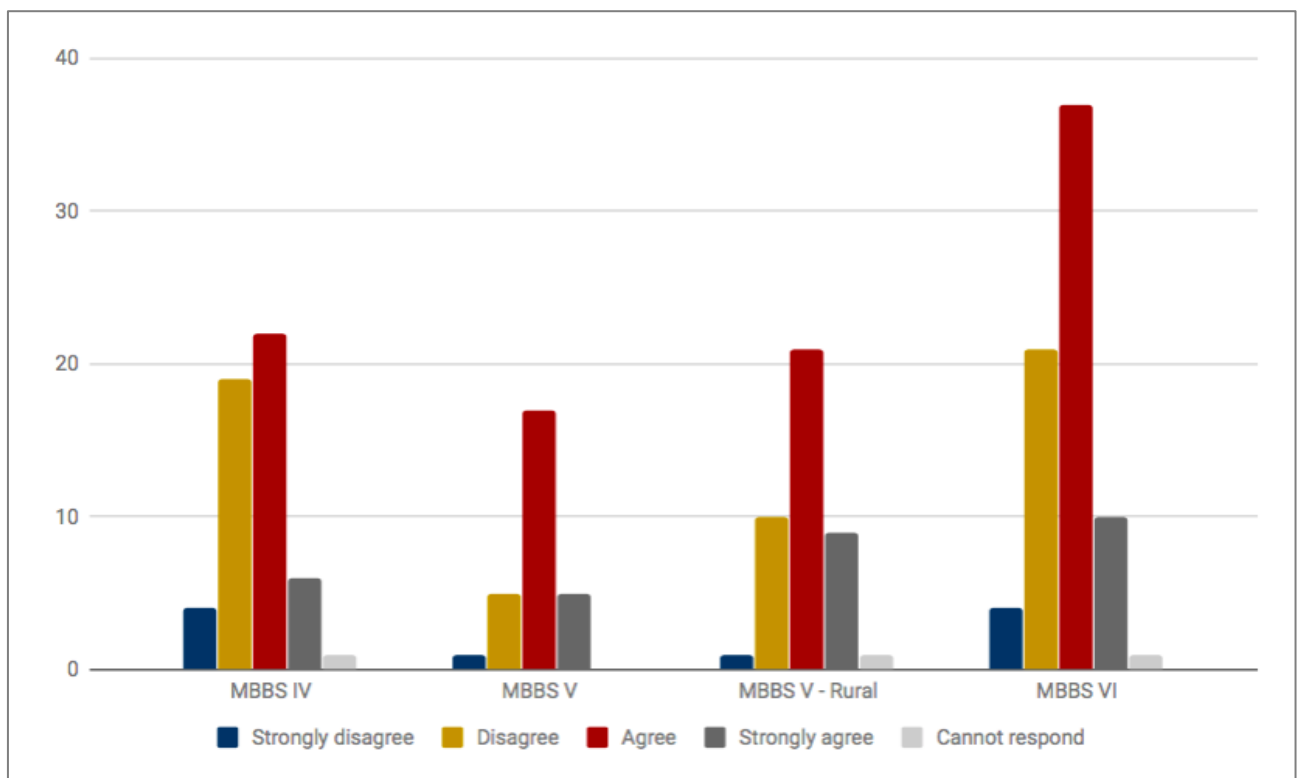
### Results

Students overall agreed that clinical supervisors and preceptors are well-informed regarding student objectives and required baseline knowledge for their rotation (mode: [51%] +1 | mean: +0.43 | range: -2 to +2 | n = 192 from 195). When dividing the responses into their respective year levels, metropolitan and rural-based Year 5 students were positive (mean: +0.71 and +0.66 respectively) while Year 4 and 6 students were equivocal (mean: +0.14 and +0.39 respectively). However, the 47 open-text responses suggested a more negative opinion. The most common view was that supervisor knowledge is

variable (16 comments), others expressing purely a negative view (11 comments) and 4 comments describing good supervisor knowledge, particularly the RAH MHU tutors/preceptors and psychiatry supervisors. Other predominant themes were some supervisors prioritising the content of their speciality without awareness of the broader content required of students on their core rotation (4 comments) and suggestions that supervisors were unlikely to have read/received course objectives from the university (3 comments). One student suggested:

“My experience is that only those supervisors who hold academic organising positions with the uni[versity] seem informed of the learning objectives and required knowledge of students on their rotation.”

**Figure 4: Student opinion of Curriculum: How well informed are Clinical Supervisors of learning objectives - Clinical Students**



## Conclusion of Standard

The communication of curriculum objectives to lecturers, tutors and clinical supervisors overall is variable and thus remains to be an area for improvement. Given students experience teaching from a wide range of clinicians who are otherwise not involved within the Medical Program, it is imperative that communication of specific learning objectives and outcomes are communicated to lecturers and clinical teachers, and if possible, lecturers are given access to objectives of other lectures in order to

streamline lecture delivery and avoid unnecessary content repetition. The work being undertaken by staff to map the curriculum is key to this process.

## Standard 3.5 | Indigenous Health

*'The medical program provides curriculum coverage of Indigenous Health (studies of the history, culture and health of the Indigenous people of Australia or New Zealand'*

### Efficacy of Indigenous Health Teaching

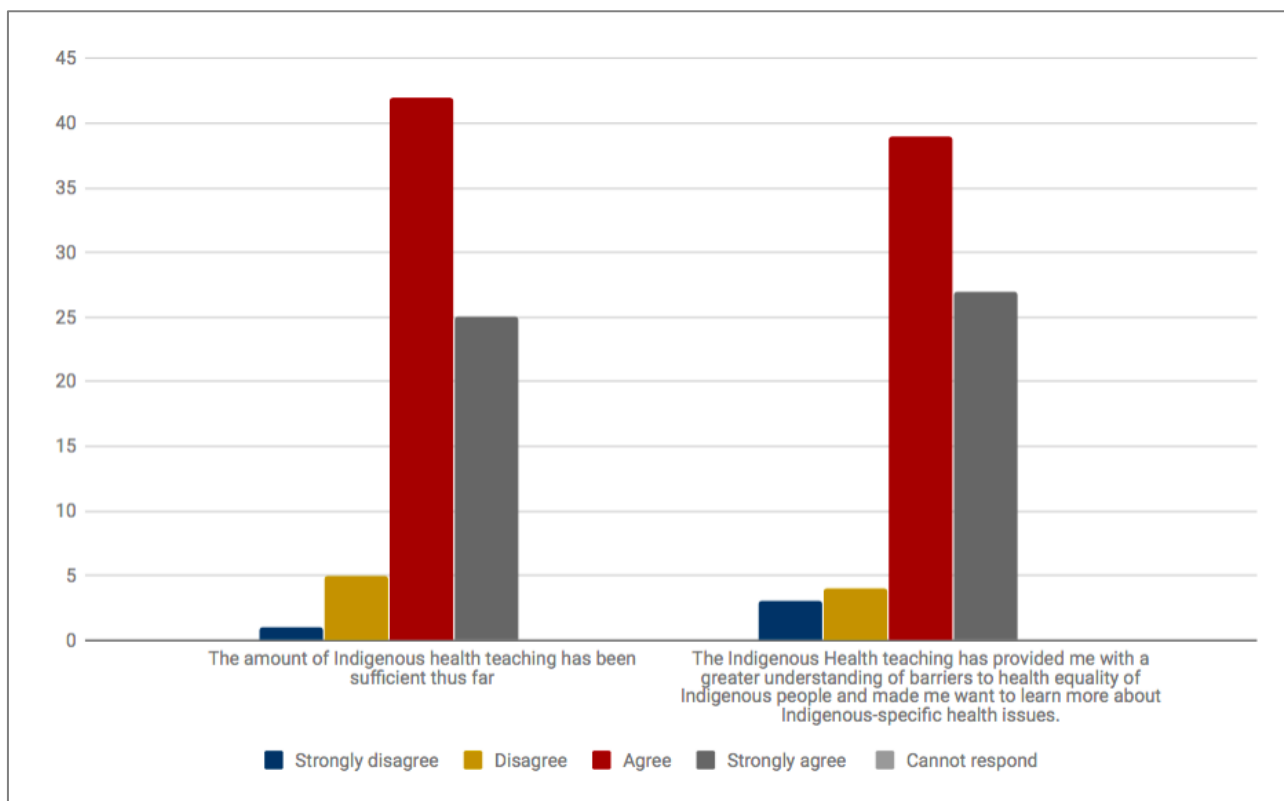
#### Methodology

Students in Year 1 were asked to evaluate the efficacy of the current teaching of Indigenous Health by rating level of agreement based on the following statements: **“The amount of Indigenous health teaching has been sufficient thus far”** and **“The Indigenous Health teaching has provided me with a greater understanding of barriers to health equality of Indigenous people and made me want to learn more about Indigenous-specific health issues”**. Answers were obtained via Likert scale from -2 (representing strongly disagree) to +2 (representing strongly agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

#### Results

Students agree that the current teaching of Indigenous Health has been sufficient thus far (mode [57.53%]: +1 | mean: +1.16 | range: -2 to +2 | n = 73 from 73). Students also agree that current teaching has provided a greater understanding about the barriers of health equality of Indigenous people and encouraged learning about Indigenous-specific health issues (mode [53.42%]: +1 | mean: +1.14 | range: -2 to +2 | n = 73 from 73). However, 6 open text responses were more equivocal, with 3 responses indicating a negative opinion. The most common responses were about including more seamless and thorough integration of content throughout the course (4 comments). Another theme included a lack of clinical focus and practical skills throughout the content (2 comments), and suggested placing a deeper focus on Indigenous Health overall (1 comment).

**Figure 5: Year 1 student opinion on efficacy of Indigenous Health Teaching**



## Conclusion of Standard

Indigenous Health teaching was identified as an area for improvement in the 2017 AMC Student submission. We acknowledge that efforts have only just gotten underway to reinvigorate the teaching in this area across the program and hence, it was decided to defer in-depth evaluation of Indigenous Health teaching and to focus primarily on Year 1 students who are experiencing the new Indigenous Health teaching program with “fresh eyes.” The findings of this submission regarding Indigenous Health are positive and we are optimistic that the program will continue to improve. We encourage staff to continue taking on board student feedback in this process, such as the suggestions raised by students in the results section of this standard.

Additional data regarding Indigenous Health Teaching are outlined under Standard 4.1.

# Standard 4 | Learning and Teaching

## Standard 4.1

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

### Delivery of Course Components

#### Pre-Clinical Disciplines

##### Methodology

Students in preclinical year levels were asked to evaluate the efficacy of various disciplines and areas within the preclinical years of the Medical Program by rating the **quality** and **delivery** of **'Anatomy & Resource'**, **'Professional & Personal Development'**, **'Histology'**, **'Physiology'**, **'Pathology'**, **'Pharmacology'**, **'Clinical Reasoning'**, **'Clinical Skills'**, **'Indigenous Health'**, **'Communication Skills'**, **'Population and Public Health'**, **'Law and Ethics'**, **'Fundamentals of Biomedical Science'** (first years only), **'Medical Microbiology and Immunology'** (second years only) and **'Research Proposal and Critical Appraisal'** (third years only). Answers were obtained via Likert scale from -2 (representing very poor) to +2 (representing very good). No equivocal midpoint was provided to attempt to reduce central tendency bias. A "cannot respond" category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

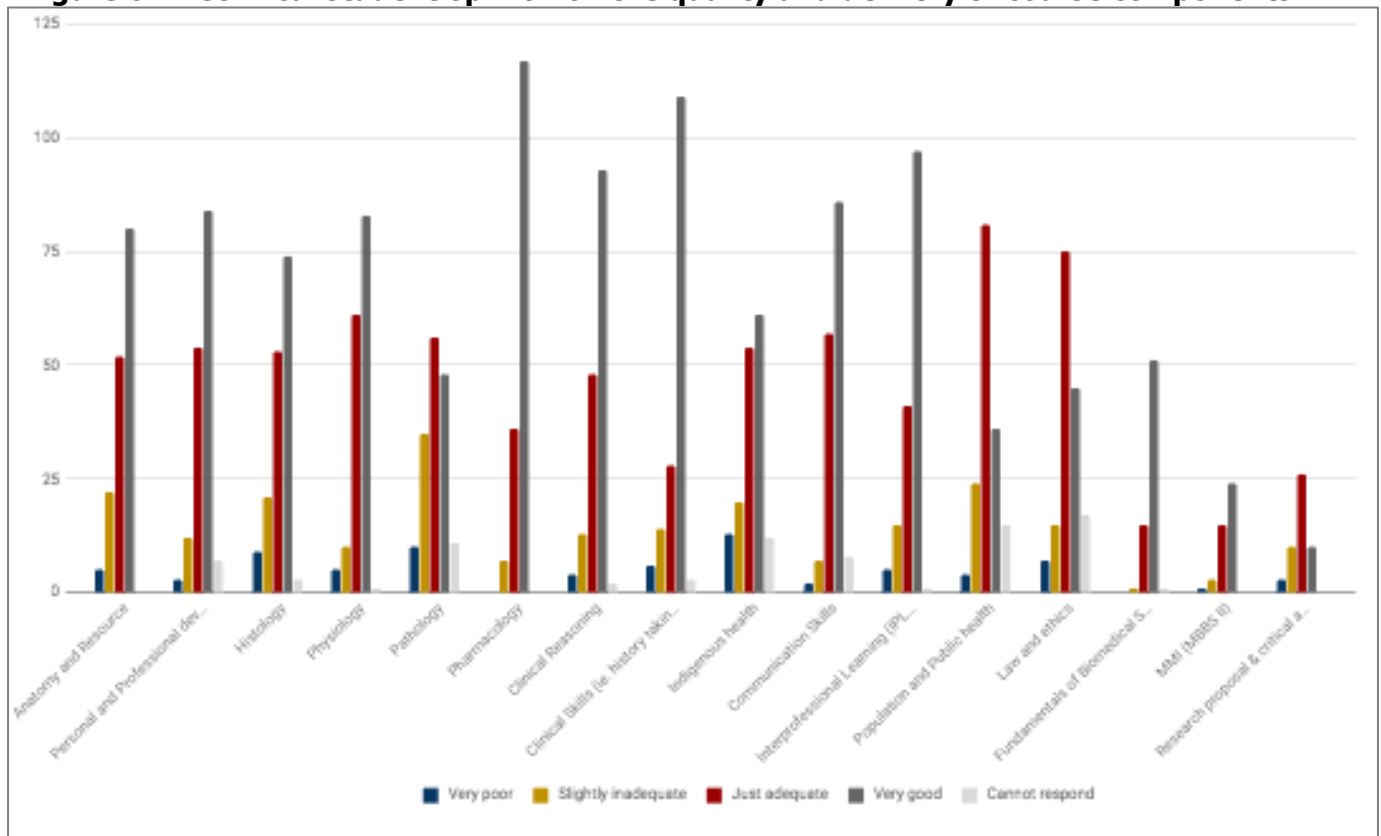
##### Pre-Clinical Discussion

Students agreed that all courses were adequate in quality and delivery. Students were most positive about Communication Skills, Clinical Skills, Clinical Reasoning and Physiology. Students were least positive regarding Pathology, Indigenous Health and Population and Public health. The values for categories pertaining to all preclinical year levels were:

- Anatomy & Resource (mode: [50.3%] +2 | mean: +1.23 | range: -2 to +2 | n = 159 from 159)
- Personal and Professional Development (mode: [54.9%] +2 | mean: +1.33 | range: -2 to +2 | n = 153 from 160)
- Histology (mode: [47.1%] +2 | mean: +1.03 | range: -2 to +2 | n = 157 from 160)

- Physiology (mode: [52.2%] +2 | mean: +1.31 | range: -2 to +2 | n = 159 from 160)
- Pathology (mode: [37.6%] +1 | mean: +0.64 | range: -2 to +2 | n = 149 from 160)
- Pharmacology (mode: [73.1%] +2 | mean: +1.65 | range: -2 to +2 | n = 160 from 160)
- Clinical Reasoning (mode: [58.9%] +2 | mean: +1.35 | range: -2 to +2 | n = 158 from 160)
- Clinical Skills (mode: [69.4%] +2 | mean: +1.39 | range: -2 to +2 | n = 157 from 160)
- Indigenous Health (mode: [41.2%] +2 | mean: +0.80 | range: -2 to +2 | n = 148 from 160)
- Communication Skills (mode: [56.6%] +2 | mean: +1.43 | range: -2 to +2 | n = 152 from 160)
- IPL with Nursing (mode: [61.4%] +2 | mean: +1.33 | range: -2 to +2 | n = 158 from 159)
- Population and Public Health (mode: [55.9%] +1 | mean: +0.82 | range: -2 to +2 | n = 145 from 160)
- Law and Ethics (mode: [52.3%] +1 | mean: +0.94 | range: -2 to +2 | n = 142 from 159)

**Figure 6: Preclinical student opinion on the quality and delivery of course components**

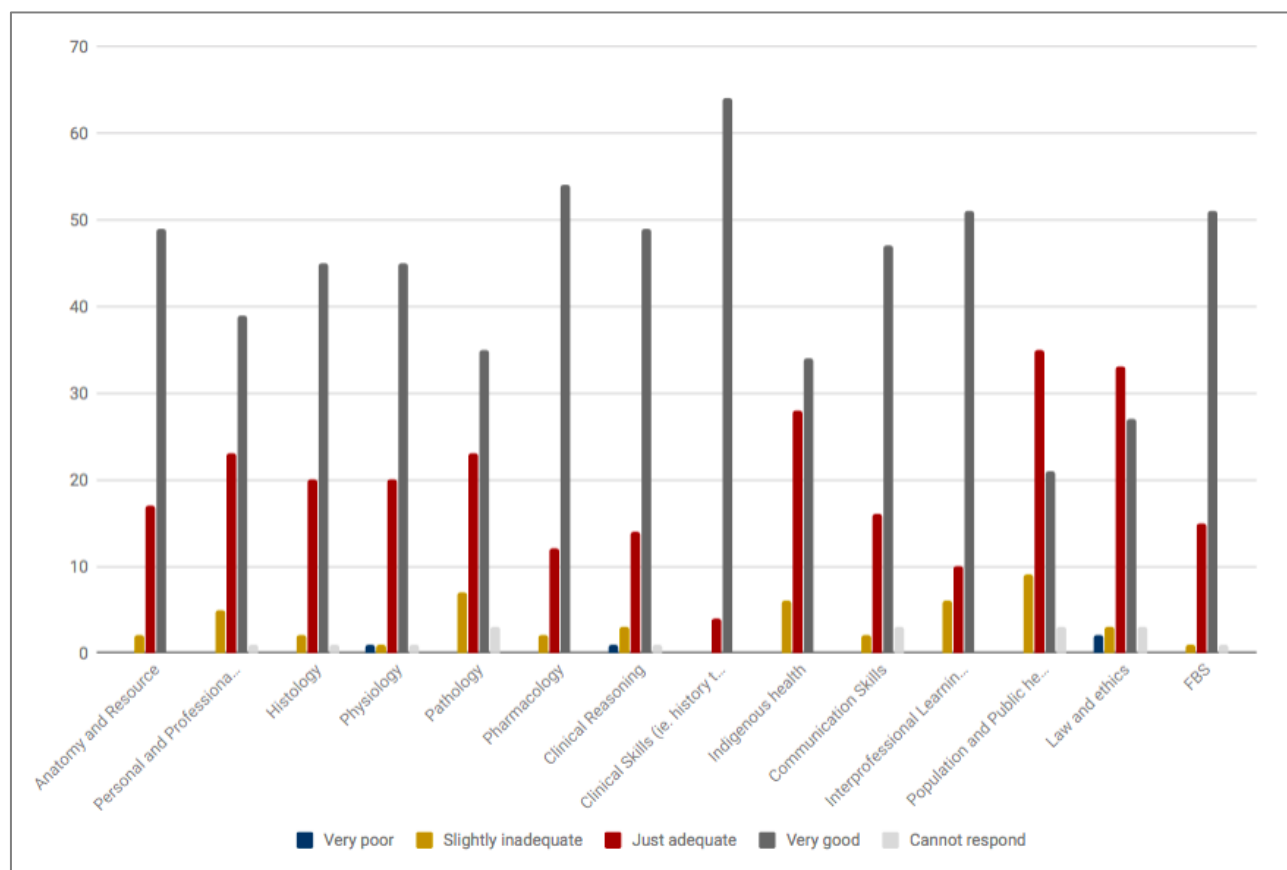


## First Year

Students were generally positive about the quality and delivery of most course components, including 'Anatomy & Resource', 'Professional & Personal Development', 'Histology', 'Physiology', 'Pathology', 'Pharmacology', 'Clinical Reasoning', 'Clinical Skills', 'Indigenous Health', 'IPL with Nursing', 'Communication Skills', 'Population and Public Health', 'Law and Ethics'. Students were also pleased

with the delivery of Fundamentals of Biomedical Science, which is delivered only in the first year of the medical course (mode: [76.1%] +2 | mean: +1.73 | range: -2 to +2 | n = 67 from 68).

**Figure 7: First Year Student Opinion on the quality and delivery of course components**

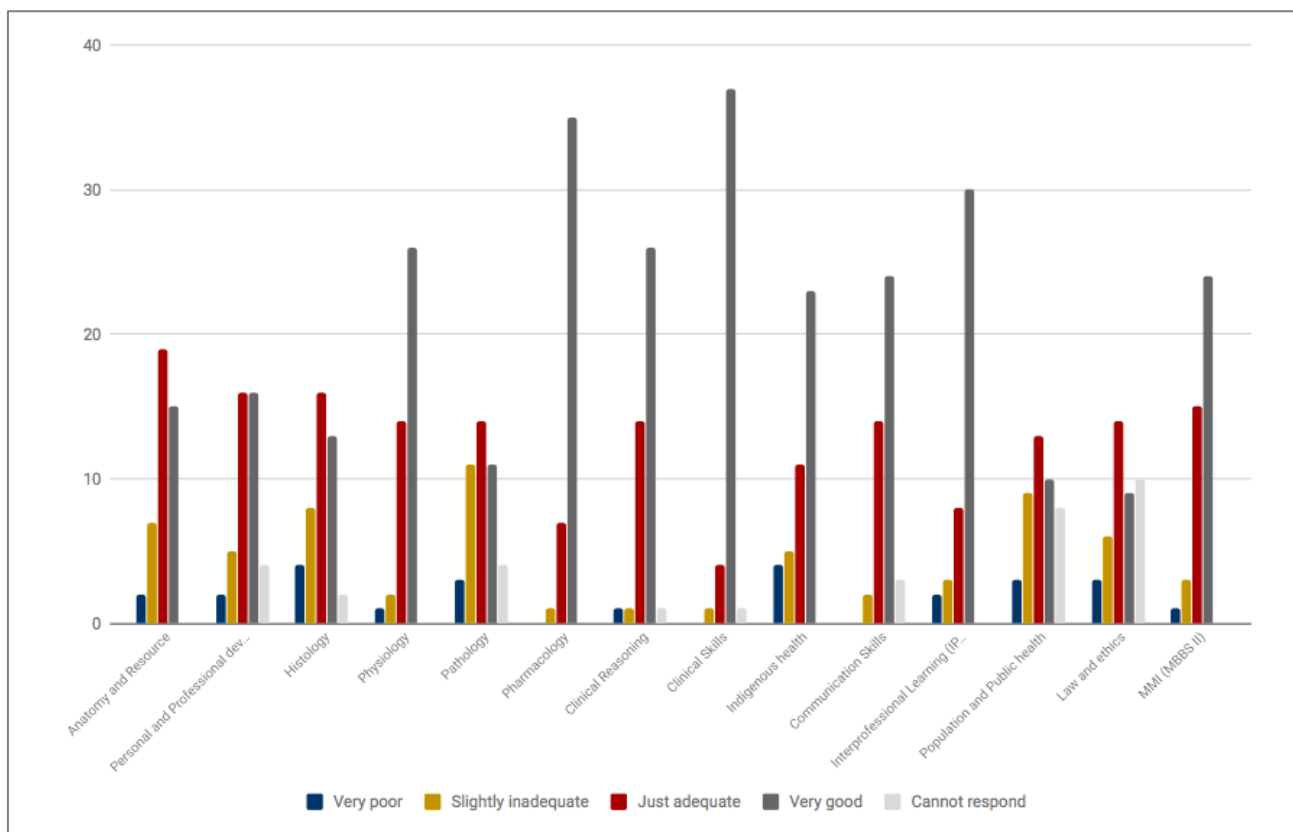


## Second Year

Students were positive about the quality and delivery of most course components, including 'Anatomy & Resource', 'Professional & Personal Development', 'Histology', 'Physiology', 'Pathology', 'Pharmacology', 'Clinical Reasoning', 'Clinical Skills', 'Indigenous Health', 'IPL with Nursing', 'Communication Skills', 'Population and Public Health', 'Law and Ethics'. Students were also pleased with the delivery of Medical Microbiology and Immunology, which is delivered in the first semester of the Year 2 course (mode: [55.8%] +2 | mean: +1.35 | range: -2 to +2 | n = 43 from 43).

Free-text responses highlighted some negative opinions regarding indigenous health delivery, notably 2 comments expressing disengagement and poor integration of Indigenous Health course components.

**Figure 8: Second Year Student Opinion on the quality and delivery of course components**



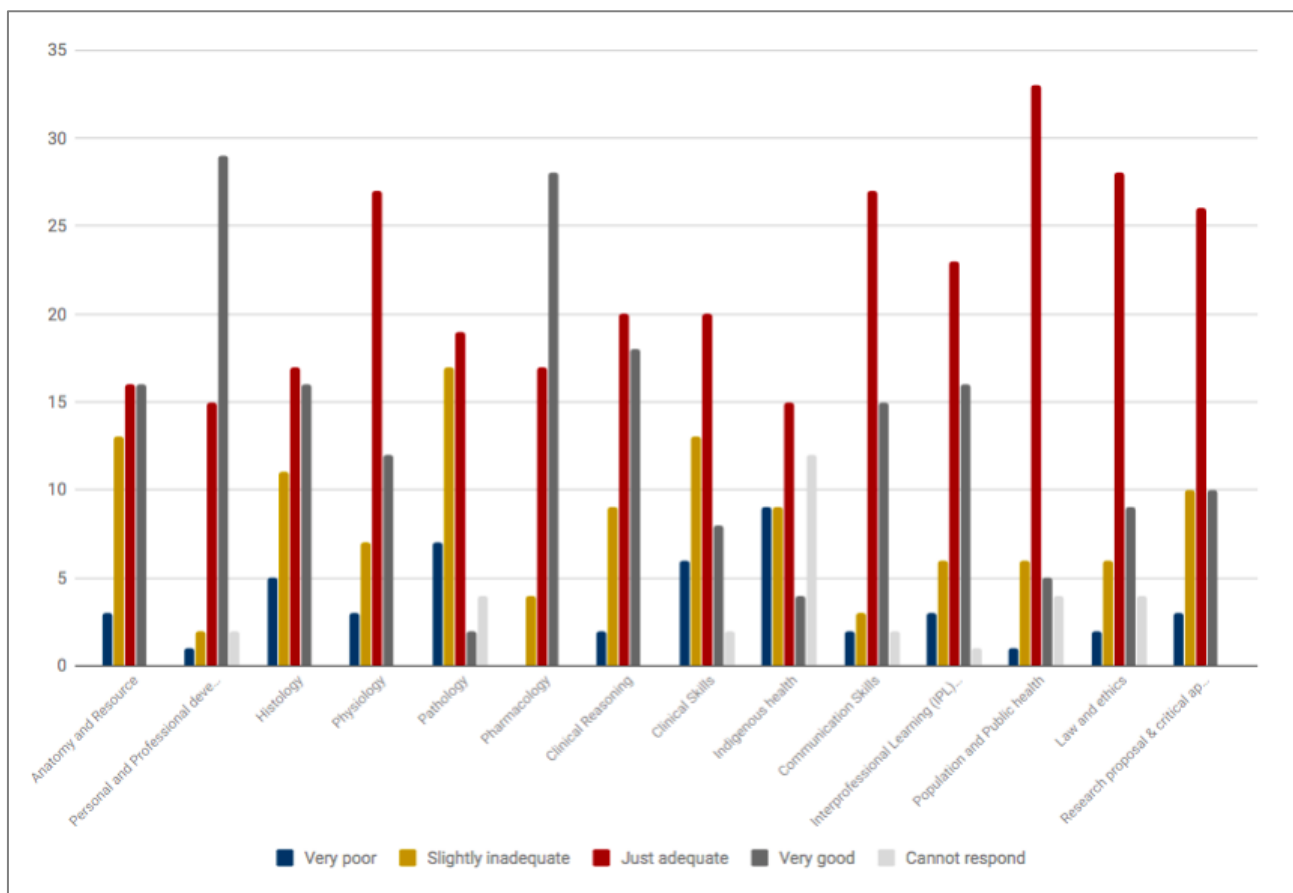
### Third Year

Students were positive about the quality and delivery of most components, including Research Proposal + Critical Appraisal (mode: [53.0%] +1 | mean: +0.61 | range: -2 to +2 | n = 49 from 49). Students were equivocal about Pathology, Clinical Skills and Indigenous health. The values are: Pathology (mode: [42.2%] +1 | mean: -0.18 | range: -2 to +2 | n = 45 from 49), Clinical Skills (mode: [42.5%] +1 | mean: +0.23 | range: -2 to +2 | n = 47 from 49) and Indigenous Health (mode: [40.1%] +1 | mean: -0.11 | range: -2 to +2 | n = 37 from 49).

The 8 free text responses suggested a more negative opinion regarding clinical skills, with students expressing the opinion that the third year clinical skills program is less well-delivered and organized relative to Year 1 and 2 clinical skills (5 comments). One student commented:

“...Students don’t have the opportunity to learn new exams for the OSCEs/practice taking focused histories because the hospital days invariably feature 2.5 hours of lecture content that is often repetitive or irrelevant to the CBL case ... bedside tutorial quality is wholly dependent on the teacher ... “

**Figure 9: Third Year Student Opinion on the quality and delivery of course components**



## Efficacy of Year 3 Clinical Skills Program

### Methodology

Students in Year 3 were asked to evaluate the efficacy of the current Year 3 Clinical Skills Program teaching by rating level of agreement based on the following statements: **“Bedside tutors are well informed of learning objectives/required student knowledge”**, **“Clinical site coordinators are well informed of learning objectives/required student knowledge”**, **“Assessment practices, processes and standards are consistent across all teaching sites”**, **“The Faculty facilitates student feedback on their bedside tutors”** and **“Lectures and Masterclasses are a useful method of teaching”**. Answers were obtained via Likert scale from -2 (representing strongly disagree) to +2 (representing strongly agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field. In a subsequent question, students were asked to answer a multiple choice question to identify the hospital site at which they were based for the Year 3 Clinical Skills Program.

## Responses

Students were equivocal (mode [34.69%] -1 | mean: -0.29 | range: -2 to +2 | n= 49 from 49) about bedside tutors being well informed of learning objectives. They agreed (mode [42.86%] +1 | mean: +0.67 | range: -2 to +2 | n = 49 from 49) that clinical site coordinators were well informed of required knowledge. They disagreed (mode [30.61%] -1 | mean: -0.54 | range: -2 to +2 | n= 49 from 49) that the teaching across all teaching sites was consistent, and also disagreed (mode [43.75%] -1 | mean: -0.55 | range: -2 to +2 | n= 48 from 49) that the Faculty facilitates student feedback on bedside tutors. Students were equivocal (mode [37.50%] +1 | mean: 0.00 | range: -2 to +2 | n= 48 from 49) regarding the usefulness of lectures and masterclasses in the program.

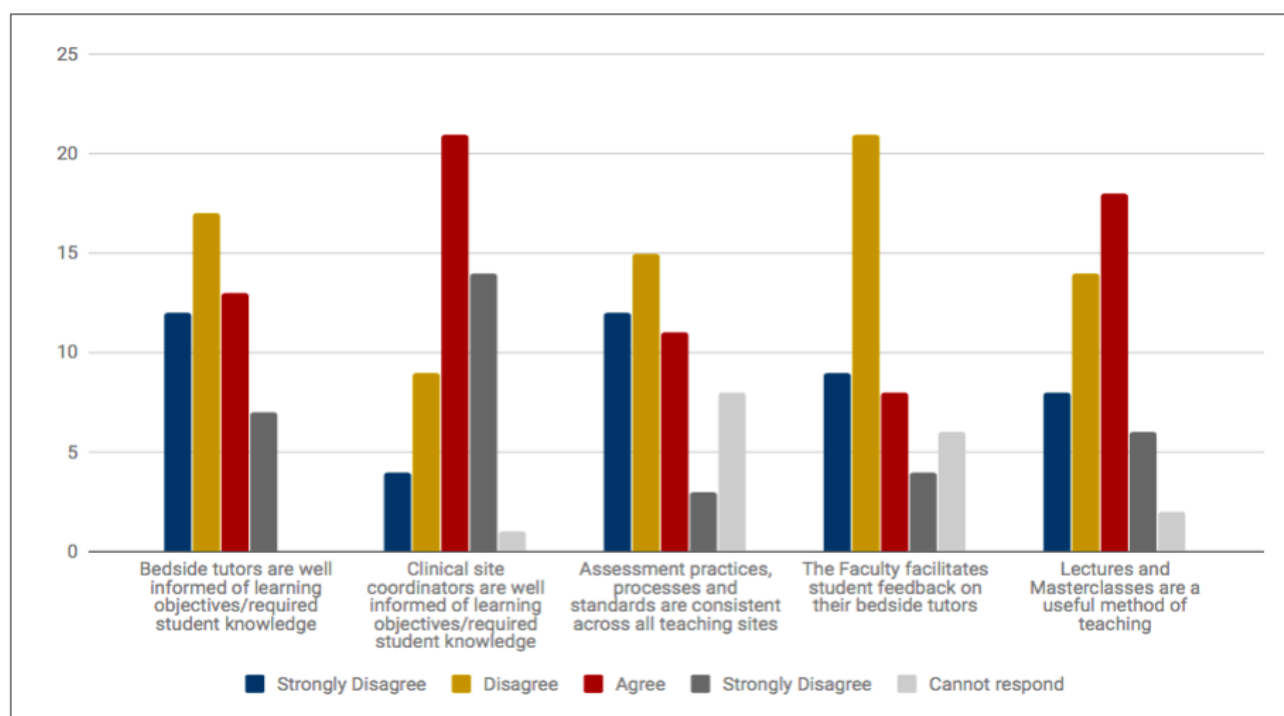
14 open text responses suggested a more negative opinion. A predominant theme surrounded the methods of teaching, in that hours of teaching in rapid succession with no breaks in between being an unfavourable way to maintain student attention as the day progresses (5 comments). Further comments highlighted that bedside tutorials were a more effective means of teaching as the delivery of lectures without context makes it "difficult to recall this information after it has been given" (4 comments). Other themes also highlighted the disparity between teaching and assessment for case write ups across hospital sites (3 comments) and the inability to provide feedback to bedside tutors (3 comments).

A breakdown of the mean responses and number of respondents for each hospital site is provided below:

<u>Question statements</u>	<b>QEH (n = 12)</b>	<b>RAH (n = 17)</b>	<b>LMH (n = 18)</b>
<b>Bedside tutors are well informed of learning objectives/required student knowledge</b>	-0.83	-0.35	+0.33
<b>Clinical site coordinators are well informed of learning objectives/required student knowledge</b>	+1.25	-0.12	+1.00
<b>Assessment practices, processes and standards are consistent across all teaching sites</b>	-0.45	-1.08	+0.07
<b>The Faculty facilitates student feedback on their bedside tutors</b>	-1.00	-0.53	-0.13

Lectures and Masterclasses are a useful method of teaching	+0.42	-0.38	+0.18
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Figure 10: Year 3 Student opinion of current Year 3 Clinical Skills Program



## Pre-Clinical Lecture Notes

### Methodology

Students in Years 1-3 were asked to evaluate the access to lecture notes by rating based on the following statement **“So far this year, on average, I find the access to lecture notes:”** Answers were obtained via Likert scale from -2 (representing very poor) to +2 (representing very good). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

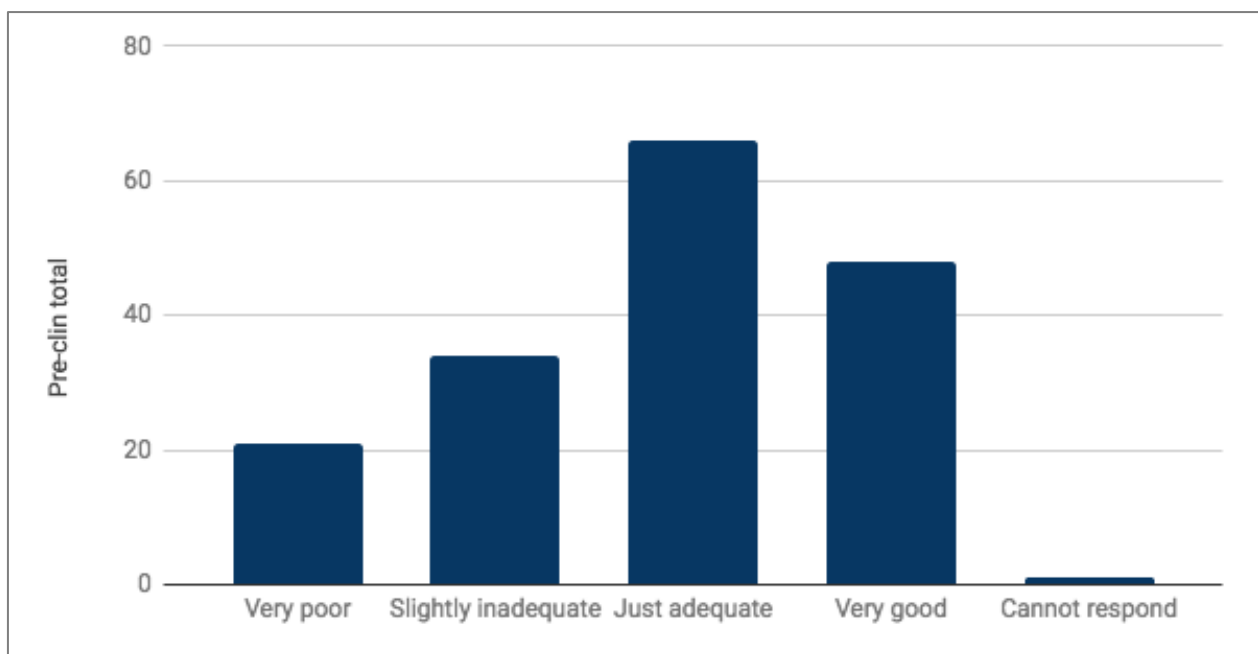
### Results

Students agreed that there was adequate access to lecture notes: (mode: [39.1%] +1 | mean: +0.51 | range: -2 to +2 | n = 169 from 170). However, 34 open text responses suggested a more negative opinion. 7 responses indicated that lecture notes were often uploaded late, while 13 responses suggested that lecture notes were not provided at all. A number of students believed that lecture notes should be

made available before the lecture (15 comments). Several students, especially third years (12 of 14 comments), suggested that access to lecture notes required students to approach the lecturers themselves. One student commented:

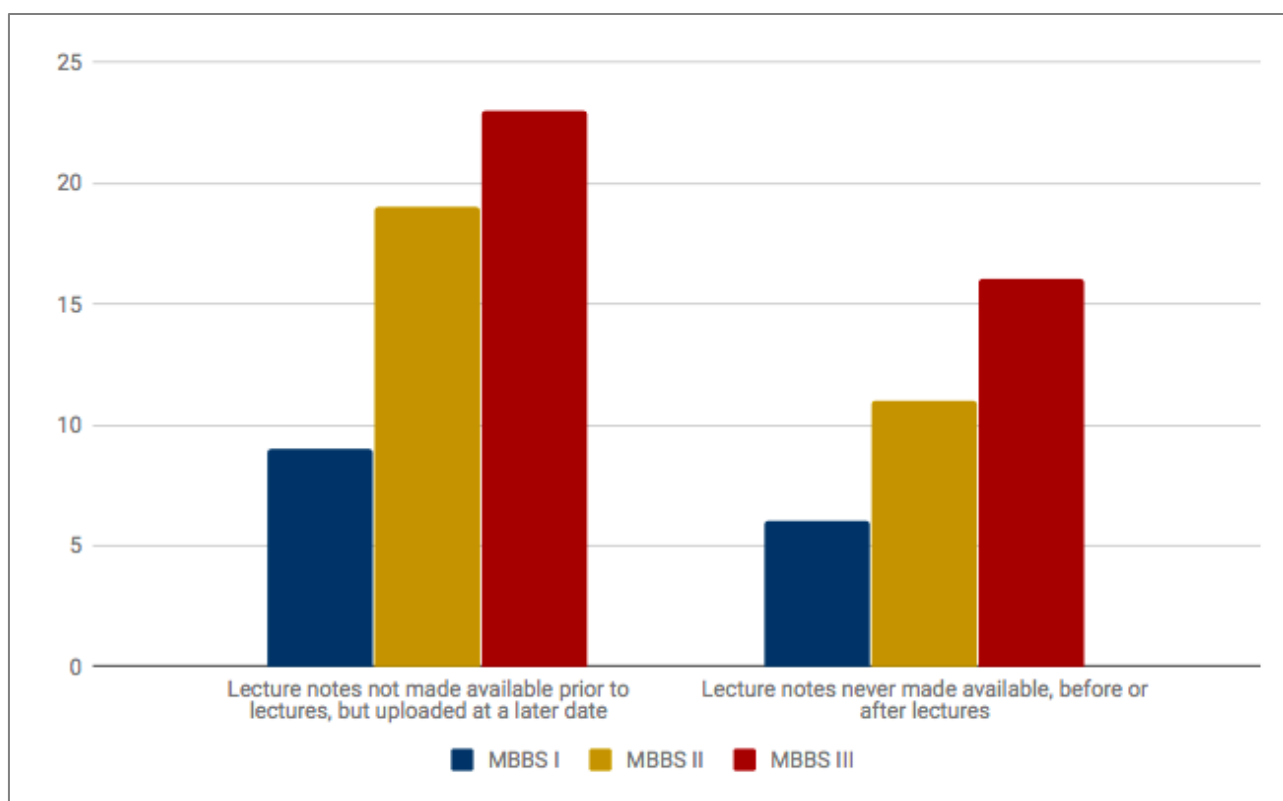
“The only way we get the majority of the lecture notes are through our Ed rep asking the lecturer for them at the beginning of the lecture. It is hard to understand content when you are unable look through it earlier. Occasionally, lecture notes are posted on MyUni prior to the lecture and this has been extremely helpful...”

**Figure 11: Preclinical opinion on access to lecture notes**



If respondents answered inadequate or very poor for the first question, a follow-up question was asked and aimed to identify the exact issue in regards to access to lecture notes. Students were asked whether the reason for their answer in the first question was primarily due to lecture notes not being made available prior to lectures but uploaded at a later date, or that the lecture notes were never made available. Majority of respondents (60.7%, n = 84 from 144) indicated that inadequate lecture note accessibility was primarily due to lecture notes not being made available prior to lectures, but were uploaded at a later date.

Figure 12: Primary reason for answering inadequate or very poor in regards to access to lecture notes



## Pre-clinical Delivery of Lecture Content (Online vs. Face-to-Face)

### Methodology

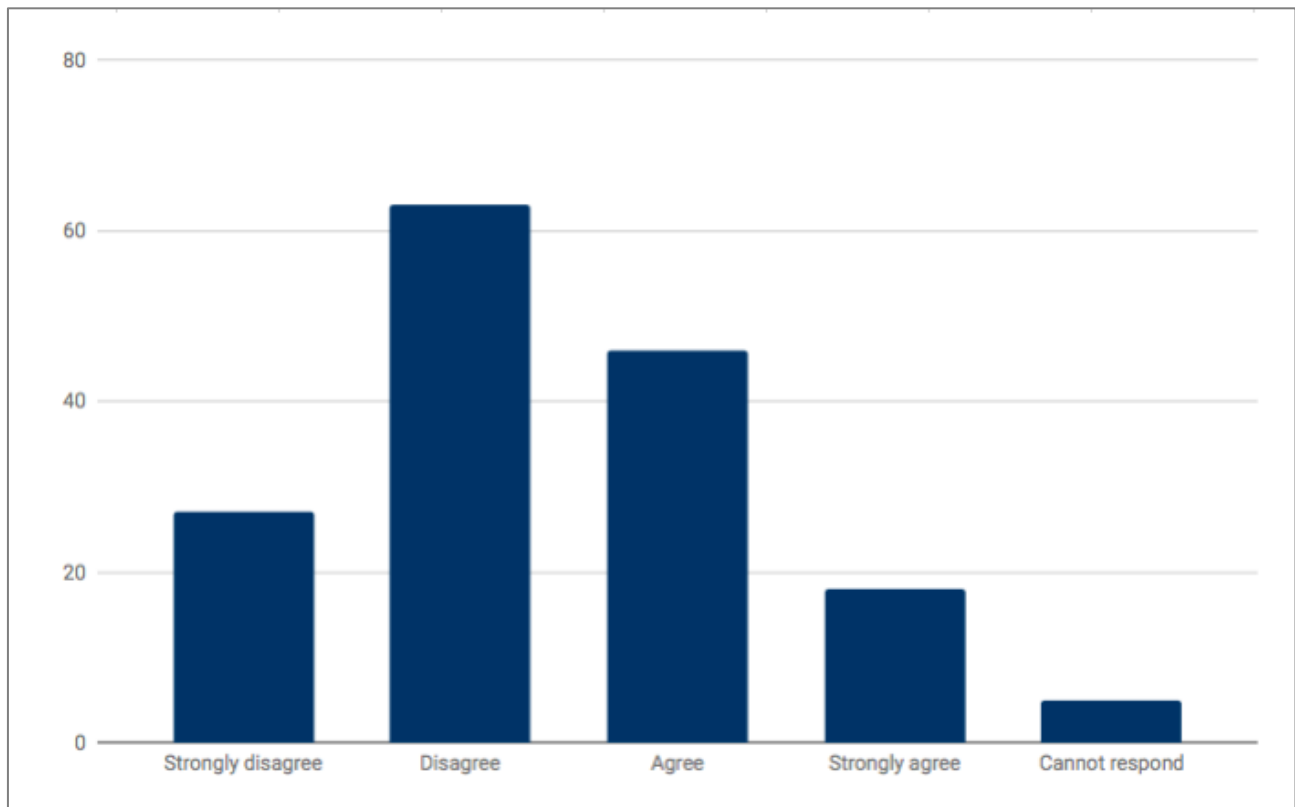
Students in Years 1-3 were asked to evaluate the efficacy of current delivery of lecture content by rating level of agreement based on the following statement **“In 2017, the SBM Lecture Program was altered to move a significant amount of content from 'Face-to-face' to an 'Online-Only' format. This approach suits my learning style and allows me to effectively learn this content”**. Answers were obtained via Likert scale from -2 (representing strongly disagree) to +2 (representing strongly agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

### Results

Students were equivocal as to whether the current format of lecture delivery suited their learning style: (mode: [40.9%] -1 | mean: -0.24 | range: -2 to +2 | n = 154 from 159). Several students conveyed negative opinions regarding the timing and release of online lectures (11 comments), suggesting that many

lectures are released all at once which is overwhelming students (4 comments). 3 responses raised the issue that the online lecture content was outdated, and 4 responses indicated technological errors were hindering learning. While 24 students commented that lecturer teaching methods were unstructured or inadequate, 49 responses mentioned that lecturers were overall effective and had sufficient expertise in their relevant fields.

**Figure 13: Preclinical student opinion that current format of ‘Online-Only’ lecture delivery suits their learning style**



## Preclinical Case-Specific Notes

### Methodology

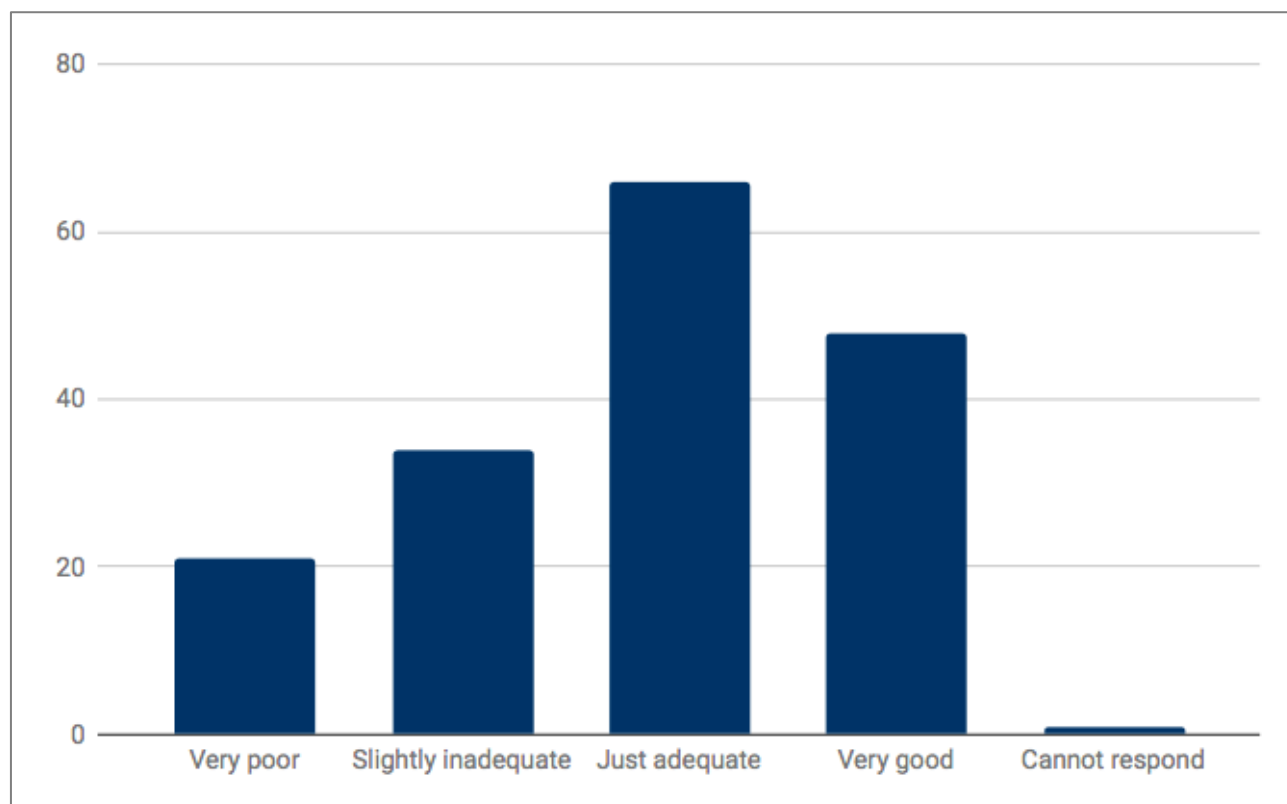
Students in Years 1-3 were asked to rate the accessibility of case-specific notes by completing the statement **“So far this year, on average, I find the access to case-specific notes i.e. anatomy, pathology and histology sheets:”**. Answers were obtained via Likert scale from -2 (representing very poor) to +2 (representing very good). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an

optional open text field.

## Results

Students agreed that the availability of case-specific notes was adequate: (mode: [39.1%] +1 | mean: +0.79 | range: -2 to +2 | n = 156 from 160). However, 16 responses suggested that the timing of release of these notes were too late or inappropriate. A prominent theme, especially among the Year 2 cohort (4 of 9 comments), was that histology teaching was not well received.

**Figure 14: Preclinical Student Opinion on availability of case-specific notes**



## Preclinical Duration of CBL and Case Summary Lectures

### Methodology

In 2018, the duration of CBL sessions was shortened from 2 to 1.5 hours in order for timetabling to permit all CBL sessions to take place in small groups. This change also led to the introduction of SCAP-led Case Wraps. Students in preclinical year levels were asked to evaluate this change based on the following statement: “The duration of CBL sessions this year, in combination with the new SCAP-led Case Wraps, has generally been sufficient for covering the core case objectives.” Answers were obtained via Likert scale from -2 (representing strongly disagree) to +2 (representing strongly

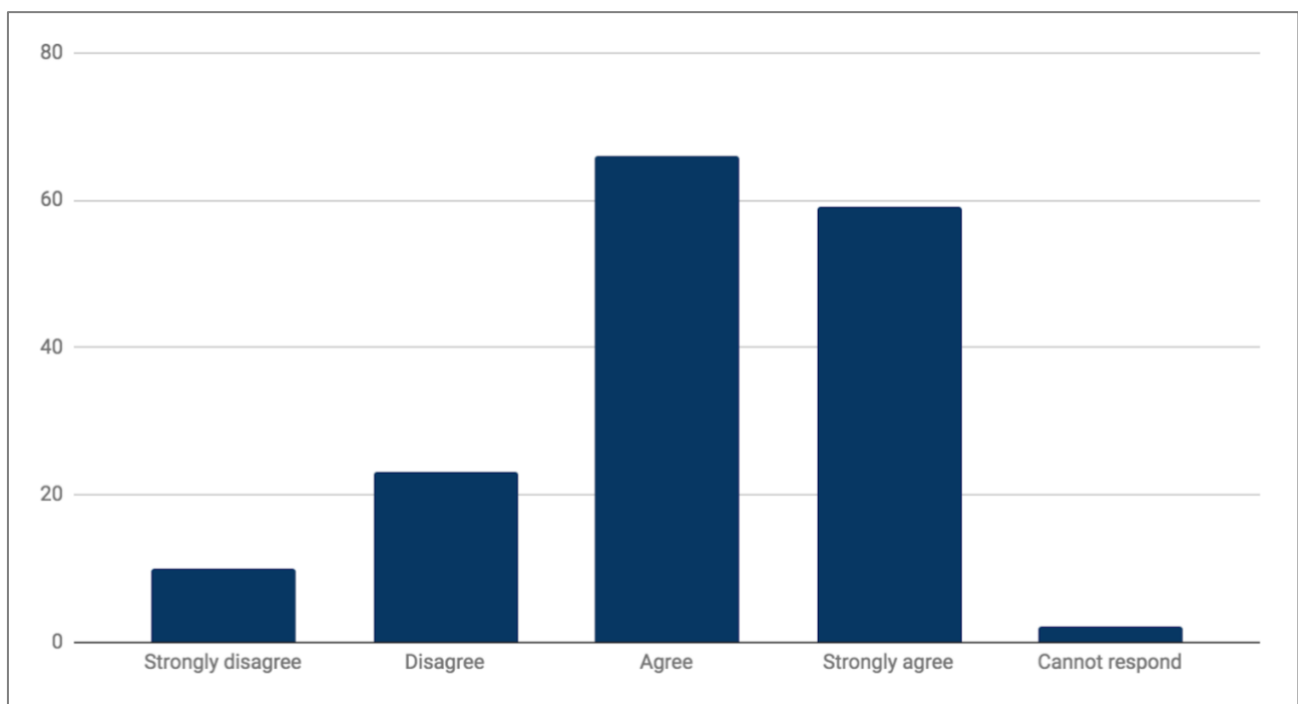
agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

## Results

On average, students agreed that the new format of shorter CBL sessions with the addition of SCAP-led Case Wraps was sufficient for covering the case objectives: (mode: [41.8%] +1 | mean: +0.90 | range: -2 to +2 | n = 158 from 160). The mean response for each year level was as follows: Year 1 (+1.41), Year 2 (+0.42) and Year 3 (+0.61). However, the free text responses expressed a more negative opinion, with 23 comments expressing that CBL duration was not sufficient to cover all objectives of each case. Second year students particularly expressed positive opinions regarding the SCAP-led case wraps, indicating that they are beneficial for learning (7 comments). Amongst third year students, the most common view was that SCAP-led case wraps are often not delivered, which is detrimental to their learning in light of a shorter duration of CBL (6 comments). One student commented:

*“It is difficult to move through the level of content required in a single session given the cut in amount of time provided. This does not have favourable consequences on our learning.”*

**Figure 15: Preclinical student opinion on the changed duration of CBL sessions in combination with SCAP-led case wraps with regards to covering core case objectives.**



# Pre-Clinical Case Based Learning

## Methodology

Students in preclinical year levels were asked to evaluate the **effectiveness of guidance provided in CBL** by rating: **“Formative Assessments”, “Case Objectives”, “SCAP Wraps/Interactive Lectures”, and “Case Conferences”**. Only first and second years were asked to additionally rate **“Tutors in Small Group Sessions”**, while only first years were asked to additionally rate **“Large Group Sessions”**. Answers were obtained via Likert scale from -2 (representing very poor) to +2 (representing very good). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

## Results

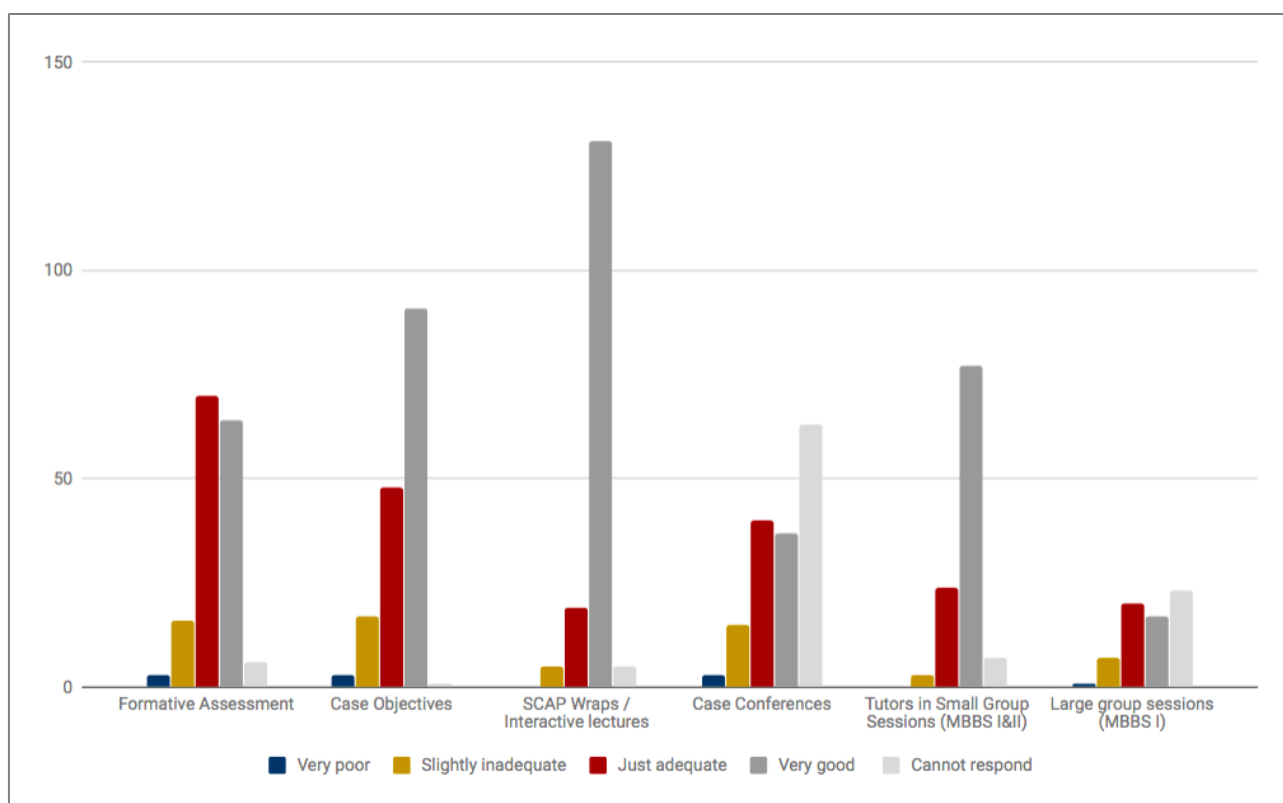
Students rated positively the use of formative assessment for guidance in CBL: (mode: [45.8%] +1 | mean: +1.16 | range: -2 to +2 | n = 153 from 159). Students also agreed that the case objectives were adequate: (mode: [57.2%] +2 | mean: +1.30 | range: -2 to +2 | n = 159 from 160). However, 5 comments did suggest that the case learning objectives were vague or insufficient.

For SCAP Wraps/Interactive lectures, students agreed that their use was effective: (mode: [84.5%] +2 | mean: +1.70 | range: -2 to +2 | n = 155 from 160). Several comments praised the introduction of SCAP Wraps (11 comments), especially third years (9). Students also agreed that case conferences were effective: (mode: [42.1%] +1 | mean: +1.01 | range: -2 to +2 | n = 95 from 158). Regarding the modalities that the Year 1 and 2 cohorts were surveyed regarding specifically, these students agreed that the tutors in small group sessions were effective in guiding CBL: (mode: [74.0%] +2 | mean: +1.68 | range: -2 to +2 | n = 104 from 111). 15 responses agreed with the effective guidance of tutors. One student commented:

*“...I think that some of the best things you can take away from CBL for life as a doctor is from the experiences and knowledge of actual clinicians. There’s more to understanding a case than reading from textbooks and so an experienced tutor can provide that.”*

Responses from first years suggested that large group sessions were also effective: (mode: [44.4%] +1 | mean: +1.00 | range: -2 to +2 | n = 45 from 68).

**Figure 16: Preclinical Student Opinion on effectiveness of guidance provided by CBL resources**



## Clinical Teaching Methods

### Methodology

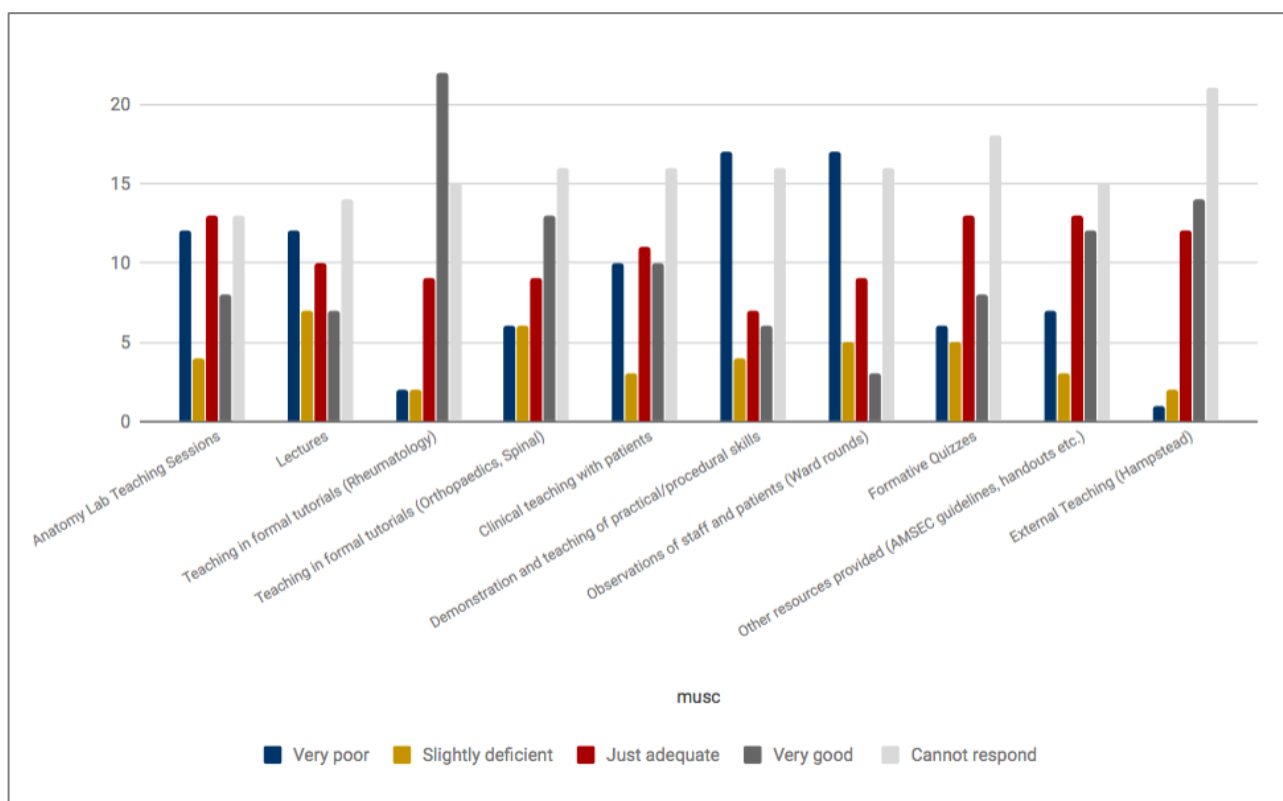
Students in Years 4-6 were asked to rate the quality of the various rotations of the course provided during the Clinical years in assisting learning for the year. Included were: Year 4 Medical Home Unit, Surgical Home Unit, Psychiatry and Musculoskeletal rotations, Year 5 Obstetrics and Gynaecology, Paediatrics, APIC, Geriatrics/GP rotations and Year 6 Medical Internship, Surgical Internship, Emergency Internship, Medical selective, Surgical selective, Psychiatry selective and Primary Care selective rotations. Answers were obtained via Likert scale from -2 (representing ‘very poor’) to +2 (representing ‘very good’). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field. Students in Year 4 were additionally asked to note whether they were based at a particular rural site, or in a metropolitan hospital.

### Year 4 and 5 Core Rotations

Student opinion regarding all the core Year 4-5 course components was positive, excluding the Year 4 Musculoskeletal rotation, where student opinion was overall equivocal, and the experience of students based at Port Augusta for their Year 4 Surgical Home Unit rotation.

Student opinion regarding the Year 4 Musculoskeletal rotation was overall equivocal. Within the musculoskeletal rotation, the teaching provided via tutorials at the Hampstead Rehabilitation Centre (mode: [28%] +2 | mean: +1.24 | range: -2 to +2 | n = 29 from 50) and tutorials on rheumatology (mode: [44%] +2 | mean: +1.34 | range: -2 to +2 | n = 35 from 50) & orthopaedic/spinal medicine (mode: [26%] +2 | mean: +0.50 | range: -2 to +2 | n = 34 from 50) garnered positive opinion. In contrast, the teaching of practical/procedural skills (mode: [34%] -2 | mean: -0.56 | range: -2 to +2 | n = 34 from 50) and opportunity for observation of staff with patients (mode: [34%] -2 | mean: -0.71 | range: -2 to +2 | n = 34 from 50) garnered negative opinion. The lectures & online resources : [24%] -2 | mean: -0.19 | range: -2 to +2 | n = 36 from 50), formative quizzes (mode: [26%] +1 | mean: +0.38 | range: -2 to +2 | n = 32 from 50), the teaching provided in the anatomy labs garnered equivocal opinion this year (mode [26%]: +1 | mean: +0.03 | range: -2 to +2 | n = 37 from 50), despite the latter being reviewed positively in 2017. Of 9 open-text comments, all were negative with the predominant perception being that the rotation is poorly organised (8 comments).

**Figure 17: Year 4 Musculoskeletal Rotation**



In contrast to all other clinical sites for Year 4 Surgical Home Unit, the 4 respondents who completed their rotation at Port Augusta provided equivocal or negative opinion regarding aspects of the course specific to their site. The mean responses of the respondents based at Port Augusta for their Surgical Home Unit rotation and the collated feedback from all respondents are included below.

<b>“In Surgical Home Unit, the quality of each of the following in assisting learning overall this year was:”</b>	<b>All Surgical Home Unit students (n = 41)</b>	<b>Port Augusta students (n = 4)</b>
<b>Teaching in formal tutorials</b>	+0.86	-0.25
<b>Clinical teaching with patients (OPD clinics, theatre)</b>	+1.04	0.00
<b>Demonstration and teaching of practical/procedural skills</b>	+0.67	-0.50
<b>Observations of staff and patients (Ward)</b>	+0.67	-0.75

## **Year 6 Internship Rotations**

Students agreed that the current Emergency Department, Medicine and Surgical Internship rotations assisted in learning overall for this year. All teaching methods were rated positively with the mean response ranging from 0.76 to 1.82. In terms of the qualitative data, multiple students rated their ED Internship rotation highly, noting their appreciation for the independence in seeing patients and supportive staff conducive to learning experience. However, 8 students noted that they believed geriatrics, medical oncology or wards with no interns were inappropriate rotations for year 6 Medicine Internship due to spending a majority of time writing discharge summaries and performing cognitive assessments (geriatrics) and being too sub-specialised (medical oncology) with little opportunity to learn practical skills.

## **Year 6 Selective Rotations**

Students generally agreed that the current Surgery, Medicine, Primary Care and Psychiatry rotations assisted in learning overall for this year. All teaching methods were rated positively except allied health tutorials for psychiatry selective with the mean response for the aforementioned selectives ranging from -0.06 to +1.64. 4 students negatively commented on the “Adelaide Clinic” psychiatry selective citing a lack of consultant presence, limited formal teaching, unrealistic expectations on students, lack of supervision from doctors leading to students feeling the placement is unsafe. 3 students felt that the “Day Surgery” surgical selective provided little opportunity for learning. Another 3 students

commented positively on the primary care selective, particularly regarding rural primary care rotations.

## Year 6 Transition to Internship Program

### Methodology

Students in year 6 were asked to evaluate the efficacy of current Transition to Internship Program teaching by rating level of agreement based on the following statement “In Transition to Internship Program, the quality of each of the following (lectures, prescribing sessions, online prescribing modules, online pre-reading (not including that for prescribing sessions), practical tutorials, simulation sessions) in assisting learning overall for this year was:” Answers were obtained via Likert scale from -2 (representing very poor) to +2 (representing very good). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with or had not yet completed the rotation. At the end of the question, students were asked to explain their answers via an optional open text field.

### Results

Students agreed that the current teaching of the Transition to Internship Program assisted learning overall for this year through lectures (mode [74.63%]: 2 | mean: +1.74 | range: -2 to +2 | n = 65 from 67), prescribing sessions (mode [85.51%]: 2 | mean: +1.82 | range: -2 to +2 | n = 67 from 69), online prescribing modules (mode [73.91%]: 2 | mean: +1.67 | range: -2 to +2 | n = 67 from 69), online pre-reading (not including that for prescribing sessions) (mode [42.65%]: +1 | mean: +0.98 | range: -2 to +2 | n = 60 from 68), practical tutorials (mode [79.41%]: +2 | mean: +1.77 | range: -2 to +2 | n = 65 from 68) and simulation sessions (mode [88.41%]: +2 | mean: +1.91 | range: -2 to +2 | n = 67 from 69). The most common theme (10 comments) in the open text responses highlighted the efficacy of simulation sessions in preparing for internship in a safe and supportive environment. Three students expressed that pre-reading content and expectations are not clearly communicated before each session.

## School of Medicine Teaching Series (SMTS)

### Methodology

Year 4-5 students were asked to rate the effectiveness of the SMTS in helping to cover expected learning objectives. Year 4-5 students were asked to rate the level of agreement based on the following broad statement **“How effective is the School of Medicine Teaching Series (SMTS) in helping you to cover the expected learning objectives so far this year”**. Year 4 students were asked in three subparts: **“Whole group lectures”, “small group lecture/tutorials” and “simulation/physical exam sessions”**

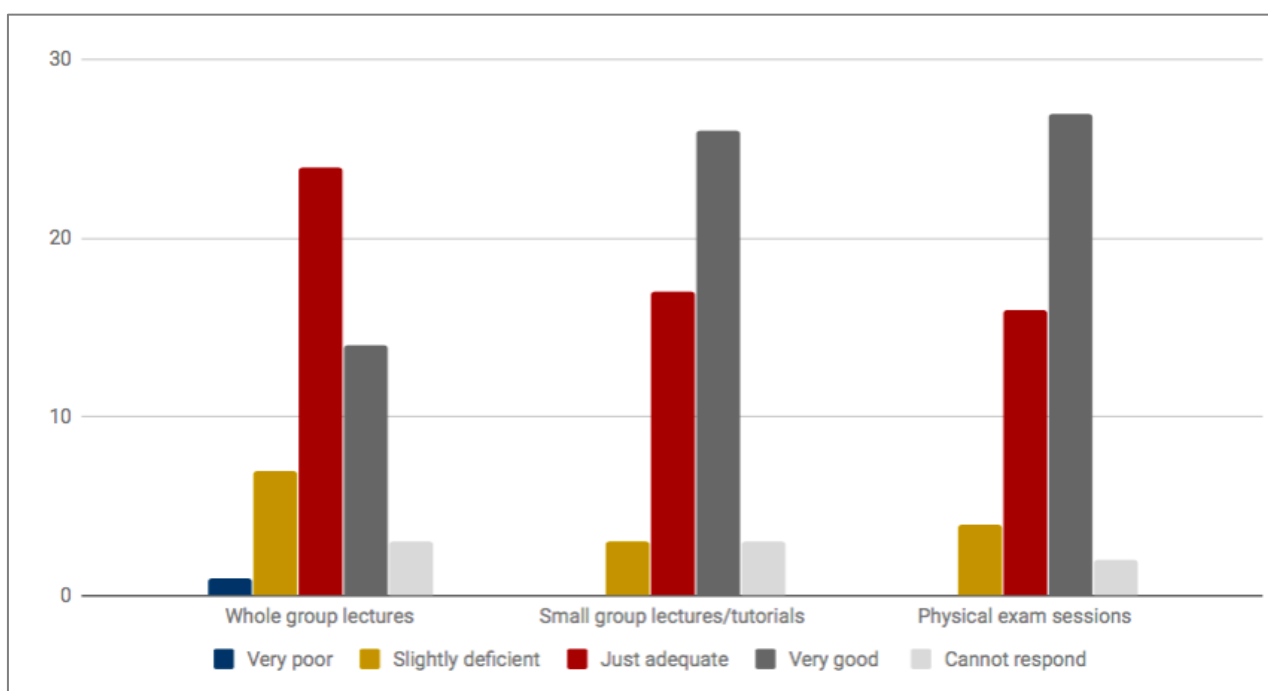


and Year 5 students were asked their level of agreement in two subparts **“Whole group lectures”** and **“small group lecture/tutorials”**. Answers were obtained via Likert scale from -2 (representing ‘very poor’) to +2 (representing ‘very good’). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

## Year 4

Students overall agreed that the SMTS was effective at covering the learning objectives through whole group lectures (mode: [48.98%] +1 | mean: +0.93 | range: -2 to +2 | n = 46 from 49), small group lectures/tutorials (mode: [53.06%] +2 | mean: +1.43 | range: -2 to +2 | n = 46 from 49) and simulation/physical exam sessions (mode: [55.10%] +2 | mean: +1.40 | range: -2 to +2 | n = 47 from 49). 6 open text responses were more equivocal. The predominant theme surrounded the timing and irregularity of the teaching sessions (3 comments), in that a lot of the sessions focus on practical skills useful for the surgical home unit OSCE, but many students had already undertaken their OSCEs due to the sessions being scheduled for the second half of the semester. Other themes included the simulations sessions being an excellent method of teaching (1 comment), the delivery of interesting lectures without context making them seemingly irrelevant (1 comment), a lack of practical skill application for rural students (1 comment) and the lack of notes provided from sessions (1 comment).

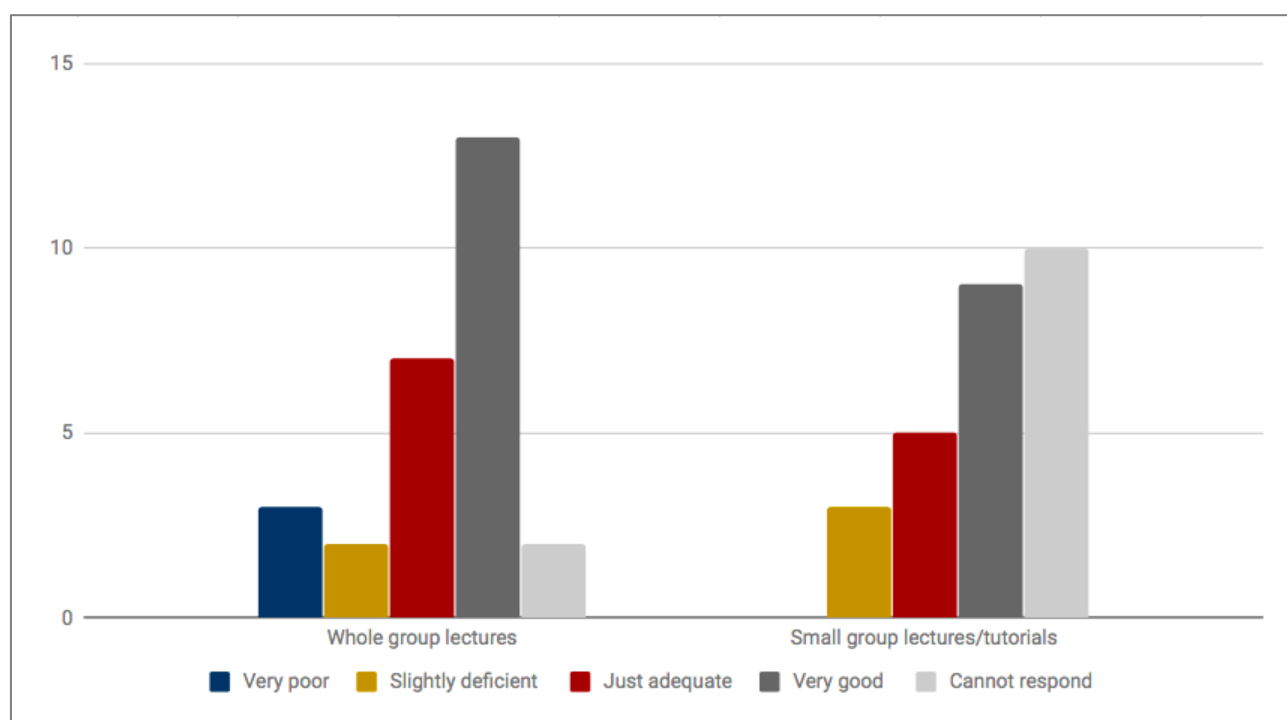
Figure 18: Year 4 student opinion of SMTS



## Year 5

Students overall agreed that the SMTS was effective at covering the learning objectives through whole group lectures (mode: [48.15%] +2 | mean: +1.00 | range: -2 to +2 | n = 25 from 27) and small group lectures/tutorials (mode: [33.33%] +2 | mean: +1.18 | range: -2 to +2 | n = 17 from 27). 4 open text responses were more equivocal. The predominant theme was that despite the teaching being mostly excellent (3 comments), it is often too specialised (1 comment) and the quality ranging from poor to excellent with “inter-lecturer variability” (1 comment). Other themes indicated that despite positive teaching, the format of having many lectures in a day without breaks leads to poor retention of knowledge and suggested having SMTS “more frequently but less dense” (1 comment).

Figure 19: Year 5 student opinion of SMTS



## Conclusion of the Standard

Pre-clinical students are generally pleased with the quality of delivery of all course components, though less so regarding Pathology, Indigenous Health, Population and Public Health and Year 3 Clinical Skills. Key issues from the 2017 AMC student submission have been addressed relating to the CBL and are being addressed related to lecture delivery, via the staff-student Year 1-3 lecture review. It is noteworthy that feedback regarding the aspects of CBL surveyed, particularly the new SCAP-led case wraps, is very positive. This submission does encourage the implementation of measures to ensure

SCAP-led case wraps take place even in the context of limitations such as low numbers of Medical Education Selective students for a particular rotation. Measures already underway to enhance lecture not availability, with increased communication with lecturers in the lead-up to lecture delivery, are also encouraged by this submission.

In the Clinical Years, students surveyed were generally pleased with the quality and delivery of all clinical lecture series (SMTS and TTIP) and core rotations, with the exception of the Year 4 Musculoskeletal Medicine rotation. Communication with student representatives is encouraged in mitigating the issues identified regarding the Musculoskeletal Medicine rotation and some Year 6 rotations mentioned in the relevant results summary.

## Standard 4.3

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

### Efficacy of Core Skills Teaching

#### Methodology

Students in all year levels were asked to evaluate the teaching of core skills that could be applied to the clinical setting by rating their level of agreement with the following statement: **“To what extent do you feel the medical program has equipped you with basic core skills that can be applied in a clinical setting?.”** The skills were divided into **“Clinical Skills (eg. physical exam, history taking),”** **“Communication & Professionalism,”** **“Procedural skills (eg. venepuncture, cannulation, advanced life support),”** and **“Management Plans and Prescribing.”** Year 1 and 2 students were only asked to evaluate “clinical skills” and “communication & professionalism.” by rating their level of agreement based on the following statement. Answers were obtained via Likert scale from -2 (representing ‘strongly disagree’) to +2 (representing ‘strongly agree’). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

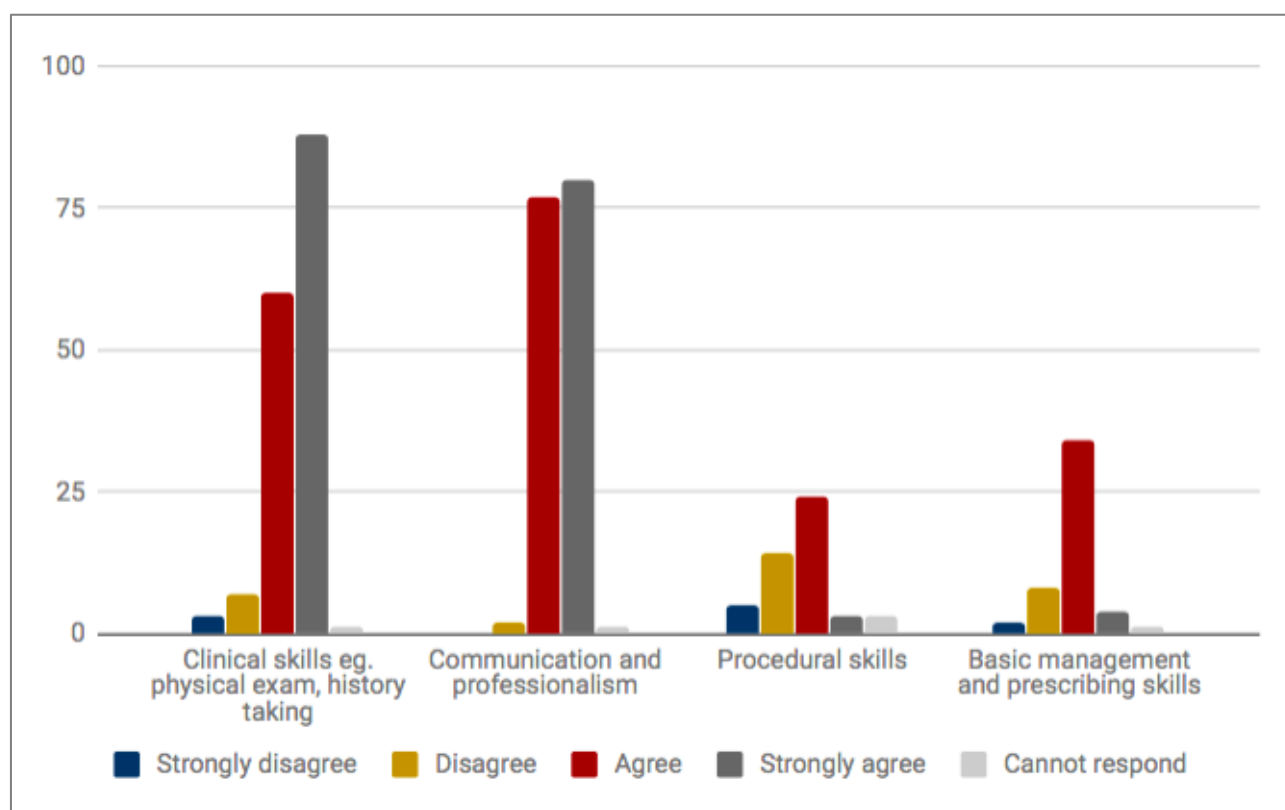
#### Preclinical

With regard to clinical skills the majority of students in Years 1-3 strongly agreed with the above statement (mode [55%] +2 | mean: +1.38 | range: -2 to +2 | n = 158 from 159). For communication and professionalism students also agreed (mode [50%] +2 | mean: +1.46 | range: -2 to +2 | n = 159 from 160). Sections on Management and Prescribing, and Procedural Skills were only asked to 3rd year students. For management and prescribing students agreed with the statement (mode [69%] +1 | mean: +0.63 | range: -2 to +2 | n = 48 from 49). For procedural skills students were more equivocal (mode [49%] +1 | mean: +0.13 | range: -2 to +2 | n = 46 from 49).

A total of 14 comments were received for specific comments on these areas. 6 open text comments from 1st and 2nd students suggested that the clinical skills program is great at reinforcing essential history and exam taking skills. Comments from Year 3 students suggested they would like more opportunities to practice venepuncture and cannulation (7 comments) and more practice managing and

prescribing for patients (4).

Figure 20: Preclinical Student opinion of current teaching in of core skills



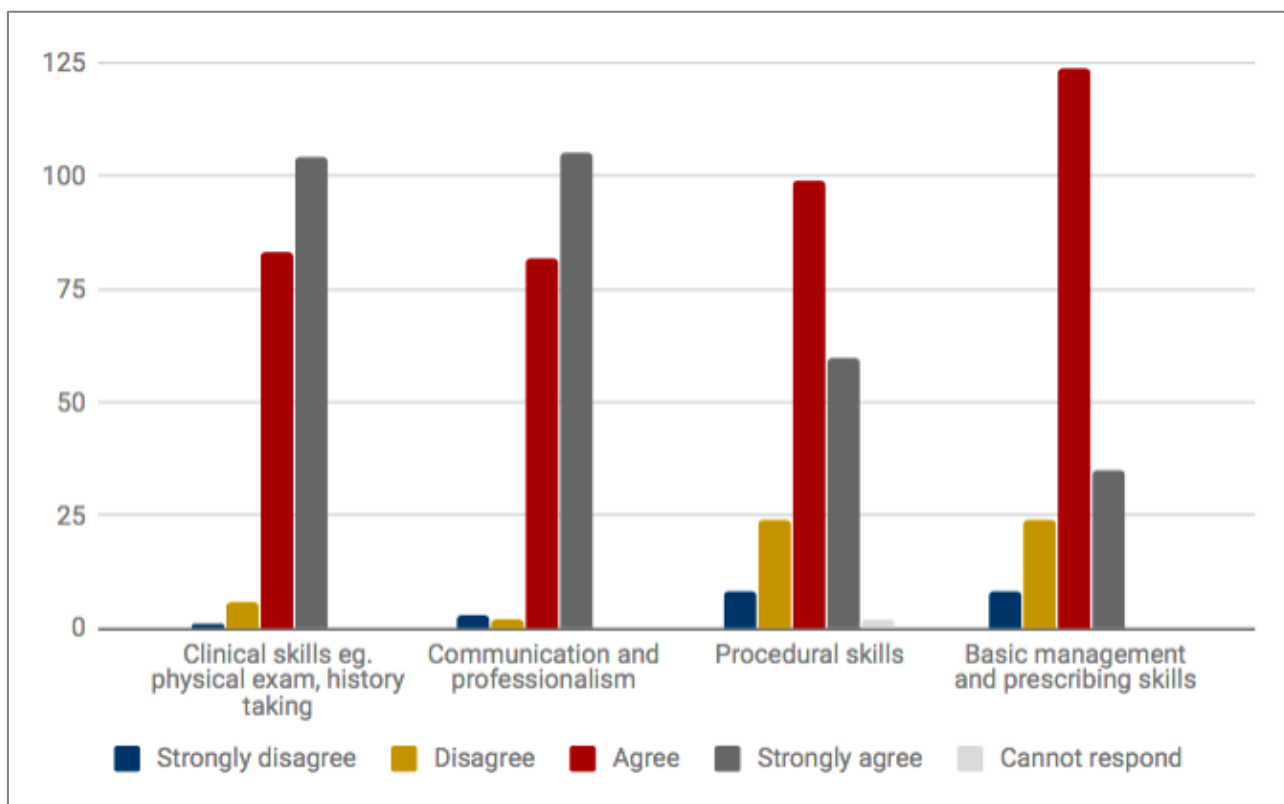
## Clinical

With regard to clinical skills the majority of students in clinical years strongly agreed with the above statement (mode [54%] +2 | mean: +1.44 | range -2 to +2 | n = 194 from 194). For communication and professionalism, students also strongly agreed with the above statement (mode [55%] +2 | mean: +1.45 | range -2 to +2 | n = 192 from 192). Students agreed with the statement to a lesser degree for Procedural skills (mode [52%] +1 | mean: +0.91 | range -2 to +2 | n = 191 from 193) and Management and Prescribing (mode [65%] +1 | mean: +0.78 | range -2 to +2 | n = 191 from 191).

A total of 34 comments in an open text field provided more specific feedback on particular areas. The most prominent themes were request from greater exposure to formal teaching of procedural skills (14 comments) with multiple comments noting lack of direct teaching or supervision for these skills on the wards. A large number of students felt there was not enough teaching with regard to management plans and prescribing (8 comments). Other common themes included praise for preclinical teaching of clinical skills (6 comments) but criticism of lack of standardisation of in-hospital teaching after Year 3 (4 comment) and that this learning is too self-driven (3 comments). Students spoke highly of simulation

teaching, particularly teaching of ALS and BLS (5 comments).

Figure 21: Clinical Student opinion of current teaching of core skills



## Preparedness for Internship

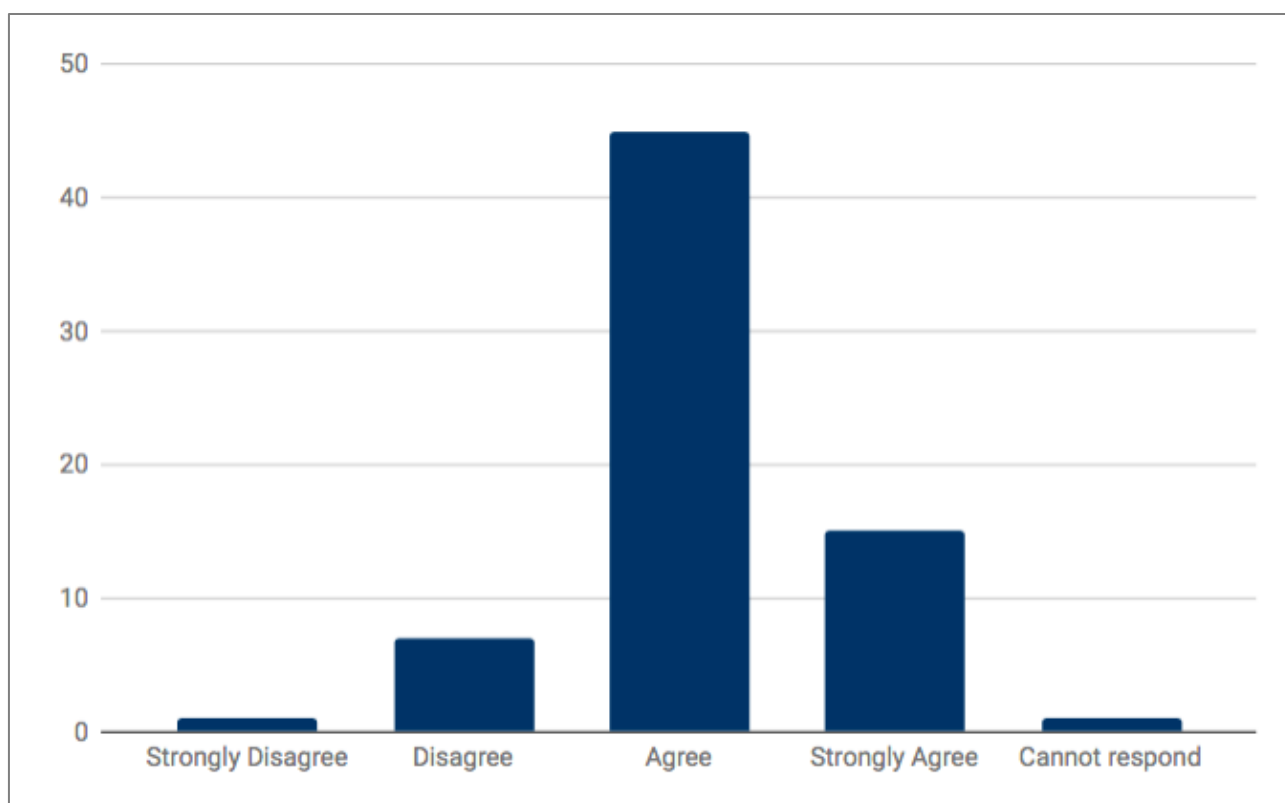
### Methodology

Students in year 6 were asked to evaluate the statement; “approaching now the end of my medical schooling, I would consider myself prepared for medical internship.” Answers were obtained via Likert scale from -2 (strongly disagree) to +2 (strongly agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

### Results

Students generally agreed that they considered themselves prepared for medical internship, approaching the end of medical schooling (mode [65.22%] +1 | mean: +0.97 | range: -2 to +2 | n = 68 from 69). There were 8 comments lacking in predominant themes. 1 student noted a common anecdotal complaint, which is that they feel unprepared for internship at the RAH as they had not had a rotation at the nRAH whilst other students have completed multiple rotations there.

Figure 22: 6<sup>th</sup>-year student opinion regarding their preparedness for internship



## Conclusion of Standard

The feedback contained in this standard identifies highlights of the program, being the quality of preparation provided for Internship and teaching of core skills for clinical practice. The current teaching sessions provided on procedural skills are rated highly and feedback from clinical students requesting more formal teaching of procedural skills has already been, at least, partially incorporated into the program.

# Standard 4.7 | Interprofessional Learning

*'Students very much value the Interprofessional Learning opportunities within the new Adelaide Health and Medical Sciences (AHMS) building'*

## Interprofessional Learning in the MBBS Program

### Efficacy of Interprofessional Learning Teaching

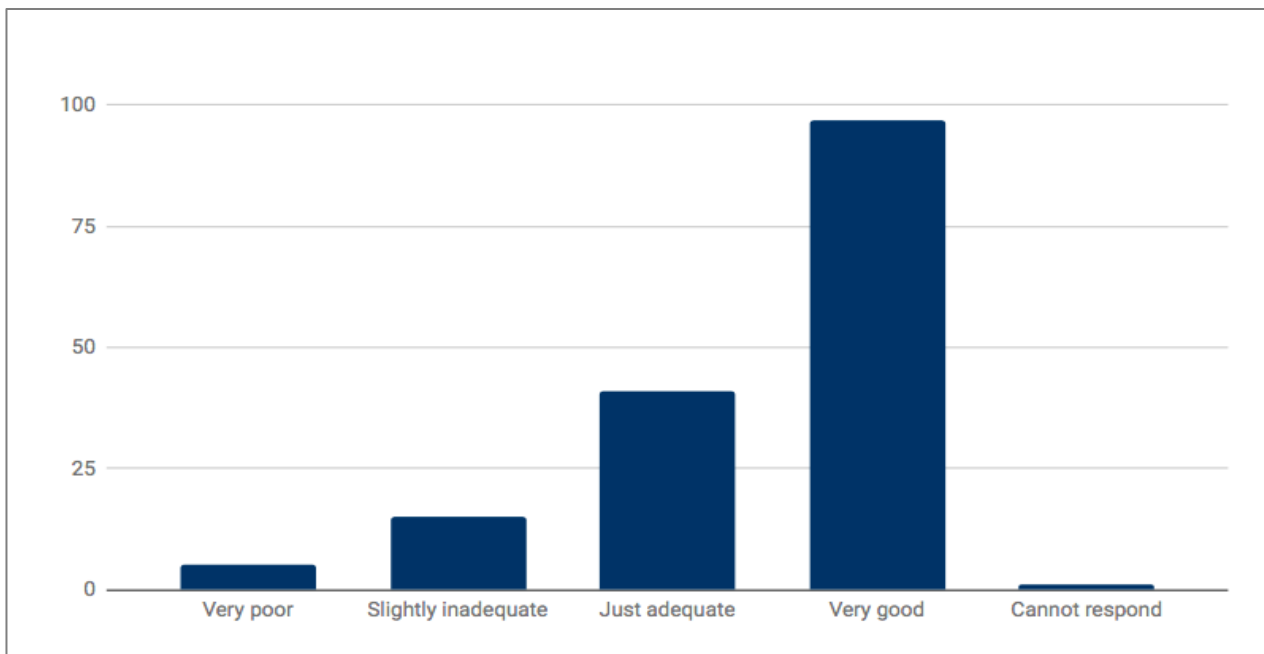
#### Methodology

Within a broader question on the quality of a range of different course components, students in years 1 to 4 were asked to evaluate the efficacy of current Interprofessional Learning teaching. Preclinical students were asked to rate the level of agreement based on the following statement **"For the year level that you undertook in 2018, please comment on the quality and delivery of [Interprofessional Learning (IPL) with nursing]"**, whereas 4<sup>th</sup>-Year students were asked to rate the level of agreement based on the statement **"In Medical Home Unit, the quality of [IPL Pharmacology Tutorials] in assisting learning overall for this year was..."**. Answers were obtained via Likert scale from -2 (representing very poor) to +2 (representing very good). No equivocal midpoint was provided to attempt to reduce central tendency bias. A "cannot respond" category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

#### Preclinical

Students responded positively regarding the quality and delivery of IPL (mode: [61.4%] +2 | mean: +1.33 | range: -2 to +2 | n = 158 from 159). There were no comments relating to IPL in the open responses section of the survey question.

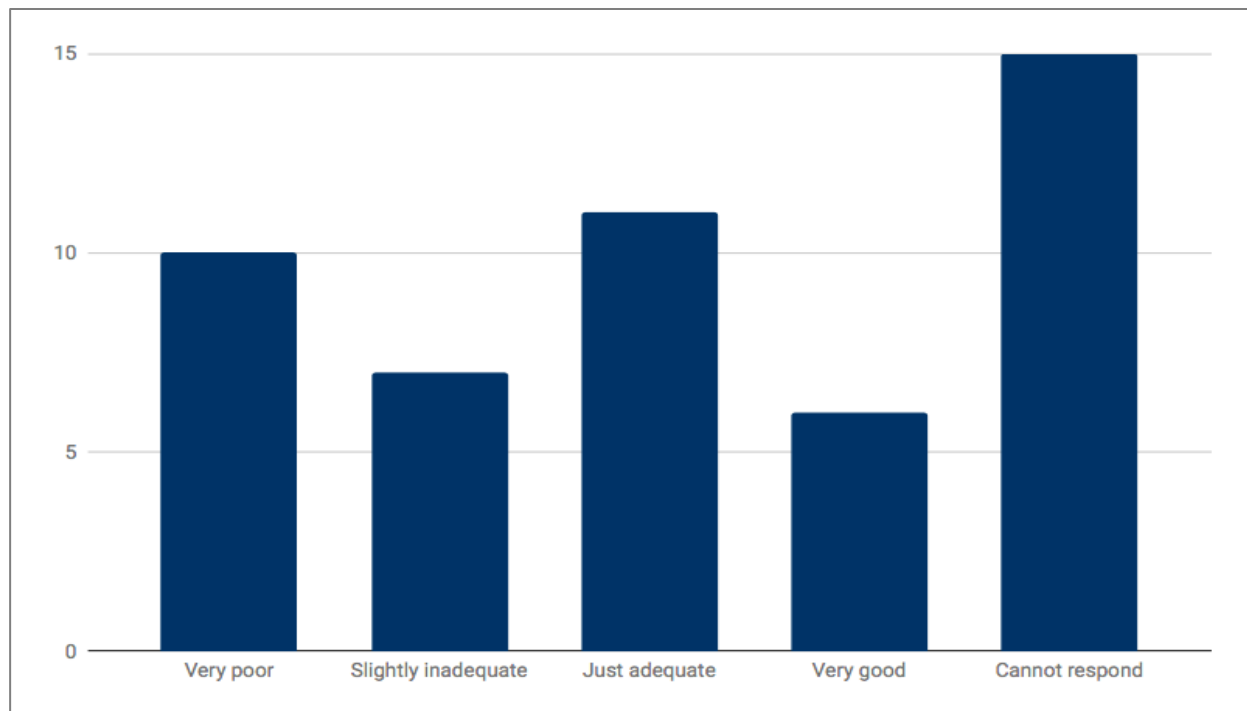
Figure 23: Preclinical student opinion of current IPL teaching



## Clinical

Students were equivocal regarding the quality of IPL Pharmacology tutorials in the Year 4 Medical Home Unit rotation (mode [22.45%] +1 | mean: -0.12 | range: -2 to +2 | n = 34 from 49). There were two associated open-text responses which noted logistical issues surrounding the timing of the scheduled tutorials for one rotation clashing with the regular university holidays, resulting in no attendance from the pharmacology students, and decreased attendance in another tutorial.

Figure 24: Opinion of current teaching in Year 4 Pharmacology tutorials (IPL)



## Conclusion of Standard

Preclinical students were largely pleased with the quality and delivery of Interprofessional learning teaching. Year 4 Pharmacology tutorials, which were conducted in an IPL format, were deemed equivocal but comments emphasised the timing clash with holidays resulting in poor attendance from pharmacology students, impacting and limiting the interprofessional learning environment.

# Standard 5 | Assessment

## Standard 5.3 | Assessment feedback

*In 2014 the Faculty ceased the return of examination papers to students. In 2015 the Faculty began providing discipline-based feedback to pre-clinical students in the form of Quartile rankings of performance in Mid-Semester and End-of-Year Examinations. Feedback in the form of grade bandings (A-E) continues to be provided across all year levels. At the end of 2016, quartiles were not released to students due to an administrative error with the MLTU website preventing them from being created. In 2017 the Faculty underwent a major change in the way in which they give pre-clinical examination feedback, changing from quartiles to individual question feedback. Clinical students are yet to experience such a change. In the 2018 pre-clinical mid-year examinations, question-specific learning points were provided in feedback, in contrast to descriptions of the answers to question as per 2017 examinations. This change was not formally surveyed although some qualitative comments discussed this change.*

### Methodology

Students in all year levels were asked to evaluate the feedback received from assessments based on the following statement: **“How effective was the following assessment feedback in enabling you to focus your study on specific areas of weakness?”** Answers were obtained via Likert scale from -2 (representing very ineffective) to +2 (representing very effective). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

The specific modes of feedback evaluated varied with each year level as follows:

- All preclinical year levels were asked to evaluate **“CBL Tutor Feedback”** and **“MPPD Tutor Feedback”**.
- Only first and second year students were asked to consider **“Clinical Skills Tutor Feedback”**
- Only second and third year students were asked to consider **“Question based feedback + percentage score (e.g. 2017 end-of-year MKE)”**.
- All clinical year levels were asked to consider **“End-of-rotation assessment feedback”** and **“Consultant/team feedback during rotation.”**

- Only fourth and fifth year students were asked to consider “Grade bands only (2017).”

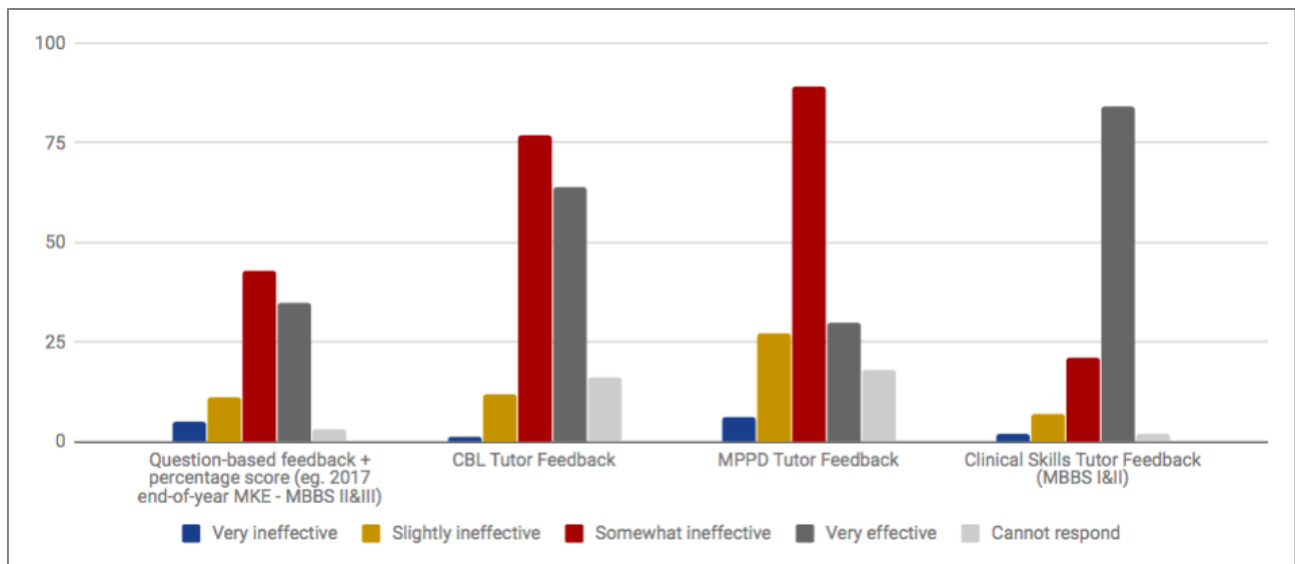
Students in Years 4-6 were additionally asked to evaluate the efficacy of current end-of-rotation ward assessments by rating level of agreement based on the following statement **“End-of-rotation ward assessments performed by my supervisor are a useful and accurate reflection of my knowledge and competency and help me identify areas of further improvement.”** Answers were obtained via Likert scale from -2 (representing “strongly disagree”) to +2 (representing “strongly agree”). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

### Pre-clinical responses

Students were positive about CBL tutor feedback: (mode: [50.0%] +1 | mean: +1.23 | range: -2 to +2 | n = 154 from 170) and MPPD tutor feedback (mode: [58.6%] +1 | mean: +0.71 | range: -2 to +2 | n = 152 from 170). Free-text responses from first year students indicated a more negative opinion regarding MPPD feedback, with 4 comments indicating a lack or insufficiency of MPPD tutor feedback. Students were very positive about Clinical Skills tutor feedback: (mode: [73.7%] +2 | mean: +1.56 | range: -2 to +2 | n = 114 from 116).

Students agreed that the question-based feedback in conjunction with the percentage score was effective: (mode: [45.7%] +1 | mean: +0.98 | range: -2 to +2 | n = 94 from 97). Free-text responses represented a more equivocal opinion, with the predominant theme being that the feedback format employed in 2017 was preferred over the 2018 format (5 comments). Students suggested that more specific feedback rather a general area of study would be more effective (5).

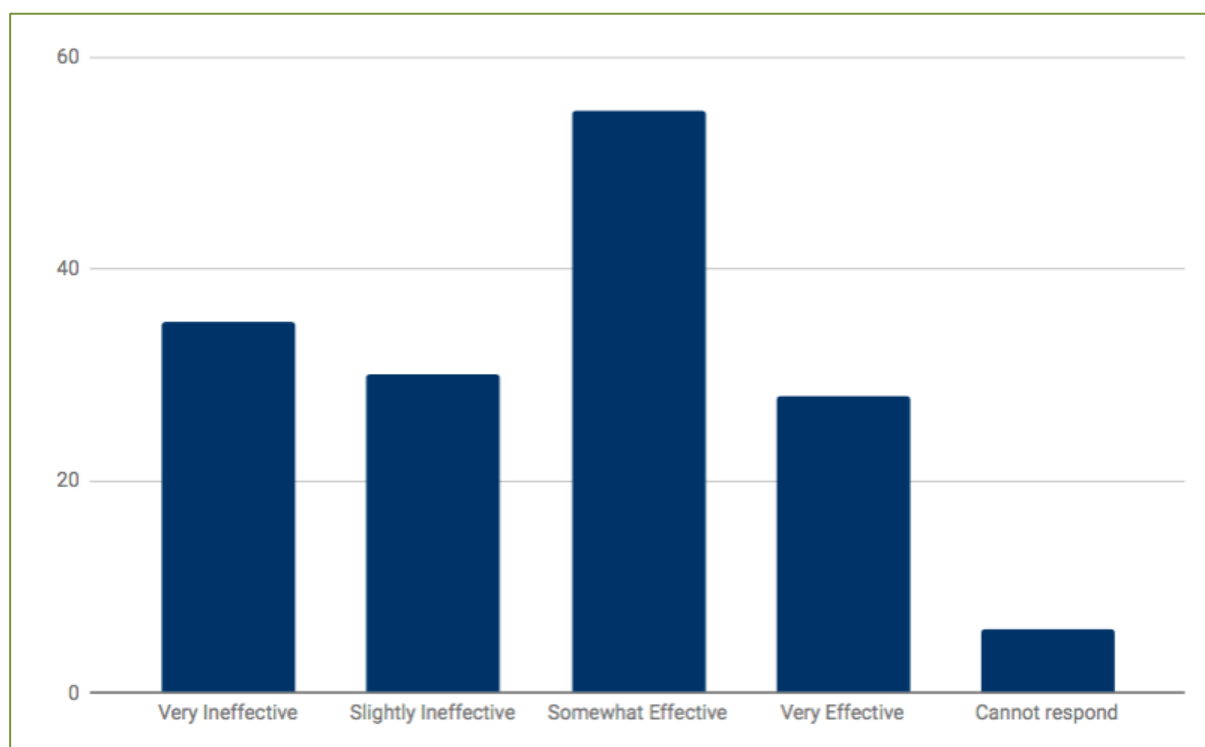
Figure 25: Preclinical student opinion on the quality of assessment feedback



### End-of-rotation assessment feedback

Students were equivocal regarding whether end of rotation assessment feedback enabled them to focus their study on specific areas of weakness (mode [37.2%] +1 | mean: +0.08 | range: -2 to +2 | n = 148 from 154). However, 47 open text responses suggested a more negative opinion with 45 responses indicating a negative opinion. The most common view was that end-of-rotation OSCEs provided insufficient feedback (25 comments), with one student commenting that they had “received zero feedback after our final fifth year OSCE’s”, and another student commenting that “OSCE’s should have feedback on each station, otherwise you never know how you went.” Other predominant themes included the disapproval of the delay in return of OSCE and end of rotation feedback (8 comments), that the quantity of rotation feedback provided is limited (9 responses), and that rotation feedback is often impersonal and generic (4 responses). However, 2 responses indicated a positive opinion with the student expressing that the “rural clinical school gave very good feedback throughout the year”.

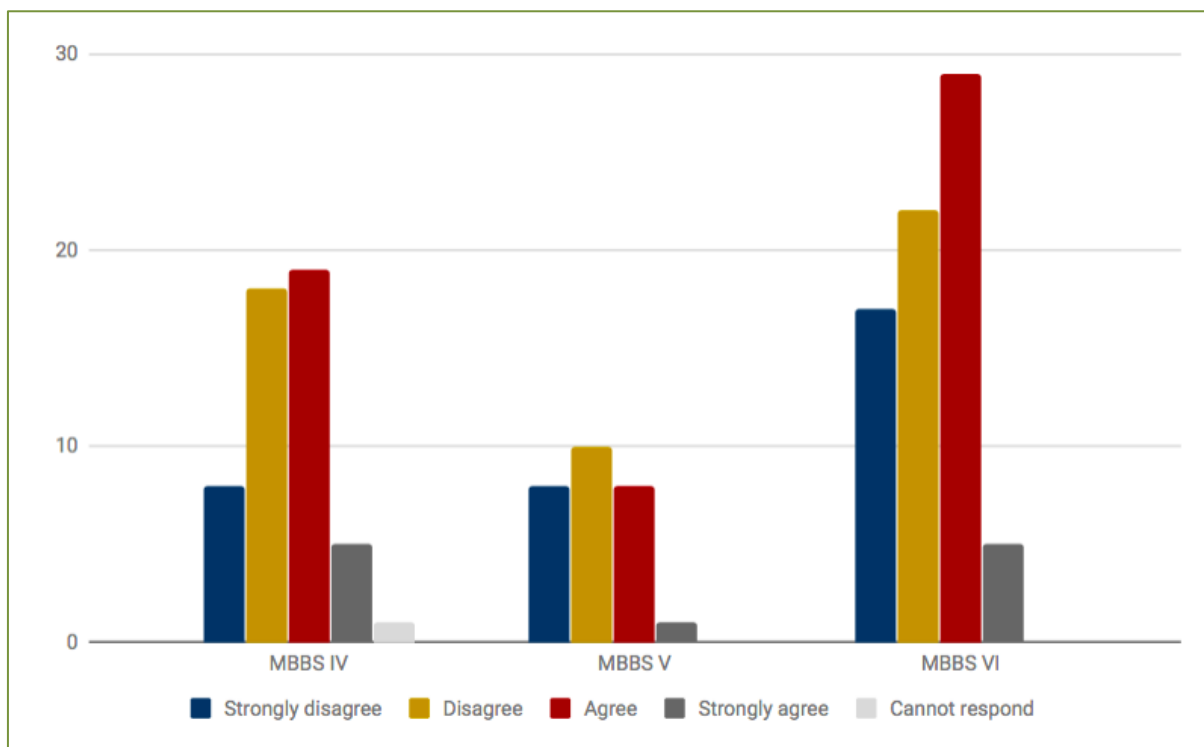
**Figure 26: Clinical Student opinion of whether end-of-rotation assessment feedback enabled them to focus their study on specific areas of weakness**



### End-of-rotation Ward Assessment

Students were equivocal regarding whether the end-of-rotation ward assessments provided a useful and accurate reflection of student knowledge and competency: (mode [37.3%] +1 | mean: -0.25 | range: -2 to +2 | n = 150 from 151). However, 59 open text responses suggested a more negative opinion. The most common view was that the amount of time spent with supervisors was too limited to complete a reasonable assessment (26 comments), with one student commenting that *“ward supervisors eg. consultants often do not have enough contact with medical students compared to RMOs and registrars hence have a very superficial understanding of student performance on the ward.”* Other predominant themes include significant variability depending on the supervisor completing the assessment (16 comments), overall generic feedback (8 comments), assessments including too many areas of assessment (4 comments), and the assessment not reflecting clinical skills (3 comments).

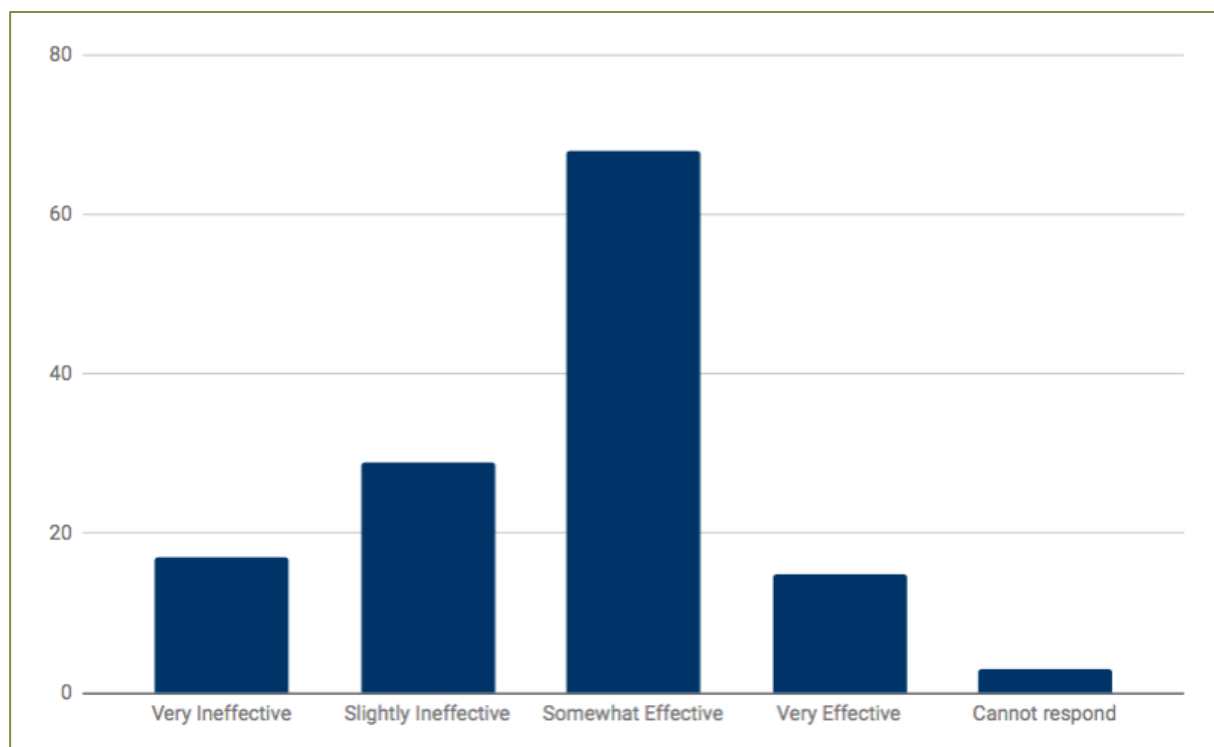
**Figure 27: Clinical Student opinion of whether the end-of-rotation ward assessments provide a useful and accurate reflection of student knowledge and competency**



### Supervisor / Consultant / Team Feedback

Students agree that the current supervisor / consultant / team feedback provided was adequate in enabling them to focus their study on specific areas of weakness: (mode [49.7%] +1 | mean: +0.40 | range: -2 to +2 | n = 150 from 153). However, 9 open-text responses suggested a more negative opinion. The most common view was that the team feedback provided is impersonal, inconsistent, and generic (5 responses). Another predominant theme was that the team feedback provided was not representative of their knowledge (2 comments), with one student commenting that consultant / team feedback is “not very relevant to my study as they focus on my participation and engagement... but often do not know what level of knowledge we are supposed to have”.

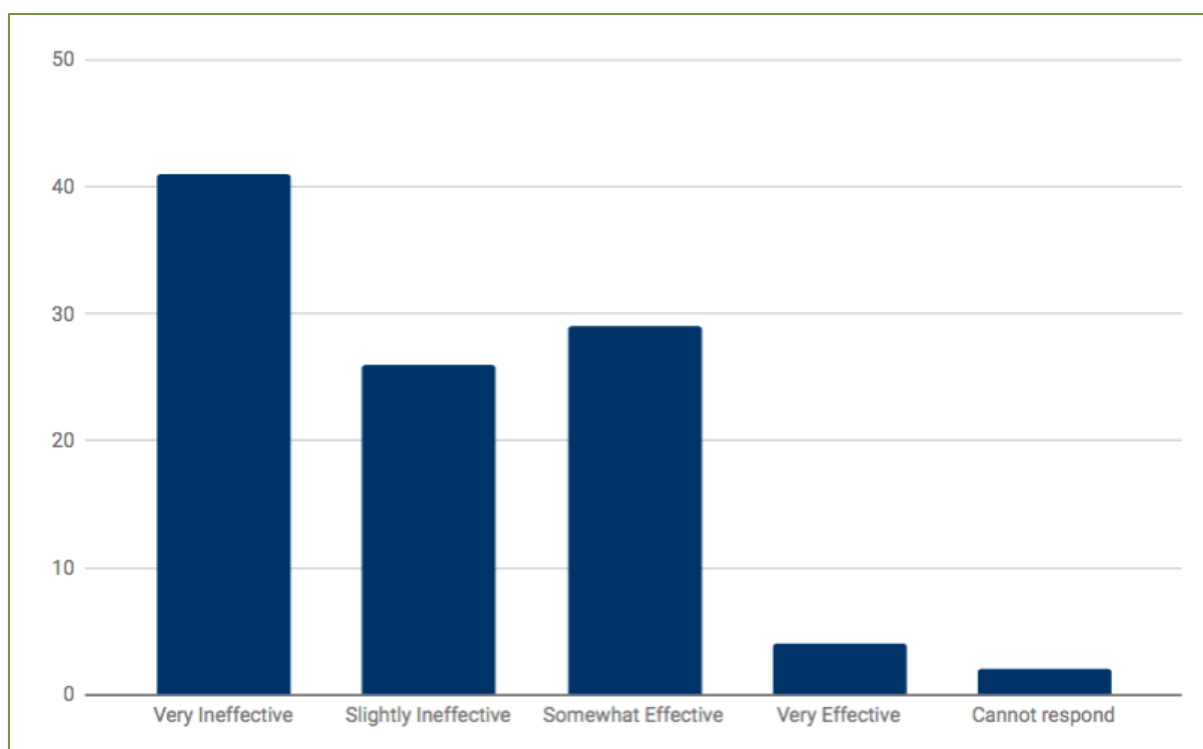
Figure 28: Clinical Student opinion on the efficacy of supervisor / consultant / team feedback



### End-of-year examination feedback (grade bands)

Students disagreed regarding the adequacy of grade bands for end-of-year examination feedback (mode [36%] -2 | mean: -0.60 | range: -2 to +2 | n = 142 from 144). 13 open text were congruent. The most common view was that the grade bands provided no specific or informative feedback (7 comments), with one student commenting that “*grade bands are enough to know that I’d passed, but do not tell me where I went wrong*”. Another predominant theme was that the grade bands were ineffective (6 comments), with one student commenting that “*grade bands are not in any way effective feedback when the context of an exam is so broad and the grades are received months later*”.

Figure 29: Clinical student opinion on the efficacy of grade bands



## Conclusion of Standard

Pre-clinical students continue to review the current methods of assessment feedback positively following their alterations over the past few years. In this survey, students noted a preference for the feedback employed for the 2017 end-of-year examinations over that of the 2018 mid-year examinations. However, the latter was not formally surveyed.

In contrast, the opinions of clinical students were generally equivocal or negative with students expressing a desire for more detailed end-of-rotation and end-of-year examination feedback to help them focus their study on areas of weakness. It is likely that if similar changes in pre-clinical examination assessment feedback were made to clinical end-of-rotation and end-of-year examination feedback that the opinions of clinical students regarding the utility of assessment feedback would be more positive.

# Standard 6 | Monitoring and Evaluation

## Standard 6.1 | Monitoring

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

### eSELT Feedback

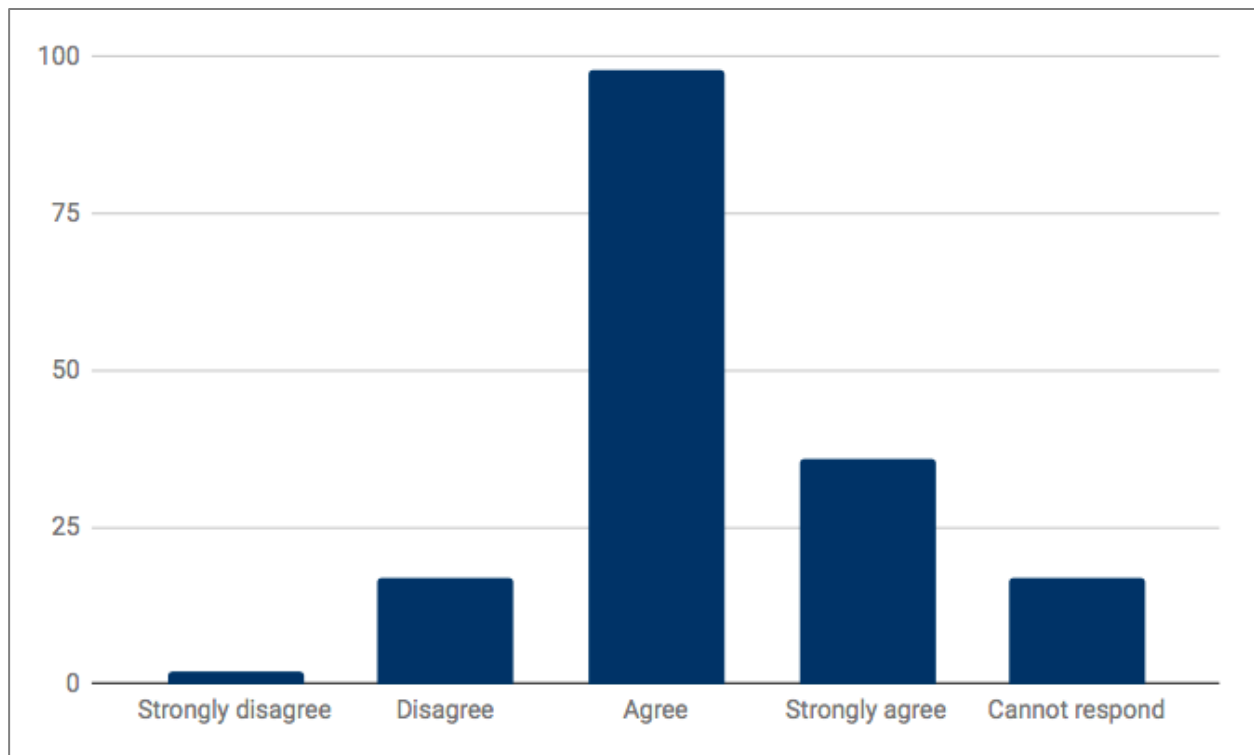
#### Methodology

Students in all year levels were asked to evaluate the efficacy of the use of eSELTs (the standardised mode, across the University of Adelaide, of gathering student feedback on the course/semester they are about to complete) as a form of feedback by rating level of agreement based on the following statement **“eSELTs are an effective means by which students may convey feedback on the course and tutors.”** Answers were obtained via Likert scale from -2 (representing strongly disagree) to +2 (representing strongly agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

#### Preclinical

Students agreed that eSELTs are an effective means by which students may convey feedback on the course and tutors.: (mode [64%] +1 | mean: +0.94 | range: -2 to +2 | n = 153 of 170). However, 15 open text responses suggested a more equivocal opinion. The most common view was that eSELTs are tedious to complete, taking >20 minutes on average (8 comments). Another predominant theme was that students haven't had feedback from the Faculty as to what has changed due to eSELTs (3 comments).

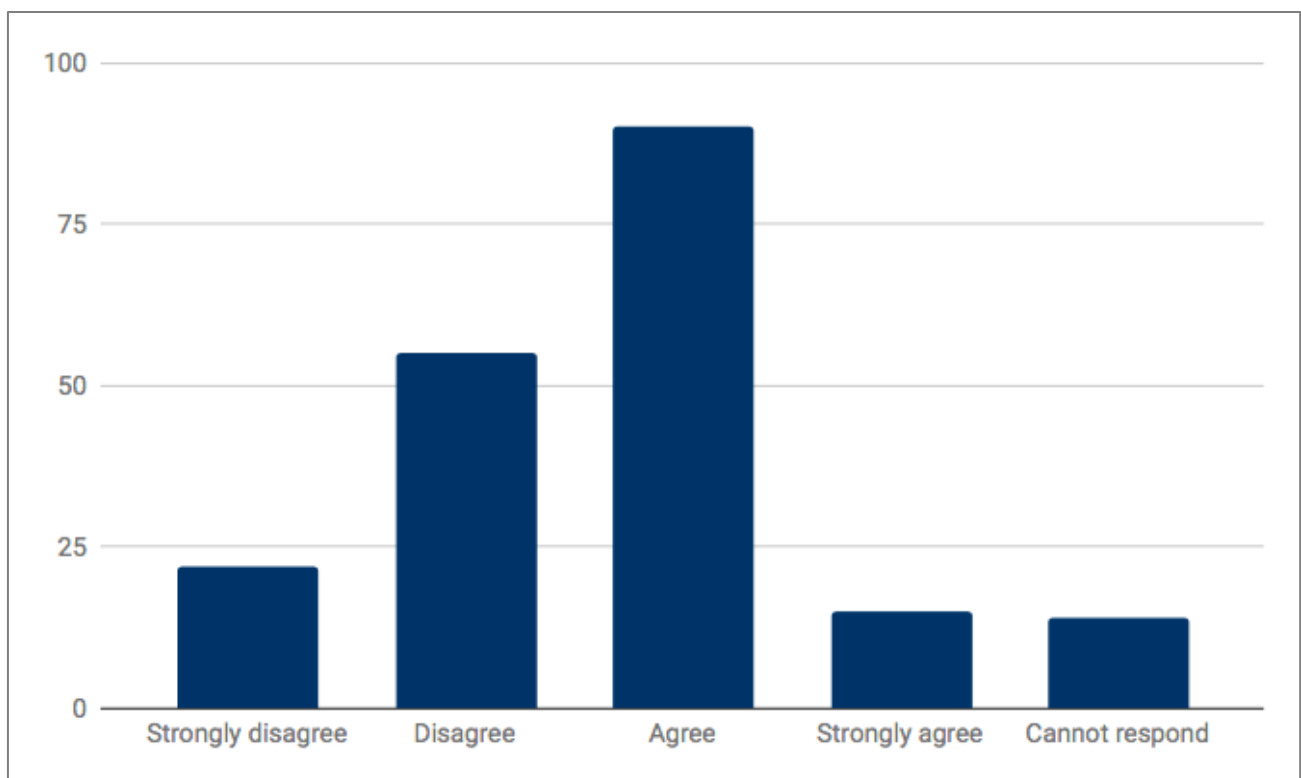
Figure 30: Preclinical student opinion of eSELTs



## Clinical

Students were equivocal regarding the efficacy of eSELTs as a means by which students may convey feedback on the course and tutors (mode [49%] +1 | mean: +0.18 | range: -2 to +2 | n =182 from 196). However, a total of 35 open text responses suggested a more negative opinion. The most common views were that the structure of eSELTs is inappropriate in collating feedback for the clinical course due to its rotational structure (7 comments) and that in most cases do not provide the opportunity to provide feedback on supervisors and tutors as they are not listed (9 comments). Other common themes were that the timing of the surveys was inconvenient in that it often occurred directly before exams (3 comments) and that the surveys were too lengthy (3 comments). Some students also felt there were not sufficient outcomes from the feedback provided (5 comments) and that there was no information provided on how the feedback is acted upon (4 comments).

Figure 31: Clinical student opinion of eSELTs



## Conclusion of Standard

Students in the pre-clinical years were overall positive regarding the efficacy of eSELTs as a tool for collating student feedback on the medical course. In contrast, students in clinical years were overall equivocal and this can be mainly attributed to (1) issues relating to limitations in reviewing staff members that students actually had contact with on their clinical rotations and (2) issues relating to timing of eSELTs, being in the SWOT-VAC period when a more ideal time would be at the end of each clinical rotation. Students in pre-clinical and clinical years also note a desire for the eSELTs to be more concise.

# Standard 7 | Students

## Standard 7.3 | Student Support

*'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.'*

Under the Professional Services Reform (PSR) The Faculty of Health and Medical Sciences (previously Faculty of Health Sciences) underwent dramatic changes to staff structuring, individual personnel and delivery of professional and administrative services in 2016. The PSR centred on a restructure of professional services such that individual schools and programs would no longer provide these services but instead they would be centralised such that professional and administrative services to all programs are provided by through the Faculty by multiple teams covering Placements and Internships, Assessment and Student Program Support Services.

A new policy was enacted in 2018 in the clinical years of the program to permit students to take unplanned short-term leave from clinical rotations for mental health reasons (colloquially referred to by students as “Mental Health Days-off”). Such a policy was already in place for pre-clinical students and was extended to clinical year students in response to the relatively high burden of mental health issues in the medical students relative to the general population. Students were surveyed regarding this policy to establish awareness and approval of the policy.

### Mental Health Days-Off

#### Methodology

Students in all year levels were asked to evaluate the policy permitting students to take unplanned leave as required for mental health reasons, colloquially being referred to as “Mental Health Days-off” by rating their level of agreement with the following statements **“I was aware of Mental Health Days-off prior to taking this survey,” “I have, on at least one occasion, taken a “Mental Health day-off” and “I approve of the current policy/process for taking Mental Health days-off.”** Answers were obtained via the Likert scale from -2 (representing ‘strongly disagree’) to +2 (representing ‘strongly agree’). No equivocal midpoint was provided, to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with.

At the end of the question, students were asked to explain their answers via an optional open text field.

## Preclinical

Students disagreed that they were aware of the policy on “Mental Health Days-Off” (mode [31%] -1 | mean: -0.71 | range: -2 to +2 | n = 170 from 170), however approved of the current policy/process for taking “Mental Health Days-Off” (mode [57%] +2 | mean: +1.46 | range: -2 to +2 | n = 154 from 170). Of pre-clinical respondents, 36 of 170 students noted as having taken a “Mental Health Day-off” (as assumed by their agreement with the aforementioned statement) on at least one occasion. There were 16 open text responses that suggested an overall positive opinion regarding the implementation of the Mental Health Days-Off policy with (8 responses) indicating a positive opinion. The most common view being it was a necessary and very valuable policy, especially for medical students (8 comments) and the inclusion of these policies would contribute to “*chang[ing] the stigma around mental health*” (1 comment). Students also noted a desire for the Faculty to take more control of promotion and awareness of Mental Health Days-Off (1 comment).

## Clinical

The majority of students agreed they were aware of Mental Health Days-off. (mode [41%] +1 | mean: +0.57 | range: -2 to +2 | n = 193 from 194). However, 9 open text responses suggested a more negative opinion with 8 responses indicating that they weren’t “formally made [aware] that they exist[ed], [and know] more so from word of mouth” and “this should be more easily accessible knowledge”. The most common view was that the hospital team and staff weren’t aware of the Mental Health Days-Off scheme, “frowning at the idea,” and often students “still required paperwork” to justify their absence, defeating the purpose of this policy (13 comments). Other predominant themes included “student’s abusing the opportunity” and not taking the “concept seriously” (2 comments).

78 of 194 clinical student respondents noted as having taken a “Mental Health Day-off” on at least one occasion and the majority of students supported the current policy/process for taking “mental health days-off” (mode value: [57%] +1 | mean: +1.88 | range -2 to +2 | n = 187 from 194). 8 open responses expressed positive sentiments, emphasising that “mental health days off are necessary for students for this degree, [which is] stressful at times” and that it was a great initiative all round (2 responses).

Other predominant themes included individual’s appreciation of the medical student society drawing attention to this policy, but suggested there was “minimal effective communication of these policies by the medical school or university” (5 responses).

Figure 32: Student awareness of “Mental Health Days-off prior to survey”

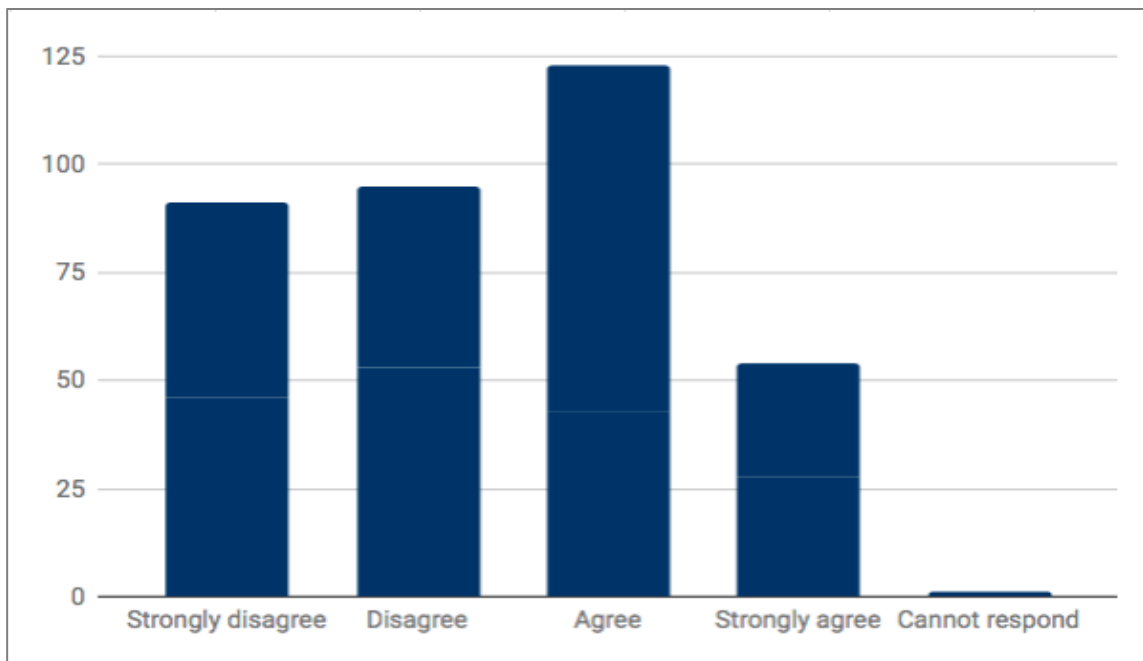
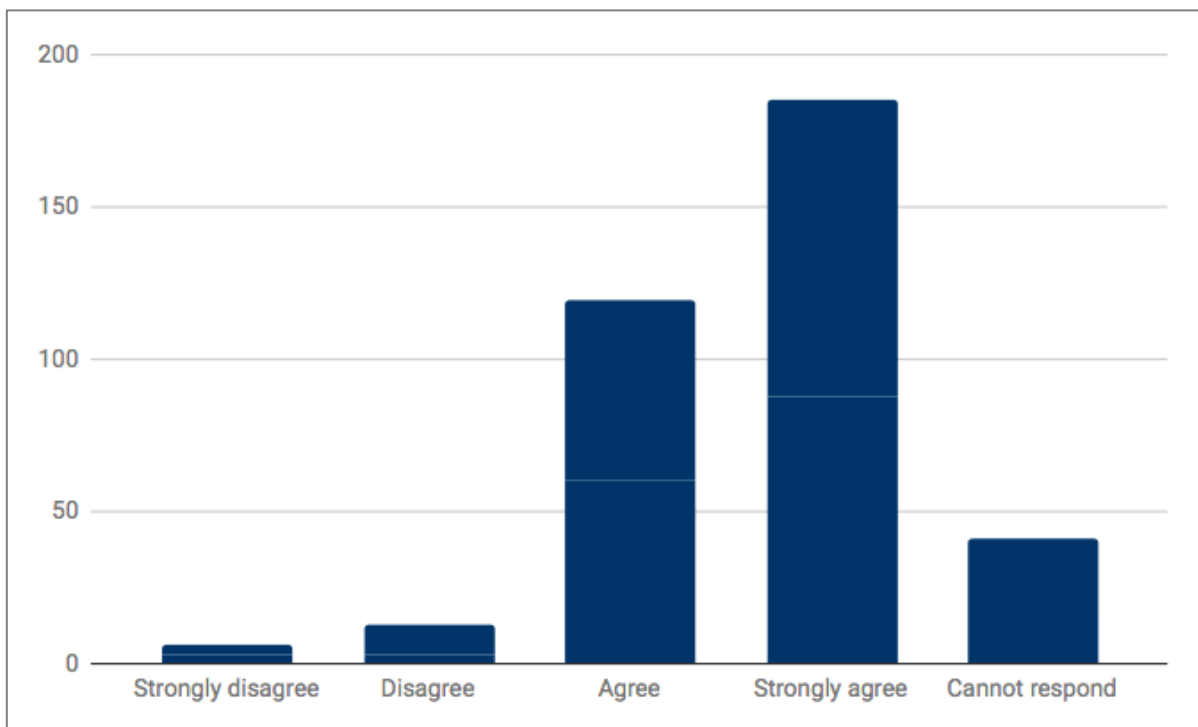


Figure 33: Student approval for the current policy/process for taking “Mental Health Days-off”



## Access to Student Support Services

### Methodology

Students in all year levels were asked to evaluate current access to student support services by rating level of agreement with the following statement **“Many students can experience difficulty during their time in Medical School with maintaining academic progress, good health and wellbeing including mental health, financial difficulty and maintaining work-life balance. How accessible do you feel student support services are to medical students, regarding both general resources as well as specific one-on-one support.”** Answers were obtained via the Likert scale from -2 (representing ‘very inaccessible’) to +2 (representing ‘very accessible’). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

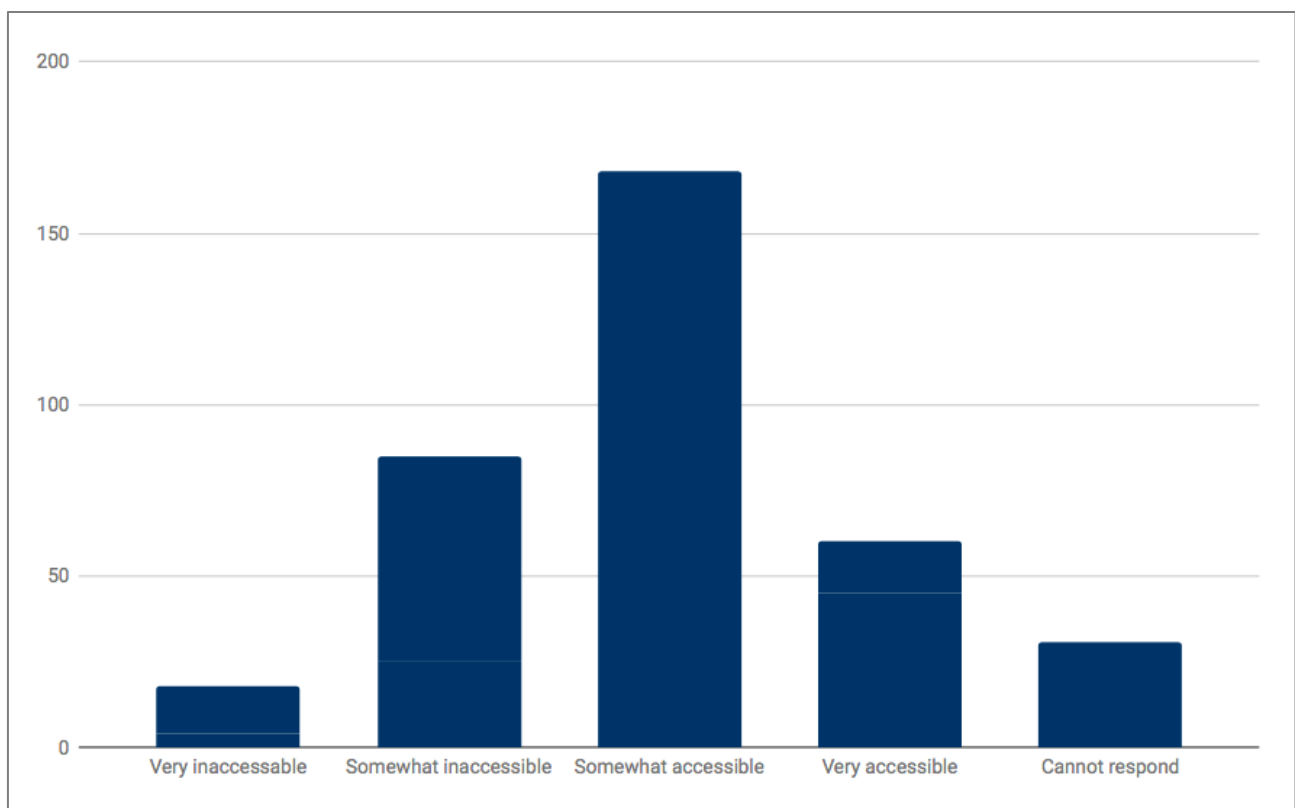
## Preclinical

Students agreed that student support services are accessible (mode [51%] +1 | mean: +0.85 | range: -2 to +2 | n = 152 of 169). 3 open responses articulated that resources were *“well advertised and circulated”* and that it was *“encouraged and easy to get in touch with [a] coordinator in regards to mental health”* (1 response). However, 5 open text responses suggested a more negative opinion (5 responses) indicating that support is *“limited”* and *“rather inaccessible”* despite the presence of counselling services.

## Clinical

Students agreed that student support services are accessible (mode [50%] +1 | mean: +0.75 | range: -2 to +2 | n = 179 of 193). 6 open text responses indicated that despite the provision of resources, often they operate in *“hours not suitable to clin students”*. The most common theme is that there is *“minimal authenticity and follow-up by the med school”* despite the emphasis on the importance of taking care of their mental and physical wellbeing. 3 responses highlighted the geographical hindrance caused by distance to the main campus. Furthermore, 7 open responses from the Year 5 rural cohort were mixed. 3 students commented that resources were inaccessible because the only available resource was in an adjacent town or that there were difficulties in finding consultations with someone who they didn’t know personally. 4 responses from the Year 5 rural cohort stated otherwise, emphasising the *“supportive and caring”* nature of the community and the willingness to provide time off when required.

Figure 34: Students opinion on the accessibility of student support services



## Administrative Support

### Contact for common enquiries

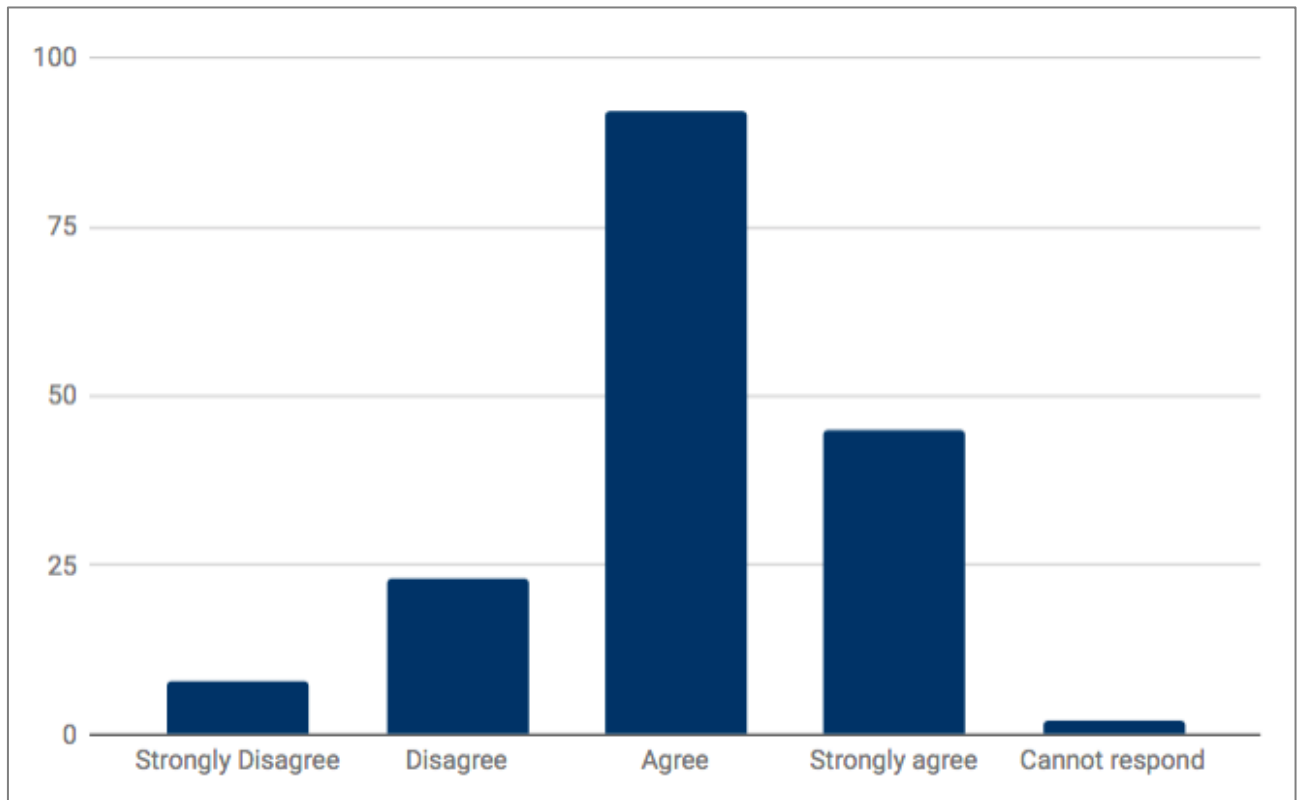
#### Methodology

Students in all year levels were asked to evaluate the efficacy of current administrative staff and services by rating level of agreement based on the following statement **“In 2016, the Faculty of Health and Medical Sciences underwent a professional services reform that centralised the administration from the MLTU to the Faculty of Health and Medical Sciences. In 2018: It has been made clear to me as a student who to contact for common enquiries e.g. applying for leave.”** Answers were obtained via Likert scale from -2 (representing strongly disagree) to +2 (representing strongly agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

#### Preclinical

Students agreed that it has been made clear who to contact for common enquiries (mode +1 | mean: +0.84 | range: -2 to +2 | n = 168 from 170).

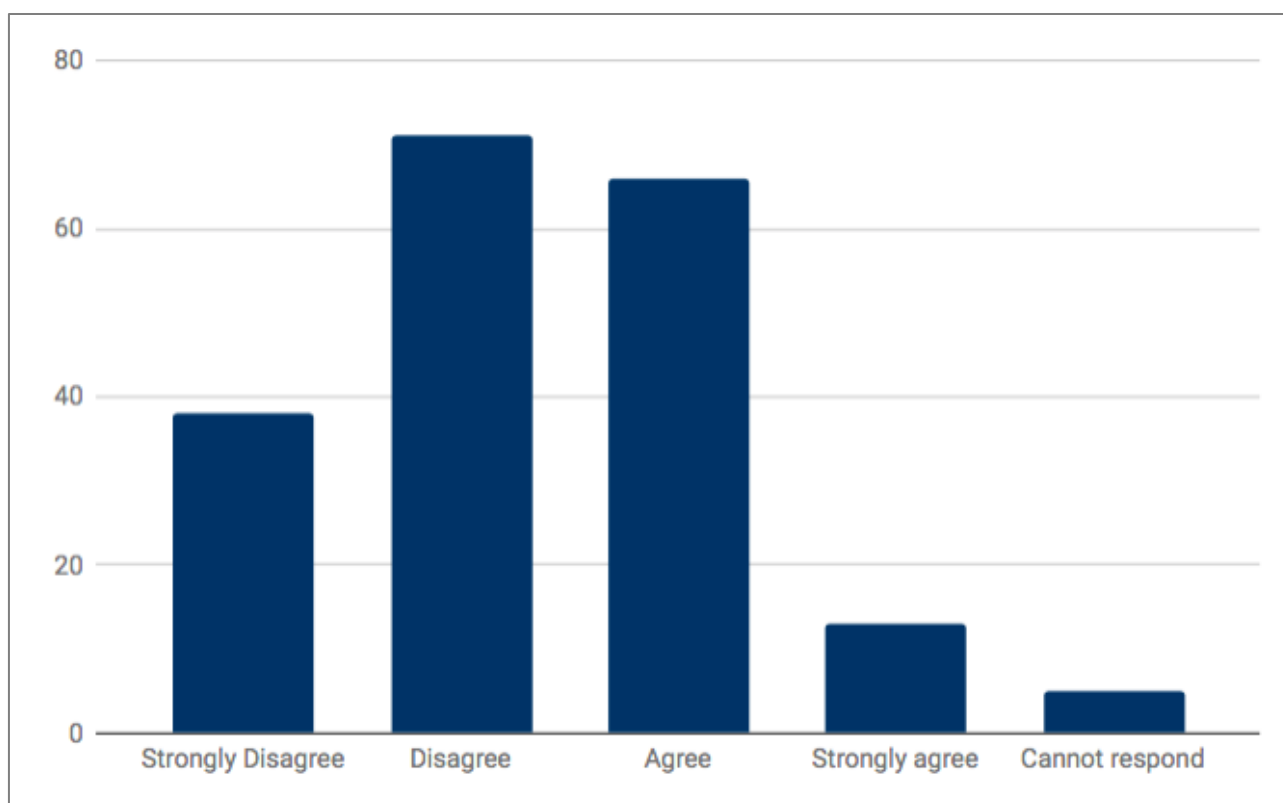
**Figure 35: Preclinical Student opinion on ease of contacting staff regarding common enquiries**



## Clinical

In contrast, clinical students were equivocal regarding whether it had been made clear who to contact for common enquiries: (mode (38%) -1 | mean: -0.31 | range: -2 to +2 | n = 188 from 193). A negative opinion was communicated through 19 comments in an open text field noting a lack of clarity of administrative contacts and subsequent difficulty in accessing assistance, including 4 respondents who reported complete unawareness of who to contact. Other themes included, frustration with emails being redirected through multiple channels for a single issue (7 comments) and difficulty in finding relevant contacts for specific issues (4 comments).

Figure 36: Clinical Student opinion on ease of contacting staff regarding common enquiries



## CANVAS Platform

### Methodology

Students in all year levels were asked to evaluate the efficacy of the use of the CANVAS/MyUni platform by rating level of agreement based on the following statement **“In 2016, the Faculty of Health and Medical Sciences underwent a professional services reform that centralised the administration from the MLTU to the Faculty of Health and Medical Sciences. In 2018: the CANVAS/MyUni platform has been used effectively such that it is clear where to access important information/documents e.g. Lecture notes and recordings, assignments/assessments.”** Answers were obtained via Likert scale from -2 (representing strongly disagree) to +2 (representing strongly agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

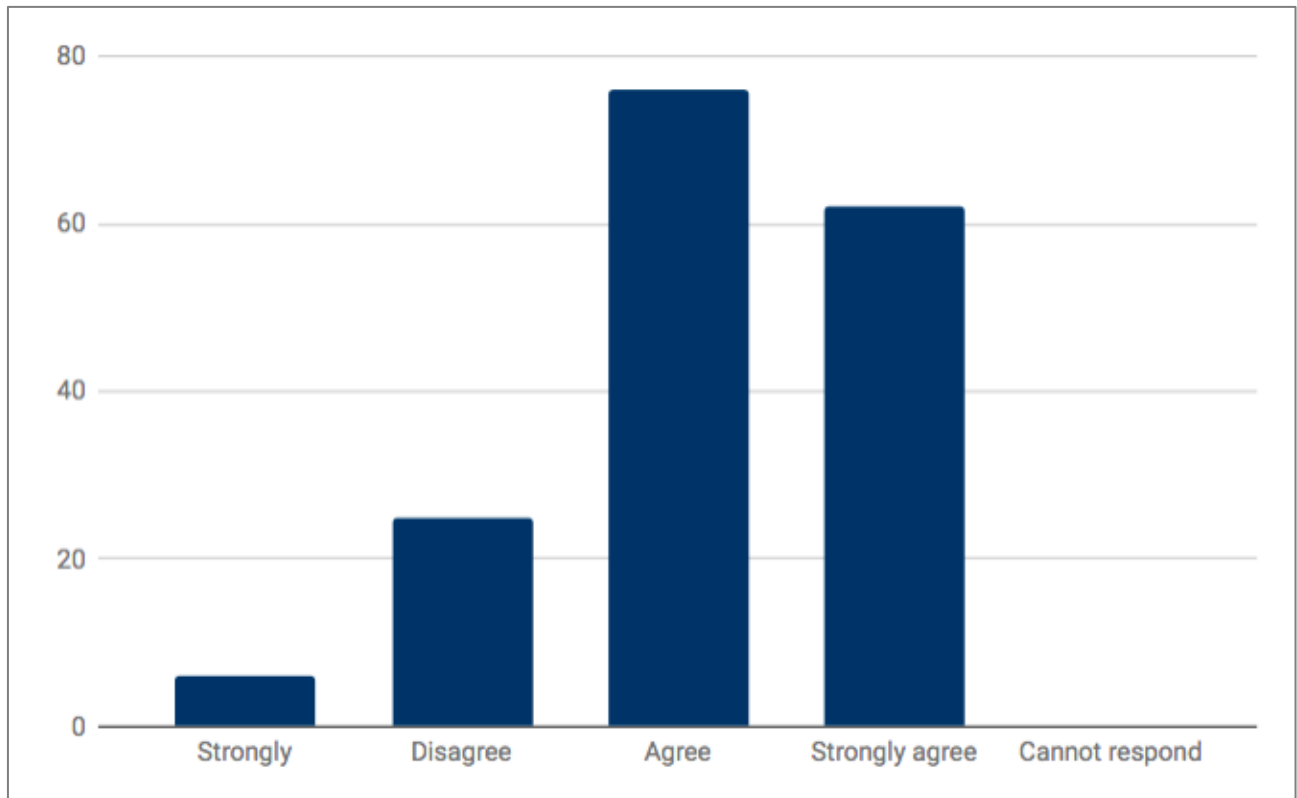
### Preclinical

Students agreed that the CANVAS/MyUni platform has been used effectively such that it is clear where to access important information/documents (mode [45%] +1 | mean: +0.89 | range: -2 to +2 | n



= 169 from 169). However, 31 open text responses suggested a more negative opinion. The most common view was lecture notes and recordings are not uploaded in the same place and it makes them very difficult to locate (22 comments). Another predominant theme was that online lectures are often uploaded late or not at all (8 comments).

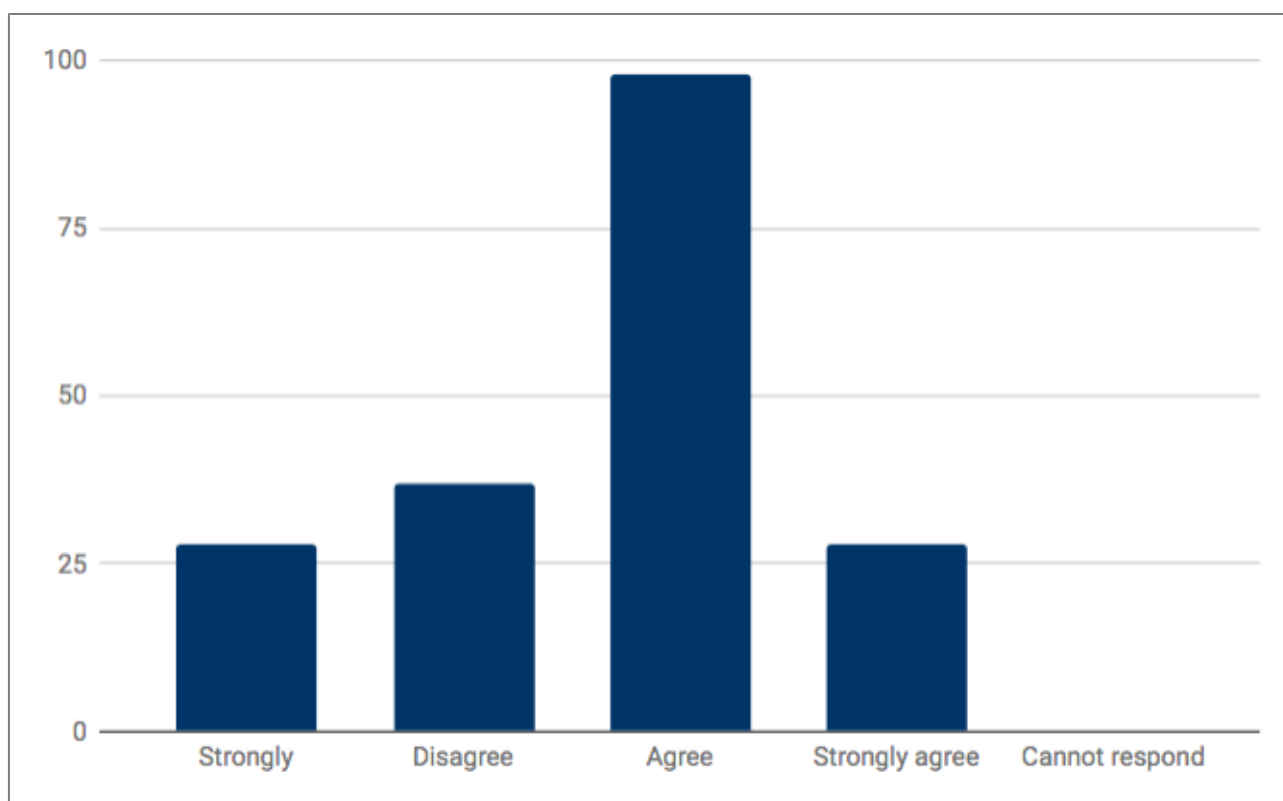
**Figure 37: Preclinical Student opinion of the efficacy of the use of CANVAS/MyUni Platform**



## Clinical

Students were equivocal regarding whether the CANVAS/MyUni platform has been used effectively such that it is clear where to access important information/documents (mode [51%] +1 | mean: +0.30 | range: -2 to +2 | n = 191 from 191). However, 20 open text responses suggested a more negative opinion. The most common view was that CANVAS/MyUni is disorganised and materials difficult to find (22 comments). Another predominant theme was the lack of consistency in use and organisation of CANVAS/MyUni across different clinical placements (8 comments).

Figure 38: Clinical Student opinion of the efficacy of the use of CANVAS/MyUni Platform



## Sonia Portal for Organisation of Clinical Placements

### Methodology

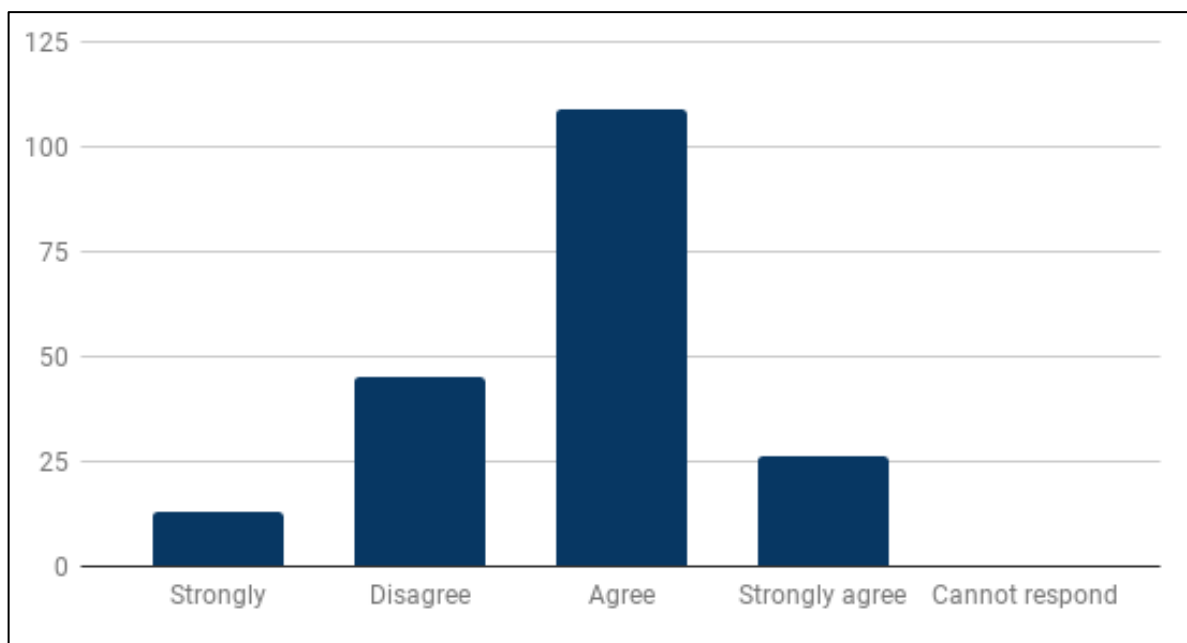
Students in Clinical year levels only were asked to evaluate the efficacy of the use of the CANVAS/MyUni platform by rating level of agreement based on the following statement “In 2016, the Faculty of Health and Medical Sciences underwent a professional services reform that centralised the administration from the MLTU to the Faculty of Health and Medical Sciences. In 2018: It has been made clear how to use SONIA, our online clinical placement management portal” Answers were obtained via Likert scale from - 2 (representing strongly disagree) to +2 (representing strongly agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

### Results

Students agreed that it has been made clear how to use SONIA: (mode [56%] +1 | mean: +0.51 | range: -2 to +2 | n = 193 from 193). However, 4 open text responses suggested a more equivocal

opinion. With contrasting themes that the platform was effective (1 comment) and not user-friendly (2 comments).

**Figure 39: Clinical student opinion on communication from the Faculty re use of SONIA**



## Conclusion of Standard

Students approved of new measures to improve student health & well-being in the form of the new policy surrounding “Mental Health days-off” and increased provision of support services at the AHMS. Students however, noted a lack of awareness and enactment of the policy at some clinical placements due to their clinical supervisors remaining unaware and questioning the legitimacy of “Mental Health days-off.” This is a significant issue as it has the potential to cause harm rather than support for student health & well-being. It was suggested that these issues could be mitigated by increased communication of this policy both to students and clinical supervisors by staff.

Students generally were overall positive regarding student support services and administrative support. Clinical students were however, less positive than pre-clinical students, which can be attributed in part to their previous use of an alternative administrative system but also the more complex administrative structure of the clinical courses. Additionally, clinical students continue to note a lack of clarity in who to contact for common enquiries following the shift to the new centralised administration.

# Standard 8 | The Learning Environment

## Standard 8.3 | Physical Facilities

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

### Preclinical AHMS Building Quiet Study Spaces

#### Methodology

Students in preclinical year levels were asked to evaluate the availability of quiet study spaces within the AHMS building by rating level of agreement based on the following statement “In 2017, the Medical School moved from Frome Road to the Adelaide Health and Medical Sciences (AHMS) Building. Within the medical school, quiet study space is available during:”. Students were asked to evaluate availability during “University term (working hours)” and “SWOTVAC/Examination Period (mid-years 2018)”. Answers were obtained via Likert scale from -2 (representing strongly disagree) to +2 (representing strongly agree). No equivocal midpoint was provided to attempt to reduce central tendency bias. A “cannot respond” category was included to avoid forcing students to make statements that they did not agree with. At the end of the question, students were asked to explain their answers via an optional open text field.

#### Results

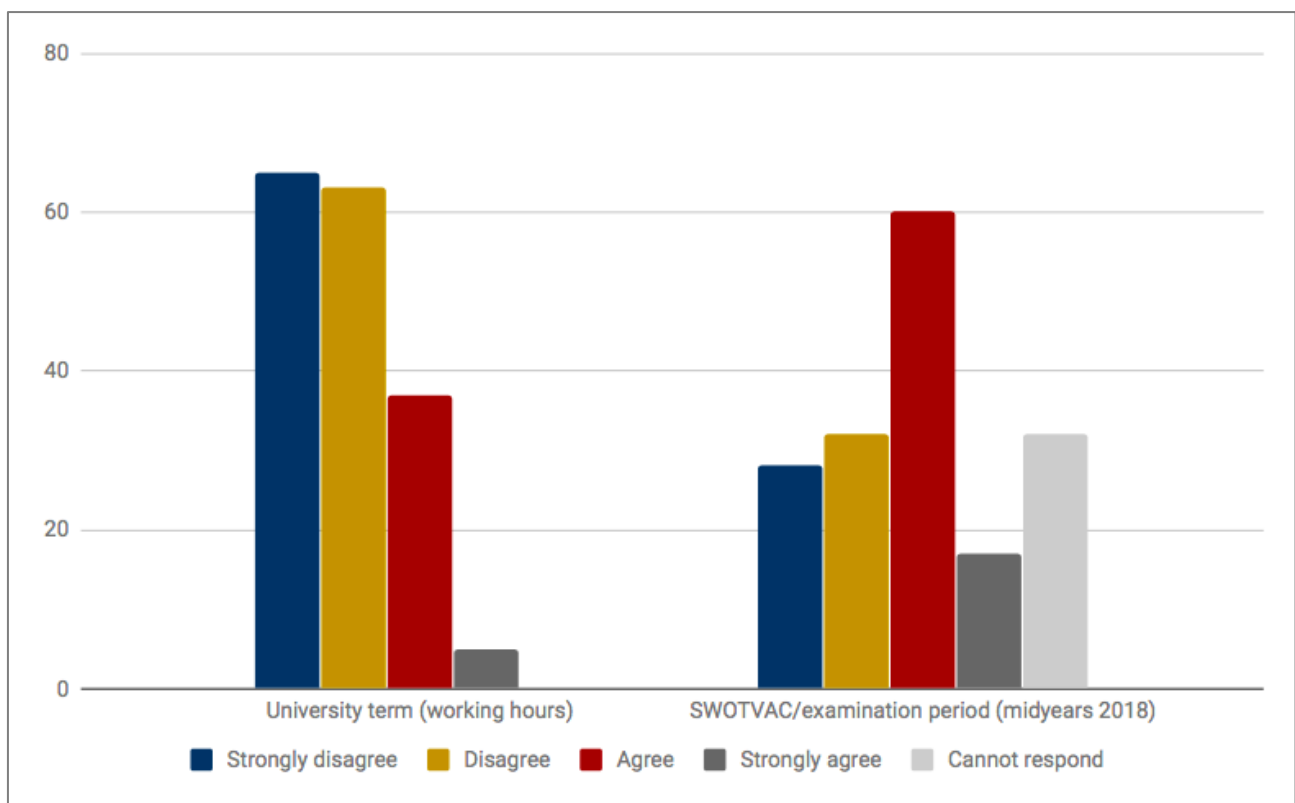
Students disagreed that there was adequate quiet study spaces at the AHMS building during the term: (mode: [38.2%] -2 | mean: -0.86 | range: -2 to +2 | n = 170 from 170). However, students were equivocal about the availability during SWOTVAC/Examination period (mid-years 2018): (mode: [43.8%] +1 | mean: +0.07 | range: -2 to +2 | n = 137 from 169). 37 responses suggested that study spaces at the AHMS building were too busy and crowded, with the available spaces being too loud (21 comments). 39 students suggested that more quiet study spaces were required at the AHMS building. A recurring suggestion throughout the comments (24 comments) was an evaluation about a possible redistribution of staff and student spaces. One student commented:

“...there are quiet study spaces, but there needs to be more. As, quite often, these quiet study spaces have 30-50 people in them, and more often than not, they go from being quiet to very loud in a matter of seconds...”

Another student commented:

“Adding even just 1 room where no talking is allowed would be helpful. As someone who likes to study at uni, I have had to walk 20 minutes to the Barr Smith instead because the AHMS is always packed with too many students...”

**Figure 40: Preclinical Student Opinion on availability of quiet study spaces at AHMS building**



## Conclusion of Standard

Students anecdotally recognise many positive of the new medical school building. However, the availability of quiet study spaces remains to be one of the most common issues raised to student representatives. The identification of a room/rooms for the specific provision of quiet study space is a priority and this is supported by the results under this standard.