ADELAIDE MEDICAL
STUDENTS' SOCIETY
EST 1889

Australian Medical Council

Student Submission 2019

Adelaide Medical Students' Society

Executive Summary

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

As with previous student submissions, the AMSS has invested significant energy in developing an evidence-based report which focuses on the core AMC accreditation standards. The survey guiding this document is of similar success to previous surveys, collecting responses from 567 students (overall 59% response rate of the total medical student cohort at the Adelaide Medical School). We believe that our methods, response rate and informed view of student opinions allows this document to be taken as a sufficiently accurate reflection of student opinion. The AMSS calls on the AMC to carefully consider this large body of data and act accordingly in ensuring the Adelaide Medical School meets the requisite high standards for medical education in Australia. However, this student submission should be interpreted within the context of its limitations (see page 10).

Furthermore, the AMC progress reporting process is particularly vital in 2019 due to the Adelaide Medical School beginning a crucial transition period. This is because the Adelaide Medical School is converting their Bachelor of Medicine & Bachelor of Surgery (MBBS) medical program to a Bachelor of Medical Studies/Doctor of Medicine (BMD) medical program (planned start date 2021). The AMSS has four key concerns regarding the transition to and implementation of the new BMD medical program.

1. The lack of information provided to students regarding the transition to and implementation of the new BMD medical program is the greatest concern. Currently, students have received no communication from the Adelaide Medical School regarding the new BMD medical program. This includes no formal communication regarding the planned start date, which student year levels might be affected, how student enrolment and fees might change, what the transition process might look like from a student perspective, or who to contact if students have concerns about the transition period. Student enquiries in person and via email have been ignored and dismissed. Despite student representatives repeatedly asking for a faculty-led information session and continuing to explain that the lack of communication is causing significant distress to students, especially preclinical students, these questions remain unanswered.
2. The lack of student input into the new BMD medical program is equally as concerning, and is in part the reason why the general student body remains uninformed. In particular, the lack of student representation on the Medical Programs Oversight and Operations Committee (MPOOC), despite repeated student requests, raises concern that the new BMD medical program will likely have limited student representation in its governance structure (*standard 7.5*). It is important to note that the terms of reference included in the 2019 staff report to the AMC regarding the Medical Programs Oversight and Operations Committee (MPOOC) (*Appendix 1.2 of the 2019 AMC staff submission*) are factually inaccurate, as there is currently no student representation and indeed students have been actively excluded from this committee despite ongoing requests. Furthermore, as part of the transition process, many formal positions currently held by

student representatives on various committees that oversee the development of the curriculum, assessment and evaluation of the medical program are beginning to be withdrawn (please see Appendix 1 – Medical Student Consultative Committee Terms of Reference). This trajectory is a cause for great concern regarding student representation in the governance structure of the new BMD medical program.

3. The resignation of the BMD Program Coordinator only 18 months prior to the planned implementation date does not inspire confidence that the new BMD medical program will be immediately successful. In fact, it raises significant concern regarding the internal organisation and upcoming implementation of the new program. From a student representative point of view, the newly elected BMD Program Coordinator is the person who continues to be the most obstructive to student feedback. Furthermore, they are continuing their previous fulltime role of MBBS Program Coordinator simultaneously, which raises uncertainty as to how much time is being dedicated to ensuring the BMD program is developed in full.
4. The fact that the new BMD medical program is being implemented as a 'Minor Change' rather than a 'Major Change' as per AMC accreditation causes significant worry. This is because there is no accountability for staff to ensure the new BMD medical program is actually complete by the planned start date. Unfortunately, there is a danger that the Adelaide Medical School's commitment to a great MD lacks credibility and that this transition period poses a significant threat to students.

This document aims to convey student opinion on matters associated with the AMC accreditation standards. The Executive Summary provides an outline of the overall student opinion regarding the medical program as it applies to specific standards (as per the document outlining the AMC Accreditation Standards for Primary Medical Education Providers 2012), however further details are provided in the remainder of this document.

As this is a Progress Report, it is useful to compare students' opinions in 2019 with those reported in 2018. Additionally, it is worth reporting student opinion regarding changes that have been introduced since 2018. Of note that this is the first year the AMSS has received the staff report, which only happened after multiple emails directly requesting the report to be sent to student representatives. Even then, we have been asked to keep its contents confidential, including from other student representatives. It is unfortunate there is has been no wider collaboration with students in the development of this staff report, despite claims of an 'AMS Annual Report', which the AMSS does not produce.

- ***Standard 1.8* Staff Resources**

  Unfortunately, there continues to be insufficient administrative staff to deliver core aspects of the medical program, and in fact, this has significantly worsened during recent years. This is particularly evident in the following three areas:

  1. The lack of lecture note uploading has been previously discussed in the 2018 (and 2017 and 2016) student submission, and has been escalated by student representatives at the Year 1-3 and Year 4-6 Course Committees respectively, as well as the MBBS Program Coordinator and the Dean, and has been documented by students in the eSELTs. This issue remains largely unchanged despite student feedback, with an overall negative opinion from students in Years 1-6.
  2. The difficulty in contacting staff regarding common enquiries also remains largely unchanged and an ongoing disappointment despite

continued student feedback. In particular, improvements in timely communication with staff have been escalated by student representatives to Year Level Advisors, the Year 1-3 and Year 4-6 Course Committees respectively, the MBBS Program Coordinator, and the Dean.

3. A newly identified problem in 2019 is that it seems the Adelaide Medical School rely on near-peer teaching to deliver the core components of the medical program, and misuse Year 6 medical students in the Medical Education Selective.

- ***Standard 3.4* Curriculum Description**

  The communication of learning objectives to lecturers, tutors and clinical supervisors remains inadequate despite being raised in the 2018 and 2017 student submissions as well as to several Course Coordinators and at both Year 1-3 and Year 4-6 Course Committees in the past. The underlying cause and major concern of students, is the **lack of a clear, well-documented curriculum, which remains unchanged despite ongoing student advocacy and this being a condition of accreditation since 2016.**

- ***Standard 3.5* Indigenous Health**

  Indigenous Health continues to require ongoing efforts to improve its practicality and relevance. The AMSS notes that **continued efforts are being made to improve Indigenous Health teaching**, especially for preclinical students, and in the case of Year 1 students these changes have been very well received. This is an excellent example of staff listening to and implementing student feedback.

- ***Standard 4.1* Range of Learning and Teaching Methods**

  The range of learning and teaching methods continues to be just adequate for most preclinical course components, as well as the School of Medicine Teaching Series (SMTS) for Year 4 and Year 5 students. **The Transition to Internship Program (TTIP) for Year 6 students is regarded as the highlight of the medical program.**

- ***Standard 4.3* Core Skills**

  The teaching of core skills and the preparedness of Year 6 students for internship both continue to be core strengths of the medical program.

- ***Standard 4.7* Interprofessional Learning**

  The access to Interprofessional Learning experiences has significantly worsened since 2018. Preclinical students have not had access to IPL opportunities in 2019. This is in stark contrast to 2018, where students responded positively to the program. **It is unfortunate that this program, which was highly regarded by students, has been removed in 2019 and that no replacement activities have been provided.**

- ***Standard 5.3* Assessment Feedback**

  Students continue to be disappointed in the feedback provided by the Adelaide Medical School, despite this being a focus of student advocacy for several years. This has been escalated by student representatives to Year Level Advisors, the Year 1-3 and Year 4-6 Course Committees respective, the MBBS Program Coordinator, the Dean, and the AMS Programs Board, as well as being documented by students in the eSELTs. Students do not find the feedback to be helpful in focusing on improving their personal areas of weakness.

- ***Standard 6.1* Monitoring**

The inadequacy of eSELTs (Evaluation of Student Experience of Learning and Teaching) as a tool for evaluation remains a largely unchanged problem despite ongoing student feedback, including escalation to the MBBS Program Coordinator, the Dean and AMS Programs Board. The Adelaide Medical School does not respond quickly or effectively to concerns about the quality of any aspect of the medical program.

- ***Standard 7.3* Student Support**

  Unfortunately, **the AMSS has significant concerns about student health and wellbeing.** Students have substantial concerns that the Adelaide Medical School is unsupportive of absences related to mental health, does not provide easy access to student support services, does not adequately prevent bullying and sexual harassment, does not separate the provision of student support from academic decision-making, and does not provide adequate support to Indigenous students.

- ***Standard 8.1* Physical Facilities**

  The new Adelaide Health and Medical Sciences (AHMS) building has provided medical students with access to state-of-the-art simulation facilities. However, the AMSS recognises it is difficult to give negative feedback about a new building, especially one that was costly to build. Unfortunately students have concerns that **it is not currently fit-for-purpose based on five key factors (all of which represent simple alterations that would greatly improve student satisfaction**): the lack of quiet study space available for students, the lack of private space available to be used for Student Counselling Services, and the lack of dedicated safe study space for Indigenous students.

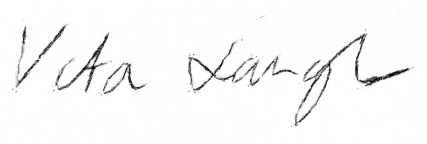
The AMC must carefully consider this data to ensure that high standards of medical education are upheld, especially as the Adelaide Medical School transitions to its new BMD medical program. The educational experience of medical students is paramount to achieving optimal long term health outcomes for Australia. Student opinion must be acted upon to ensure this occurs. Given the current climate of the Adelaide Medical School, the AMSS believes that medical students have a limited capacity to advocate for themselves and that the AMC accreditation process represents a critical opportunity for student feedback to lead to vital improvements in the medical program. This is due to a decline in opportunities for student representation (*standard 7.5*) by the Adelaide Medical School and Faculty of Health and Medical Sciences.

Overall, student opinion does not unreservedly endorse the medical program, and this document raises **serious concerns regarding the adequacy of resources available** for the continued delivery of the medical program, and suggests that the transition to the new BMD medical program may pose a significant threat to current medical students. **The AMSS does not endorse the medical program in meeting *Standard 1.8, Standard 3.4, Standard 4.7, Standard 5.3, Standard 6.1, Standard 7.3* or *Standard 8.1*. The broad picture is of a concerned student body that perceives the delivery of the medical program to be on an inexorable decline, and that this is unlikely to be reversed with implementation of the new BMD medical program.**

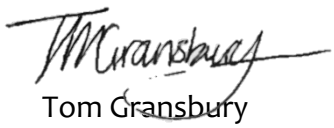
Lastly, we acknowledge the efforts of other students who were involved in creating this student submission, as listed below:

- **Teham Ahmad** Junior Education Officer
- **Emily Hammond** Rural Representative (Year 5)
- **Ella Obst** Year 4 Education Representative
- **Sridharnya Sirikrishnabala** Year 3 Education Representative
- **Don Kieu** Year 3 Education Representative
- **Kaviya Kalyanasundaram** Year 2 Education Representative
- **Neel Mishra** Year 2 Education Representative
- **Kseniia Bogatyreva** Team Education Secretary
- **Daniel Sansome** Honours student

The AMSS calls on the AMC to carefully consider this submission and act accordingly, given that this is a crucial time in the transition to the new BMD medical program. We sincerely thank the AMC for the opportunity to submit this document and would be very happy to provide any additional information.



Victoria Langton
Vice President (Education)



Tom Gransbury
President

On behalf of the Adelaide Medical Students' Society

Contents

Acronyms

Common Phrases

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

Teaching components

CBL	means Case Based Learning
MPPD	means Medical Professional and Personal Development
SMTS	means School of Medicine Teaching Series
TTIP	means Transition to Internship Program

Clinical Placements

SHU	means Core Surgery Placement (Surgical Home Unit)
MHU	means Core Medicine Placement (Medical Home Unit)
MSK	means Musculoskeletal Medicine Placement
Psych	means Psychiatry
O&G	means Obstetrics and Gynaecology Placement
Paeds	means Paediatrics Placement
Geris	means Geriatrics Placement
GP	means General Practice Placement

Buildings

AHMS	means the Adelaide Health and Medical Sciences building

Methods

Survey design

The survey used to collect data for this student submission contained questions tailored to each Year Level. Respondents submitted opinions regarding the Year Level they expect to complete in 2019. The specific formats of the survey questions are described in the body of this report. In general, Likert scales without neutral midpoints were used to minimise central tendency bias. All questions included a 'cannot respond' response category to ensure respondents were not forced to make a statement that they did not agree with. At the end the questions, respondents were asked to explain their answers via an optional free-text field.

Survey promotion

Participation was promoted to all students enrolled in the Adelaide Medical School medical program in 2019. A cash prize of $50, as well as 3 merchandise prizes, were funded by the AMSS and randomly provided to respondents to encourage participation. 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 were included in this analysis. We considered both mode and mean values were considered in the analysis of Likert scale data. Graphs of responses to Likert scales were included to assist in data interpretation.

The following criteria were applied when categorising data from Likert scales from -2 to +2 with no neutral mid-point.

- Positive response = mode > 0 AND mean > +0.4
- Negative response = mode < 0 AND mean < -0.4
- Equivocal response = mode = 0 OR $-0.4 \leq \text{mean} \leq +0.4$

We 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 was merely to identify the areas that student opinion would suggest require additional attention. 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.

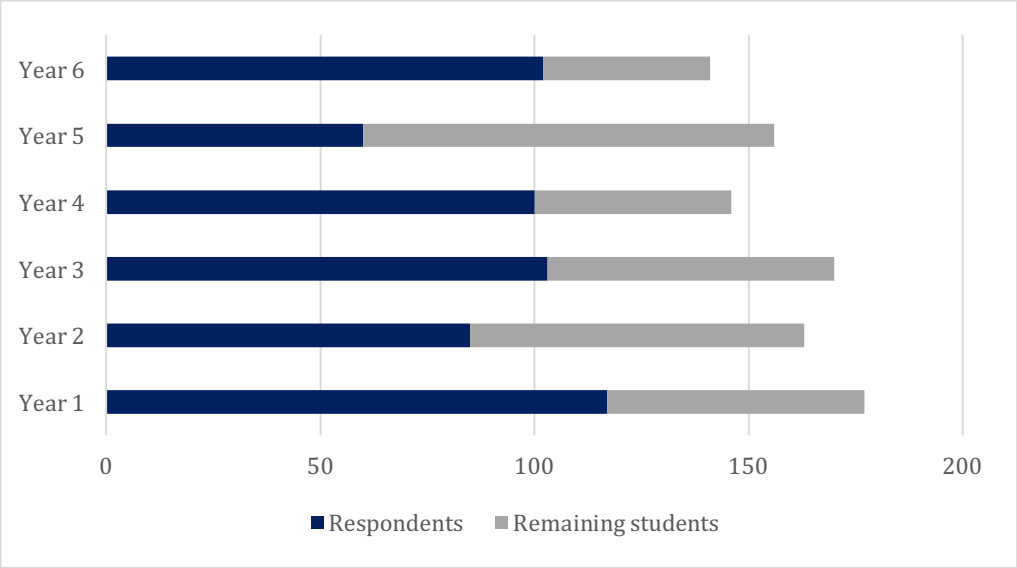
We have attempted to fully describe all data arising from the primary survey informing this document, regardless of whether they were categorised as positive or equivocal or negative. We have not included graphs for every Likert scale present in the primary survey, due to concerns regarding the length of the report. 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 has illustrated the excellent areas of the medical program, and also the areas that have improved in response to changes stemming from earlier feedback.

Demographics

The data presented in this report describes the responses of the 567 students who completed the survey. This equates to 59% of the 953 medical students at the Adelaide Medical School. The number of respondents per year level is demonstrated in the figure below (117 respondents of 177 Year 1 students, 85 respondents of 163 Year 2 students, 103 respondents of 170 Year 3 students, 100 respondents of 146 Year 4 students, 60 respondents of 156 Year 5 students, 102 respondents of 141 Year 6 students).

Figure 1: Respondents by Year Level



Limitations

Student Opinion

It is important to acknowledge that the survey and therefore this student 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 and appropriate.

Survey Timing

Due to the timing of release of the survey, students were unable to provide feedback in relation to 2019 semester 2 course content.

Response Rate

The adequacy of 567 responses (overall 59% response rate) is open to discussion and a higher response rate is always desirable to address the problem of selection bias. It is our view that obtaining a higher complete response rate to a survey of any useful length would be difficult.

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. Of the 567 respondents, 305 responses were from preclinical students (117 respondents from Year 1 students, 85 respondents from Year 2 students, 103 respondents from Year 3 students) and 262 responses from clinical students (100 respondents from Year 4 students, 60 respondents from Year 5 students, 102 respondents from Year 6 students). This slight bias towards preclinical students has the potential to confound accurate representation of general student opinion. We have attempted to mitigate the impact of this by reporting our findings broken down into preclinical and clinical groups. 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.

Central Tendency Bias

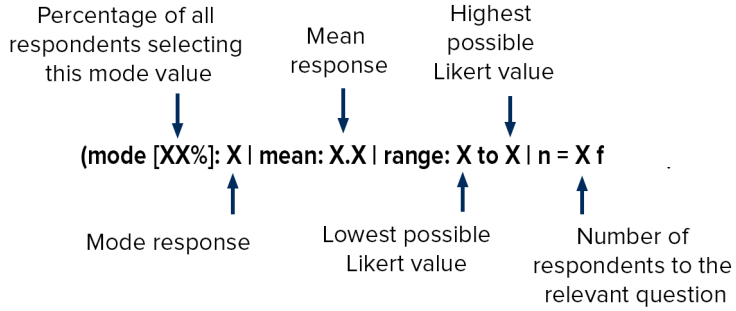
The use of Likert scales, which was extensive in the survey used to inform this document, is unavoidably associated with central tendency bias. We attempted to mitigate the impact of central tendency bias by avoiding the inclusion of neutral mid-point responses where appropriate. Nonetheless it remains 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.

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 using neutral wording throughout the survey.

Data Presentation

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



Standard 1.8 | Staff Resources

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

Availability of Lecture Notes and Lecture Recordings

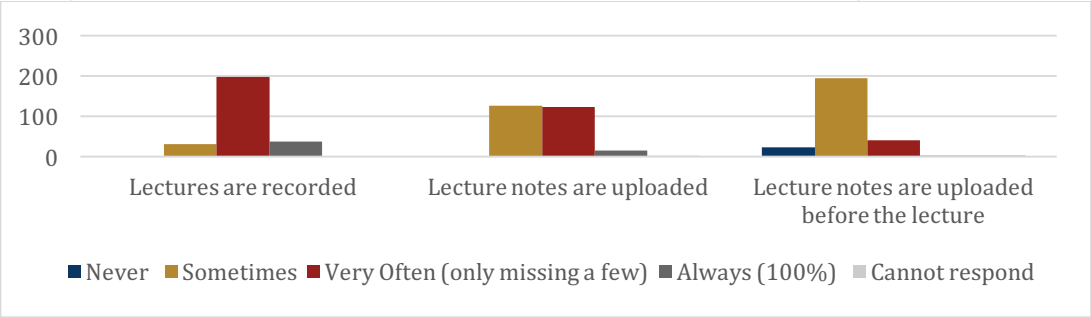
Method

Students in all year levels were asked to evaluate their access to lecture notes with the following statement **"In 2019, I find that:"** with three subparts **"Lectures are recorded"** and **"Lecture notes are uploaded"** and **"Lecture notes are uploaded *before the lecture*"**. Answers were obtained via Likert scale from -2 (representing never) to +2 (representing always). 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 free-text field.

Preclinical Results

Students agreed that lectures were recorded very often (mode [74%]: +1 | mean: +0.9 | range: -2 to +2 | n = 268). Students agreed that lecture notes were only uploaded sometimes (mode [47%]: -1 | mean: +0.1 | range: -2 to +2 | n = 268). Students disagreed that lecture notes were uploaded before the lecture (mode [73%]: -1 | mean: +0.70 | range: -2 to +2 | n = 267).

Figure 2: Availability of Lecture Notes and Lecture Recordings (preclinical)



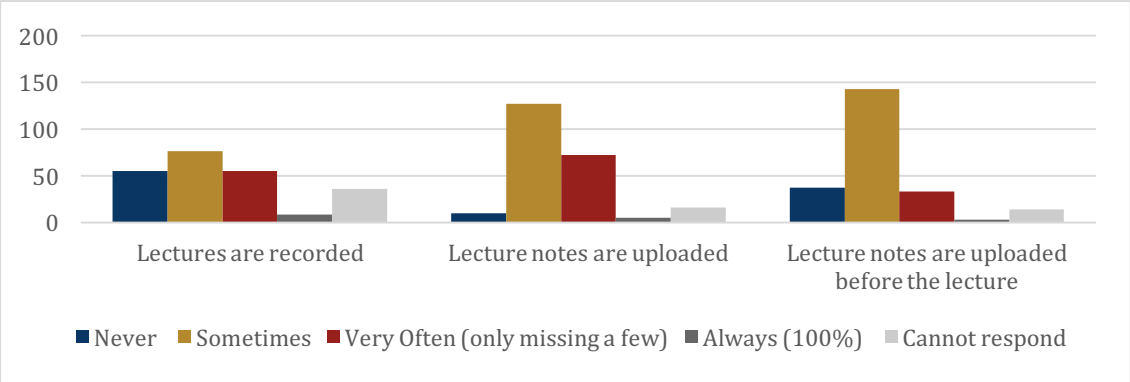
Furthermore, 64 free-text responses suggested a more negative opinion (13 from Year 1 students, 19 from Year 2 students, and 32 from Year 3 students). The majority of the free-text responses focused on lecture notes being unavailable prior to the lecture (45 comments), and that this inhibited preparation for the lecture and consequently made it harder to learn during the lecture. Example comments include: **"It is rare that the lecture notes are uploaded before a lecture, which is extremely frustrating because many of us work best when we have the**

notes available to us beforehand. It is something that never seems to be able to be corrected no matter how much the students push for this." and **"Lecture notes are uploaded maybe [half] the time and almost never before the lecture (which is preferred by most students). Despite constant requests, the medical school is not improving in this regard."** and **"… lecture slides are almost never uploaded before the lecture, and are often not uploaded at all"** and **"Lecture notes before the lecture would greatly help with the comprehension of material"** and **"The only reason why I no longer attend lectures [is] because I would much rather have the notes with me in the lecture, and they are rarely, if ever, uploaded before the lecture… Sometimes notes are not even uploaded at all, or are very late and this impeded the efficiency of my learning and effectiveness of lectures".** Other significant themes included the inconsistent recording of Year 3 clinical practice lectures (5 comments) and the inconsistent recording of lectures at the beginning of each semester (3 comments).

Clinical Results

Students agreed that lectures were only recorded sometimes (mode [33%]: -1 | mean: -0.6 | range: -2 to +2 | n = 230) and that lecture notes were only uploaded sometimes (mode [55%]: -1 | mean: -0.3 | range: -2 to +2 | n = 230). Students disagreed that lecture notes were uploaded before the lecture (mode [62%]: -1 | mean: -0.8 | range: -2 to +2 | n = 230).

Figure 3: Availability of Lecture Notes and Lecture Recordings (clinical)



Furthermore, 41 free-text responses suggested a more negative opinion (20 from Year 4 students, 12 from Year 5 students, and 9 from Year 6 students). The majority of the free-text responses focused on lecture notes being unavailable prior to the lecture (35 comments). Worryingly, 7 of the 20 free-text responses from Year 4 students explained that it was the responsibility of students attending the lecture to obtain the lecture notes from the lecturer, rather than Adelaide Medical School staff. Example comments include: **"We have to get the slides from the lecturer directly and distribute them ourselves in most cases"** and **"Commonly [have] to get year level reps to get slides directly from [the] lecturer and upload them to the year level [Facebook] page"** and **"Oftentimes during SMTS sessions it is the students' responsibility to get the slides from the consultant at the start of the session to distribute to students at the beginning of the lecture"**. Furthermore, 6 of the 9 free-text responses from Year 6 students suggested that access to lecture notes required students to approach the lecturers themselves. Example comments include: **"Usually a student obtains the lecture notes from the lecturer to upload, not staff"** and **"I would often ask the lecturer's permission to have their slides and upload them to our year level page… much easier than trying to get the uni to do it promptly"** and **"Thanks to other students, we often get the lecture notes at some point, not necessarily because the medical school has uploaded them at all"** and **"Efforts to**

access and make lectures slides available seem to fall in large part to proactive members of the student cohort" and **"Lecture notes are almost never available prior to the lecture… most often we have to obtain them from the lecturer personally via USB [and] this is unideal".** To further illustrate this concerning point, a Year 5 student commented **"Lecturers are often under the impression that [their] notes will be uploaded and have sent [their notes] to [university] staff, but [university staff] don't send them on [to students]"** and a Year 4 student commented **"I sympathise with the consultants' frustration when they spend hours on updating lecture slides… only to have the uni somehow [not] to upload the lectures that the consultants [send by] email".**

Communications with staff

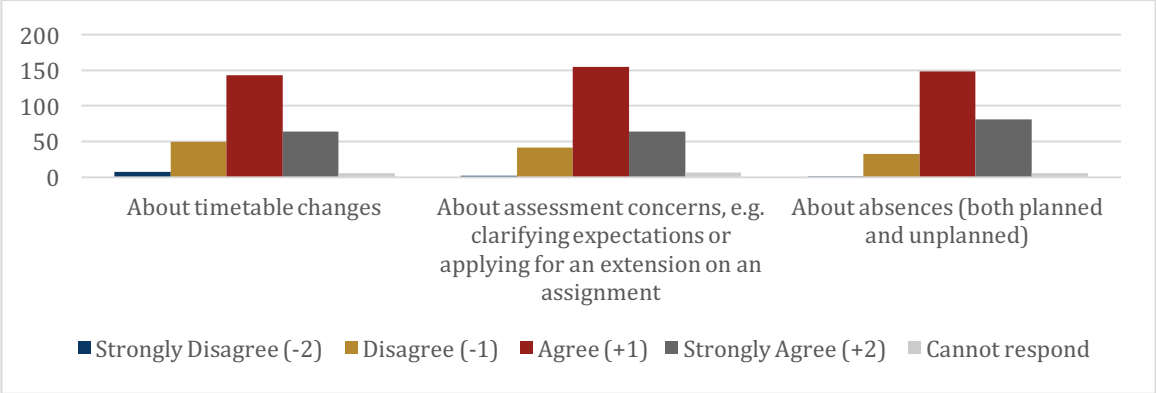
Method

Students in all year levels were asked to evaluate the efficacy of current administrative staff and services by rating their level of agreement based on the following three statements. Firstly, **"As a medical student, it has been made clear to me who to contact for common enquiries:"** with three subparts **"about timetable changes"** and **"about assessment concerns"** and **"about absences"**. Secondly, **"As a medical student, I receive prompt and clear communication from staff regarding"** with two subparts **"timetable changes"** and **"details of assessments"**. Thirdly, **"I find my interactions with staff to be useful/helpful and conducted in a polite and professional manner, without rude/unhelpful comments",** with clinical students answering this question in four subparts**: "interactions with administrative staff in person"** and **"interactions with academic/clinical staff in person"** and **"interactions with administrative staff via email"** and **"interactions with academic/clinical staff via email"**. Answers to these statements were obtained via Likert scale from -2 (representing strongly disagree) to +2 (representing strongly agree). For these statements no equivocal midpoint was provided to attempt to reduce central tendency bias. For these statements 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 free-text field.

Preclinical Results

Students agreed that it has been made clear who to contact for both timetable changes (mode [53%]: +1 | mean: +0.8 | range: -2 to +2 | n = 268) and assessment concerns (mode [58%]: +1 | mean: +0.9 | range: -2 to +2 | n = 268) and absences (mode [55%]: +1 | mean: +1.1 | range: -2 to +2 | n = 267).

Figure 4: Contacting Staff (preclinical)
"It has been made clear to me who to contact for common enquiries"



However, 26 free-text responses suggested a more negative opinion (4 from Year 1 students, 8 from Year 2 students, and 14 from Year 3 students). Example comments include: **"I have received contradictory information regarding absences [and] have been asked to refer to both the Year Level Coordinator, the [Course] Coordinator, and my tutor"** and **"It is disappointing that our key contact, our year level advisor, can be very unreliable in replying to emails"** and **"Sometimes when you send your leave absence form to the designated individual [in] the faculty – you get no response which is difficult because you don't really know whether they have received it or not"** and **"Year Level Coordinator, [Course] Coordinators, etc. – they each just forward us onto each other and it is never clear who to communicate with".**

Students agreed that they receive prompt communication from staff for both timetable changes (mode [56%]: +1 | mean: +0.9 | range: -2 to +2 | n = 268) and details of assessments (mode [62%]: +1 | mean: +0.8 | range: -2 to +2 | n = 268).

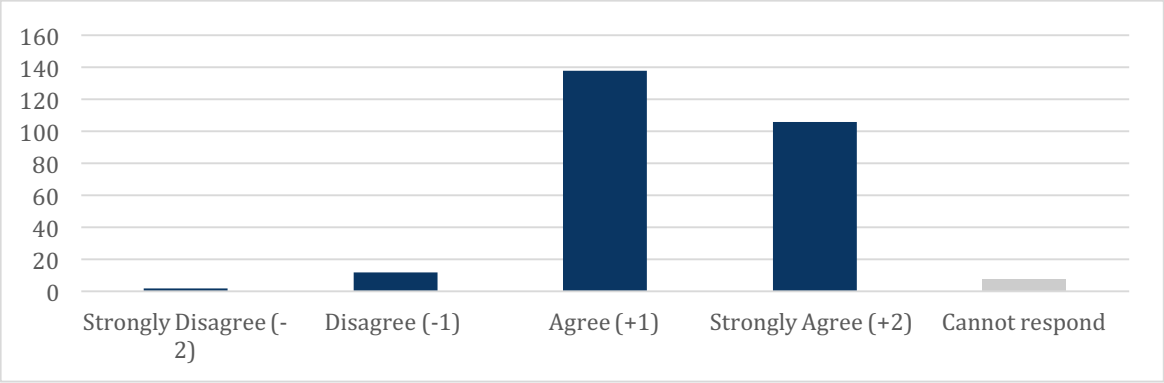
Figure 5: Receiving Communication from Staff (preclinical)
"I receive prompt and clear communication from staff"

However, 37 free-text responses suggested a more negative opinion (6 from Year 1 students, 10 from Year 2 students, and 21 from Year 3 students). The most common theme was the lack of timely communication regarding timetable changes (14 comments). Example comments include: **"Timetabling in general is poorly communicated. The distinction between compulsory activities and optional activities can become grey, especially certain workshops which are held in lecture theatres. If there are compulsory activities, these should be communicated clearly and well in advance so that students can make arrangements around them."** and **"Timetable changes are often completely last minute."** and **"Often, lectures are cancelled without any notice and students attend the time slot with no lecture delivered"** and **"Changes could be better communicated [and] also if lectures aren't going to be recorded it**

would be nice if this was communicated and done so with ample time to allow for rearrangement of work shifts etc." Another predominant theme was regarding unclear communication about assessment requirements (9 comments). **"It often takes time for assessment/changes in course details to be understood by myself, as they are often not clear, or come after significant numbers of emails sent from fellow students"**. However, there were 5 comments of a positive nature, the theme of which is most accurately illustrated by **"Communication is generally clear but not always prompt."** and **"Timetable changes are generally communicated promptly with online announcements… Assessment details and requirements are also usually provided adequately".**

Students agreed that they find interactions with staff to be useful and conducted in a professional manner (mode [62%]: +1 | mean: +0.8 | range: -2 to +2 | n = 268).

Figure 6: Interactions with Staff (preclinical)
"I find my interactions with staff to be helpful and conducted in a professional manner"

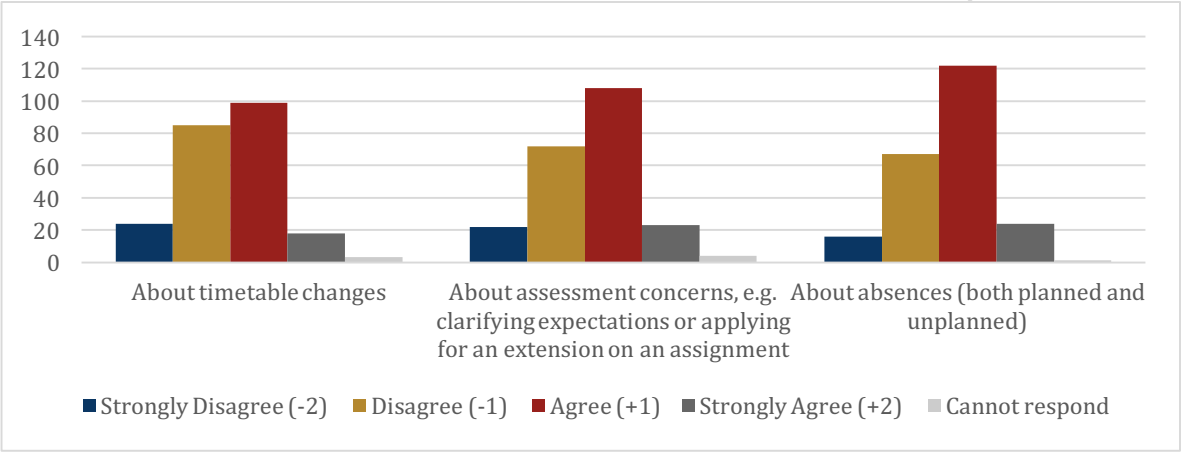


However, 19 free-text responses suggested a more negative opinion (3 from Year 1 students, 4 from Year 2 students, and 12 from Year 3 students). A concerning theme was the difficulty in receiving a response from staff (4 comments). Example comments include: **"A number of times [students] are simply not responded to, when emailing course coordinators, for many weeks, if at all, with sometimes pressing issues."** and **"It is hard to interact with staff when issues move slowly and often not in favour of students. Student representatives are much easier to talk to than staff are."** and **"Some interactions can come across as patronising or with a sense of superiority."**

Clinical Results

Students were equivocal regarding whether it has been made clear who to contact for both timetable changes (mode [43%]: +1 | mean: 0.0 | range: -2 to +2 | n = 229) and assessment concerns (mode [47%]: +1 | mean: +0.2 | range: -2 to +2 | n = 229) and absences (mode [53%]: +1 | mean: +0.3 | range: -2 to +2 | n = 230).

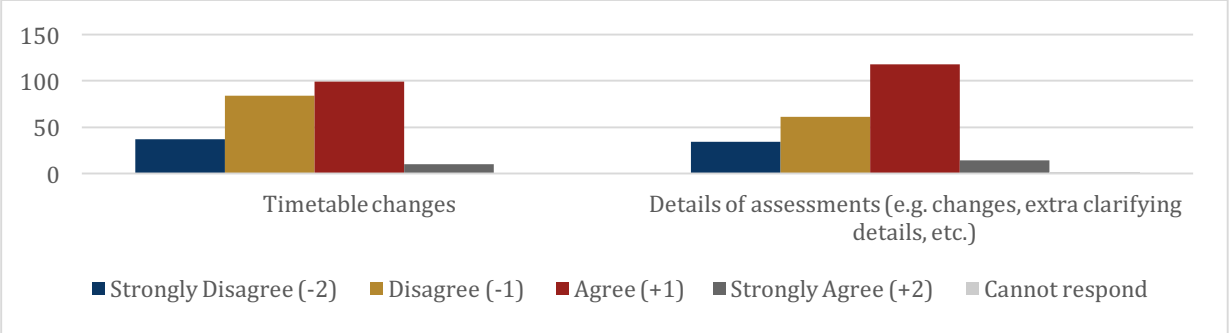
Figure 7: Contacting Staff (clinical)
"It has been made clear to me who to contact for common enquiries"



However, 50 free-text responses suggested a more negative opinion (17 from Year 4 students, 15 from Year 5 students, and 18 from Year 6 students). Students noted a lack of clarity for administrative contacts and subsequent difficulty in accessing assistance (20 comments), including some students reporting complete unawareness of who to contact (8 comments). Example comments include: **"Very unclear – and half the time if there is a designated person who is appointed to the course… they are often on leave or ignore the email."** and **"Have received conflicting advice from multiple people around who to speak to, who's responsible [for leave approval], [and the] exact order of leave process. Took seven weeks to be approved last time."** and **"Administrative staff [CP Team] can be VERY slow to reply to emails, namely, up to 5 weeks in my experience.".** Other themes included frustration with emails being redirected through multiple channels for a single issue (6 comments) and difficulty in finding relevant contacts for specific issues (6 comments). Example comments include: **"Assessment concerns [are] often regarded as 'someone else's role' to fix… and find that issues are pushed around and neglected e.g. Year 4 MSK concerns this year"** and **"Confusing as to who to contact for what. A lot of the time you end up having to chase emails and different people in circles to get your answer."** and **"Staff are often too slow to reply in the first instance, and usually are unable to help in any way other than to tell you to contact someone else."** and **"I have no idea who to contact… When I call to make an enquiry, my phone call is typically transferred 2-3 times before I reach the correct person and it seems that none of the staff even know who should be contacted. There is no way of finding which contact number is most appropriate."** and **"All requests are sent to a generic email or online portal. Issues are followed-up by a randomly allocated staff member, which may change without notice. Incident threads are [frequently] opened and subsequently lost by staff members. Relevant staff/student members are often accidentally not included in relevant communications."** and **"… I have found it difficult to know who to contact in sixth year. I also find our year level EdReps and AMSS council members are much more accessible and efficient in contacting and then providing information about either the issue or who to further contact".**

Students were equivocal regarding whether they receive prompt communication from staff for both timetable changes (mode [43%]: +1 | mean: -0.2 | range: -2 to +2 | n = 230) and details of assessments (mode [52%]: +1 | mean: +0.1 | range: -2 to +2 | n = 228).

Figure 8: Receiving Communication from Staff (clinical)
"I receive prompt and clear communication from staff"

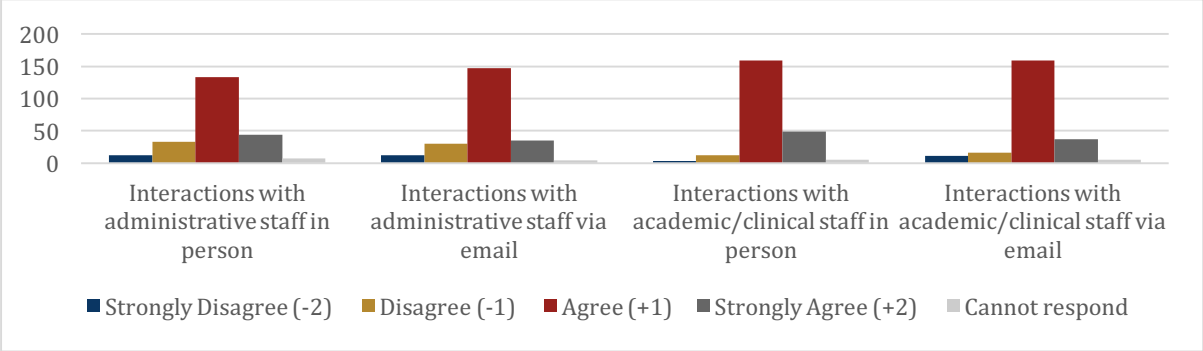


However, 57 free-text responses suggested a more negative opinion (27 from Year 4 students, 14 from Year 5 students, and 16 from Year 6 students). The most common theme was the lack of timely communication regarding timetable changes (23 comments), and that this has a negative impact on students' part-time work commitments. Example comments include: **"Timetable changes are almost never communicated properly, for instance one MHU tutorial was cancelled 15 minutes prior to the scheduled time, as a replacement tutor had not been organised despite the fact that [staff were] notified of the current tutor leaving weeks in advance"** and **"The notice for changing timetables is often extremely poor, often to the point that you can attend a [clinical] site that may be up to an hours' drive away to discover a timetable change made less than an hour ago"** and **"There have often been instances where cancellations have been made to tutorials and [students] weren't told at all. There's often significant time/money taken to travel to placements and [it] is extremely frustrating when this happens, especially if it's the only commitment you're going to the hospital for. I understand that some things are cancelled last minute and that can't be avoided. But I'm thinking of a few instances when the tutor has given staff ample time to communicate it to us and the message has never come through."** and **"Timetable changes are poorly communicated to both students and teaching clinicians at times – I personally have attended sessions where the clinician has cancelled and given notice, but students were not informed. I have similarly attended sessions where teaching clinicians were only asked to give the session with a day's notice."** and **"Usually timetables change without any notification of the change… An example was an ED tutorial [that I drove to] only to find out the start time had changed and the only notification was a single student being told who tried to circulate [the message] through student channels."**. Another predominant theme was regarding unclear communication about assessment requirements (11 comments). **"[Staff have] been [obstructive] at times when requests for public clarifications about assessment tasks [have been made], in particular in regard to exams"** and **"Timetable changes are regularly last minute and poorly communicated. Assessment details are often not provided to students until less than a week before, including the exact day of the assessment. The date and rough time should be given to students on day 1 of a rotation – the university knows when they are because they plan them well in advance – there is no reason to refuse (and in a rude tone) to let students know when their end of rotation assessment is."** and **"Wouldn't say it's prompt, and it's often very vague. I no longer go to Assessment [Information] lecture because I could read the information much more succinctly in the AMSS summary."** and **"A lot of information regarding our OSCEs and SHU quiz weren't given to us until the last 1-2 weeks of term"** and **"Assessment changes have also been bad, especially when our assessment sheet was changed retroactively on MHU and I'd already had my last day on the rotation and had it filled out. [I was] packed and ready to go rural… Common sense prevails and a lot of the time,**

[staff] don't exercise it." and **"Receiving extra information of details of assessments has also been difficult and caused a lot of stress, and without the EdReps advocating on our behalf I doubt we would ever get the information we need in a timely manner.".**

Students agreed that they find interactions with staff to be useful and conducted in a professional manner (mode [64%]: +1 | mean: +0.9 | range: -2 to +2 | n = 268).

Figure 9: Interactions with Staff (clinical)
"I find my interactions with staff to be helpful and conducted in a professional manner"



However, 41 free-text responses suggested a more negative opinion (19 from Year 4 students, 13 from Year 5 students, and 9 from Year 6 students). The most common theme was interactions with administrative staff in particular can be difficult, obstructive and condescending (37 comments). Example comments include: **"While some staff in particular are quite helpful, often students find themselves being belittled for asking questions. It is the general consensus that bar a few members, the faculty is unapproachable and unwilling to help students."** and **"Clinical staff are generally polite and helpful, however they are invariable hard to contact and often require repeated emails/contact to gain a reply. With a few exceptions, administrative staff have a tendency to be overzealous, punitive, dismissive, and condescending. They can be wildly unpredictable and inconsistent, and rarely helpful. The best reply from an administrative staff member is no reply."** and **"In all experiences with the precinct offers (our only uni staff contact from hospital) I have either been told to 1. Sort it out myself 2. There's nothing they can do (despite having the proper documentation) to change anything 3. Have been ignored on emails and refused any reasonable requests in person."** and **"My personal interactions with staff have been okay… However, I have heard of many instances from friends of a) emails being ignored for months, b) legitimate requests for leave being bounced around eternally between admin staff, c) forms not being signed by a deadline despite ample time [given], d) staff being curt/passive aggressive in their responses."** and **"I received a rather sarcastic email from one of the academic staff. It was rather distressing."** and **"Sometimes the precinct officers have been rude when asking questions about timetabling"** and **"Sometimes have experienced passive aggressive type comments via email, [especially] when asking for leave or explaining an unplanned absence"** and **"There have been a few instances where administrative staff haven't been polite and have been obstructive to simple requests (like returning an access card)."** and **"I have had extremely difficult issues with administrative staff being quite rude and almost nasty towards students which has felt almost as if it is a 'power play' – these staff have on occasion even exhibited behaviour that I would regard as bullying towards students however this has been poorly addressed by faculty when raised as a concern."** and "**[An] administrative officer at the Women's and Children's Hospital is incredibly difficult to work with. [They are frequently] rude without reason and never seem to have the best interest of students at heart. This was**

reported to the faculty who did not amend the situation." and **"I have found the administrative staff to be very rude via emails this year. After realising they had wrong or incorrect information there was no apology or admission of guilt."** and **"Administrative staff ('Ask Adelaide') in the med school on North Terrace are extremely unhelpful relating to MBBS issues/questions. Over several years they never seem to know the answer to any question, and aren't willing to look it up."** And **"I personally haven't had major issues with unhelpful email from admin staff, but I also am moderately scared to email these teams asking for what I'd like, having heard so many students getting back emails with very unhelpful comments. Most academic staff have been useful, however the MBBS Program Coordinator has been quite unhelpful and rude towards student representation… and this has been very disappointing."**

Near-peer teaching in the Medical Education Selective

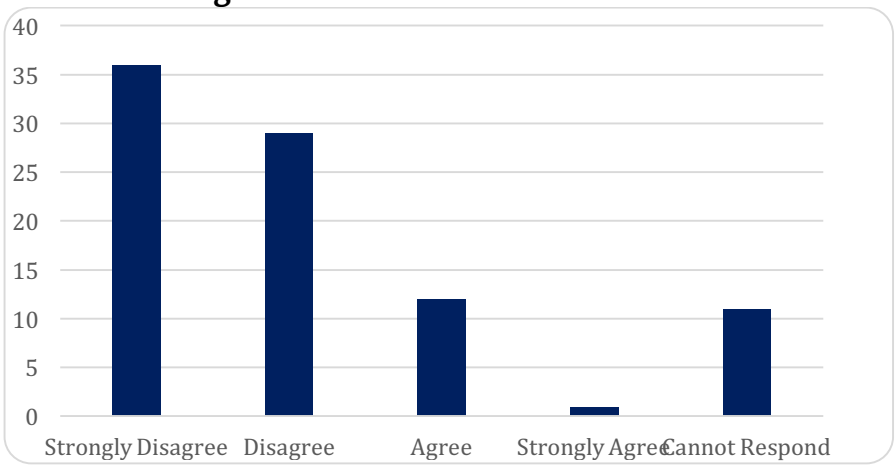
Method

Students in Year 6 were asked to evaluate their experience and opinion of the Medical Education Selective by rating their level of agreement based on the following statements **"I approve of the policy that Year 6 students completing the Medical Education Selective should NOT be paid"**. 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 free-text field.

Results

Students did not approve of the policy that Year 6 students completing the Medical Education Selective should NOT be paid (mode [64%]: -2 | mean: -1.1 | range: -2 to +2 | n = 89).

Figure 10: Medical Education Selective



Furthermore, all except one of the 25 free-text responses described a significantly negative opinion that is concordant with the above data. The most common theme was the lack of respect and outright discrimination towards Year 6 students who fulfil the same role as that of paid Adelaide Medical School employees. Example comments include: **"I understand it is difficult as SCAPs are [still] students, but they invest a lot of time and effort into a role that**

another person doing the equivalent for gets paid" and **"They work like any university employee does. So why should they not be paid?"** and **"We are filling a role that would otherwise be completed by doctors and clinical educations who would be paid a significant amount for their efforts, whereas the university uses us as free labour."** and **"[the SCAP rotation] is one of the highest workloads of all the 6th year medical placements, and it is frustrating to know that the doctor in the next cubicle who is doing the same job as you is getting paid while you are not."** and **"If you are 'working' for the medical school i.e. writing exam feedback, teaching classes, preparing projects, you should be compensated just as anyone else working in this role would be. It is not fair to pay other CBL tutors and in the next room the 6th year is doing the same job and not being paid."** and **"Due to the fact it is technically WORKING for the university and the hours are much longer and more intensive than other selective rotations it is appropriate that the policy returns to previous financial compensation (not full time pay) for students."** and **"[SCAPs] are contributing to the academic outcomes of the university and also working fulltime (preparation and teaching) in this role. To not pay them is an act of gross disrespect and a position of extremely disappointing 'pay-book before people' mentality by the faculty"** and **"SCAPs have a clearly described job/role description that matches/is equivalent to that of employed staff. SCAPs are acting [as] employees of the university in every way but title, conveniently avoiding entitlement to payment and conditions under the Fair Work Act"** and **"… The medical education selective offers students almost nothing in terms of furthering their education and teaching experience. Students are treated like free labour and are NOT integrated into the teaching team. Through my time on the medical education selective we had almost no supervision or oversight. I felt that nobody cared about our experience or learning on the rotation, despite the fact that the CBL and Clinical Skills programs are COMPLETELY reliant on students volunteering to be able to staff their programs. I have recommended other students do not [preference] the medical education selective for these reasons."** and **"We were asked to do work outside the scope of just teaching med students e.g. health sciences, nursing, and we worked long days, no doubt saving the med school money, therefore I think some degree of pay is necessary."** and **"This is why I didn't apply for this rotation this year. There is a lot of extra work that others are paid to do and I don't feel like being [free] labour in 6th year."**.

Conclusion of Standard 1.8

The Adelaide Medical School **does not meet** the sub-point under Standard 1.8 regarding sufficiency of administrative staffing, and does not have appropriate support staff to deliver the medical program. In 2016, under the Professional Services Reform, 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. The restructure of professional services was 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. **Lack of administrative staff links to a broad variety of issues, however the AMSS has chosen to highlight three of the most concerning issues: 1) the lack of lecture notes, 2) the difficulty of communicating with staff, and 3) the misuse of near-peer teaching in the Medical Education Selective.**

Lack of lecture notes

The lack of lecture notes has been a longstanding issue following the Professional Services Reform. Despite student representatives continually escalating the inadequacy of access to lecture notes at the Year 1-3 and Year 4-6 Course Committees respectively, as well as to the MBBS Program Coordinator and the Dean, staff continue to explain that the reason for lack of improvement in this area is insufficient staff resources. **The AMSS maintains that there should be enough staff resources for an employee of the Adelaide Medical School to allocate time to promptly collect and upload electronic lecture notes for medical students, as this is a core requirement of the delivery of the medical program.** Staff continually suggest that AMSS Education Representatives should take responsibility for collecting electronic lecture notes (e.g. PDF files, PowerPoint slides, etc.) from lecturers at the time of the relevant presentations. The students are then required to upload these documents. This request is made to all students across Years 1-6. There are two key aspects to this model that are unacceptable:

1. The prospective delivery of electronic lecture notes is important for students to be able to prepare for the lecture, and to maximise its educational value.

   Several students stated "**many of us work best when we have the notes available to us beforehand**".
2. The mechanism for students to upload lecture notes is not well facilitated, and thus students are currently without notes for many lectures.

The AMSS maintains that the lack of administrative staff should not be an explanation for the failure to provide lecture notes online. Electronic provision of core learning materials is a basic expectation of modern tertiary education. The AMSS also feels it is inappropriate to request that students accept responsibility for the delivery of central aspects of the medical program. There is an increasing focus on the delivery of educational material online, and this is likely to further increase in the transition to the new BMD medical program. Therefore, administrative staffing resources and information technology facilities must be increased commensurately. Measures to enhance lecture note availability, with increased communication with lecturers in the lead-up to lecture delivery, are strongly encouraged.

Difficulty communicating with staff

This can be broadly divided into two main issues: a lack of accessible, approachable and informed staff, and a lack of timely communication from staff.

1. A lack of accessible, approachable and informed staff is the main driver of students being unsure who to contact for common enquiries. One student commented: **"The AMSS has done an exceptional job in providing clear instruction regarding who to contact. The university however have made it less clear."** The difficulty in knowing who to contact for common enquires is further compounded by the **limited availability of informed administrative staff**. Access to an informed administrative staff member in person, who is able to respond promptly to medical students' enquiries, is often inaccessible during normal working hours. Once again, the reason cited for this by staff is insufficient administrative staffing to help students with their problems while simultaneously conducting necessary other tasks. Apart from being physically inaccessible (such as sitting in a staff area that students cannot access), they are also commonly uncontactable via phone during normal working hours, with the recommended number often going straight to voicemail, and have significant delays when communicating via email. Furthermore, a common anecdotal complaint is that when students do manage to approach an administrative staff member in person, this person is often unaware of the requirements of the medical program and is unable to

offer any advice, except **"please email (generic email address)"**. Students also find staff to be unapproachable, with one student stating, "**While some staff in particular are quite helpful, often students find themselves being belittled for asking questions. It is the general consensus that bar a few members, the faculty is unapproachable and unwilling to help students." It is concerning that there is insufficient administrative staffing to provide informed and readily available in-person support for medical students during normal working hours**.

2. Improvements in timely communication to students is desired. The AMSS acknowledges that generally, information regarding assignments, changes, clarifying details, and due dates is available in varying degrees to those who proactively seek it. However, as changes are occasionally signposted/ highlighted in the form or a notification or email, it is clear that better systems should be developed. **Students would prefer the consistent provision of a more comprehensive orientation with a focus on timetabling, and overview of the individual requirements and assessments to be completed ahead of the commencement of each course and clinical placement**.

Misuse of near-peer teaching in the Medical Education Selective

It is important to note that both preclinical and clinical students value opportunities for near-peer teaching. Preclinical students enjoy having the opportunity to ask questions of an experienced peer in a less threatening environment, as well as receiving explanations tailored to their level from someone who understands their needs and concerns. Similarly, clinical students value the opportunity to develop their teaching skills and derive satisfaction from feeling able to 'give back' to the medical program and 'pay it forward' from the help they received previously. **However, the AMSS maintains that near-peer teaching MOST DEFINITELY SHOULD NOT be relied upon to fill Adelaide Medical School employee staff shortages, nor used as a cost-saving measure. Unfortunately, it seems that the current Medical Education Selective, is doing both.**

The Medical Education Selective is a well-established and longstanding opportunity offered to students in Year 6. Students can preference this Selective as one of their five Selectives (normally clinical placements) in their Selective Semester of Year 6. If undertaken, students spend four weeks teaching medical students in Year 1 and Year 2, predominantly focused on facilitating CBL sessions and supervising Clinical Practice sessions. Year 6 students may also give lectures. Year 6 students who undertake this are colloquially referred to as 'SCAPs' (from the old terminology 'Student Community Ambulatory Placement'). Historically, students who undertook this Selective were paid by the University of Adelaide as a casual employee or contractor. Both the program and the payment policy were reviewed in 2017 in accordance with the Tertiary Education Quality and Standards Agency (TEQSA), and it was changed from a casual contract to payment via honorarium. In 2018, SCAPs ceased to be paid, and this has continued into 2019. During this change, additional alterations were made to the Medical Education Selective, including SCAPs supposedly being provided greater access to senior tutor supervision to ensure they benefitted from tuition. However, in practice this did not occur. The change caused significant distress to Year 6 students, and consequently the Medical Education Selective became substantially less popular. Accordingly, the presence of fewer SCAPs has increased each individual's workload, further intensifying the dissatisfaction. One Year 6 student's experience included being asked to continue their Selective into their holidays, as despite staff knowing that the Year 6 holiday period would create a shortage of SCAPs available to teach the preclinical students, the Adelaide Medical School had not recruited other teachers to cover this period. This Year 6 student was concerned that the preclinical students

would be left without a teacher if they declined, and so the Year 6 student worked as a SCAP through their holidays unpaid. In some cases, they were also required to act as a Standardised Patient (SP) given a shortage of SPs hired on that day. Likewise, preclinical students have become disgruntled at the lack of SCAPs, and therefore the lack of supervision in both CBL and Clinical Practice sessions. Furthermore, the AMSS has previously given positive feedback on lectures given by SCAPs (colloquially referred to as 'SCAP Wraps'). Unfortunately, in the context of fewer, busier Year 6 students, the frequency and quality of these have declined, much to preclinical student dissatisfaction.

This vicious cycle seems destined to continue unless something is drastically changed. **The AMSS maintains that it is unacceptable for the lack of available teachers to lead to the misuse of Year 6 medical students as a 'plug the gap' measure. Providing an adequate number of teachers is a basic expectation of modern tertiary education. It is inappropriate to request that students accept responsibility for the delivery of central aspects of the medical program by asking them to teach each other (unsupervised) core components of the medical program.** However, the AMSS hopes the implementation of measures to ensure lectures given by SCAPs continue to occur, even in the context of limitations such as low numbers of Medical Education Selective students. One Year 6 student's comment summarises the student opinion: **"[The Medical Education Selective] is an exploitative waste of students' time and should either be scrapped or reformed so that some effort is put into actually teaching the sixth years who give up 40 hours of their week for a month so the medical school doesn't have to actually pay for tutors".** One preclinical student's comment summarises the student opinion: "**Given the fees we pay to attend medical school I believe the teaching we receive does not meet the standard. For many CBL cases we had a tutor once as there were a significant lack of SCAPs. I find this unacceptable and I believe [this] was detrimental to me for my exams. Whilst I understand the importance of being able to teach yourself, this was relied on far too much by the medical school."**

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.'

Communication of Curriculum Objectives to Lectures, Tutors and Clinical Supervisors/Preceptors

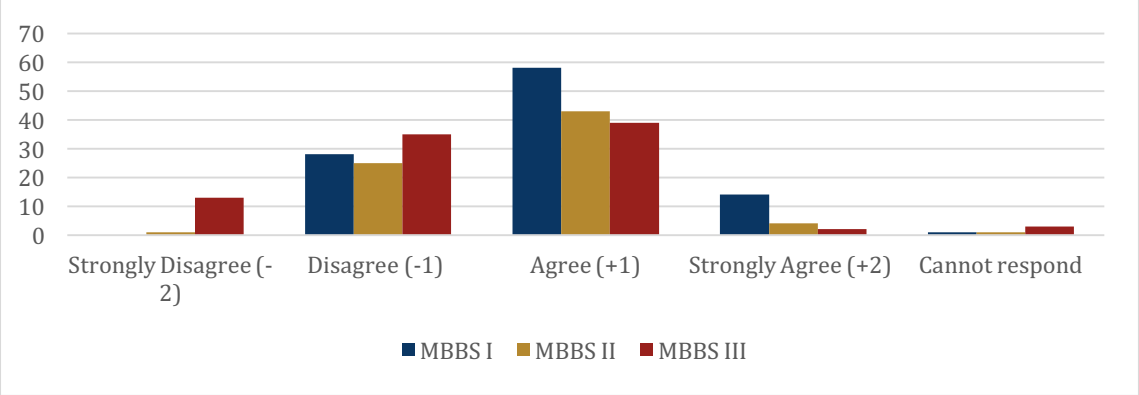
Method

Students in all year levels were asked to evaluate the efficacy of current lecture delivery by rating their 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."** Preclinical students were asked to evaluate the efficacy of their CBL tutors by rating their level of agreement based on the following statement **"Tutors are well-informed of:"** in three subparts **"the learning objectives"** and **"the depth of prior knowledge of student's in their tutorial group"** and **"the required knowledge of students in their tutorial group".** Clinical students were asked to evaluate the efficacy of their Clinical Supervisors/Preceptors by rating their level of agreement with the following statement **"Clinical supervisors and preceptors are well-informed of:"** in three subparts **"the learning objectives"** and **"the depth of prior knowledge of student's in their clinical placement"** and **"the required knowledge of students in their clinical placement".** 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 free-text field.

Preclinical Results

Students were overall equivocal in regards to how well-informed lecturers were on the scope of their lecture content and where their lecture fit in within the greater picture of the medical program (mode [53%]: +1 | mean: +0.2 | range: -2 to +2 | n = 267).

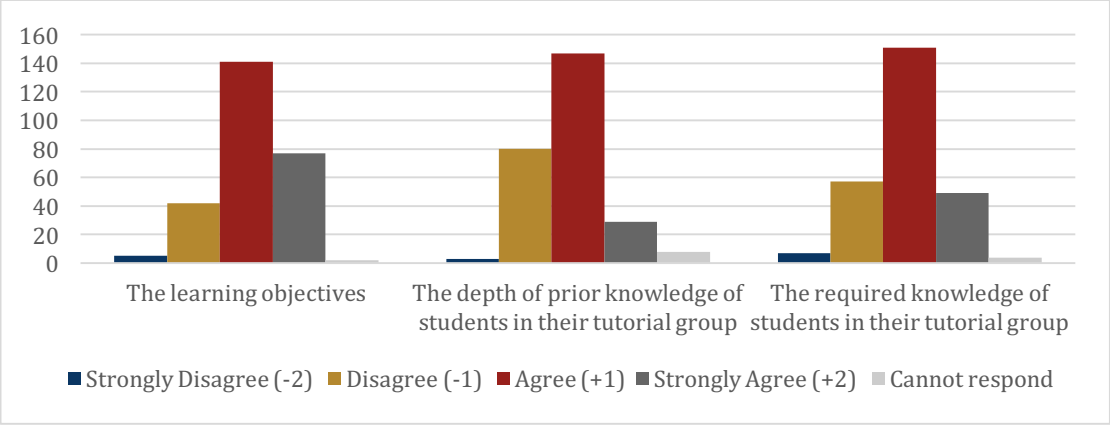
Figure 11: Lecturers are well-informed (preclinical)



However, 43 free-text responses from preclinical students suggested a more negative opinion, with 39 being particularly negative (12 from Year 1 students, 10 from Year 2 students, and 21 from Year 3 students). The most common view was that a lecturer's understanding of students' prior knowledge was dependent on their experience, and that this understanding varied widely (22 comments). Students expressed that lecturers were forced to ask students what they know, due to having no contact with Adelaide Medical School staff, such that they can then tailor their explanations appropriately (3 comments). Example comments include: **"In quite a few lectures the lecturer had to spend some time asking us whether a previous lecturer had already covered similar content… This suggests that lecturers are often uninformed about students' prior knowledge"** and **"Often lecturers will give one-off lectures and state 'let me know if this is too advanced or not' because I don't know what you guys know"** and **"I found lecturers are unsure about where we are at [in CBL cases], and what we have covered previously".** Another common theme was students' frustration at concepts not being taught well due to the lecturer's lack of matching to students' prior understanding (9 comments). Example comments include: "**Many lecturers don't even know [the CBL case] or the learning objectives which apply to their field of knowledge, meaning they either give us too much or too little or irrelevant information which I believe is not their fault"** and **"Some lectures are delivered to us when we lack the basic knowledge to comprehend the information."** Other predominant themes include extensive overlap with other lectures given for the same CBL case (3 comments). Example comments include: **"[Lectures are] often not related to what we need to know. Quite often lectures will cover the same thing without covering important other things that we're supposed to know. They are often either too simple or too difficult for our level of knowledge."** and **"[Often lectures] are very stand-alone, [lectures] haven't integrated with what we known/other lectures"** and **"Most lecturers are told nothing about where their lecture fits in with the course"** and **"Often the lectures are not relevant or the lecturer hasn't received appropriate information on what the objectives are for the lecture."** and **"I find nearly every lecture contains a great deal of irrelevant content and often lecturers are unaware of our current knowledge level or what we have had talks on prior to their lecture".** Other predominant themes include lectures not specifying assumed knowledge or stating clear lecture objectives (9 comments).

Students agreed that CBL tutors were well-informed in guiding students to the required level of knowledge while taking into account their prior knowledge. Students agreed that CBL tutors were well-informed regarding learning objectives (mode [53%]: +1 | mean: +0.9 | range: -2 to +2 | n = 267), depth of prior knowledge of students (mode [55%]: +1 | mean: +0.5 | range: -2 to +2 | n = 267) and required knowledge of students (mode [56%]: +1 | mean: +0.7 | range: -2 to +2 | n = 268).

Figure 12: Tutors are well-informed (preclinical)

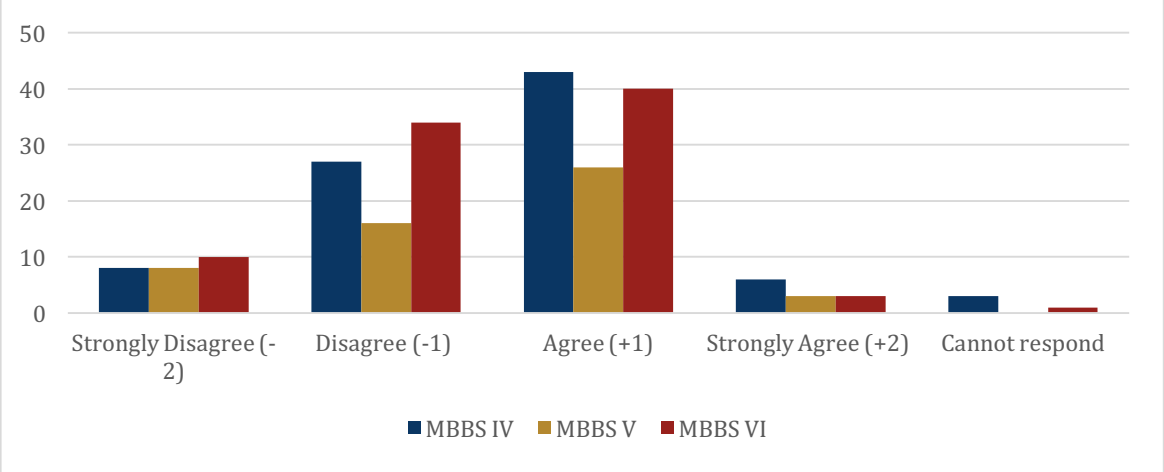


However, 30 of 41 free-text responses were of a negative opinion (6 from Year 1 students, 19 from Year 2 students, and 16 from Year 3 students). A prominent theme mentioned was that tutors did not appropriately guide groups to cover learning objectives (17 comments), with 8 comments suggesting the CBL tutors were unaware of the necessary knowledge required by students, or were not provided learning objectives. These comments were predominantly from Year 2 students (12 comments) and Year 3 students (5 comments). Students also mentioned the variability between CBL groups, stating that this reflected disparity in CBL tutors and caused students significant stress (8 comments). One student commented: **"The depth of knowledge my CBL group was expected to show was sometimes very little in comparison to other groups when discussing with friends from other groups. This seemed to point to the fact that our tutor/supervisor (e.g. SCAP) was unaware of the expected objectives/didn't direct us towards the objectives."**

Clinical Results

Students were overall equivocal in regards to how well lecturers were informed on the scope of their lecture content and where their lecture fit in within the greater picture of the medical program (mode [48%]: +1 | mean: 0.0 | range: -2 to +2 | n = 228).

Figure 13: Lecturers are well-informed (clinical)

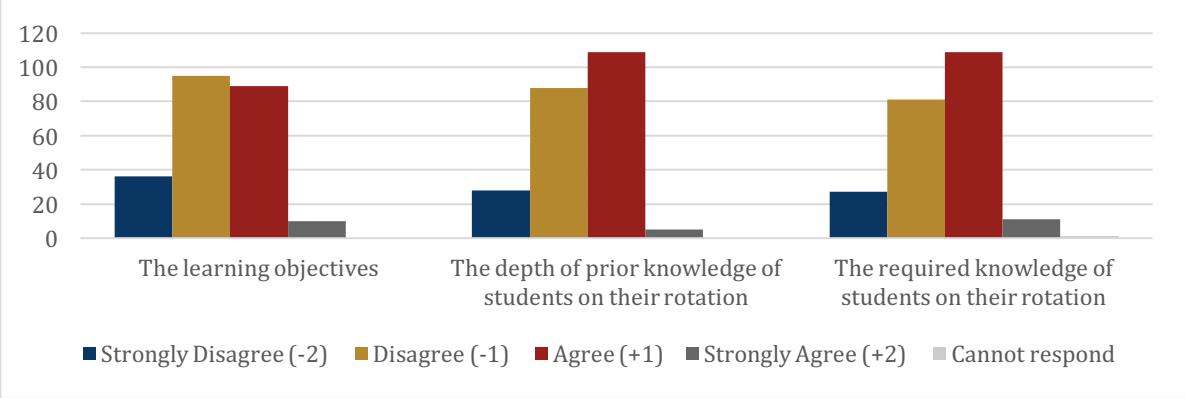


Furthermore, 30 of the 43 free-text responses indicated a more negative opinion (17 from Year 4 students, 13 from Year 5 students, and 13 from Year 6 students). The most common view was

that lecturers are unaware of the level of prior knowledge that students have or what has been covered previously (20 comments). Example comments include: **"I would be shocked to know if lecturers/preceptors were given any information about our current learning objectives let alone prior knowledge"** and **"Multiple lecturers have to literally ask us what we've been taught because they were given no background [information]"**. Multiple comments were also critical of identical content being repeated in subsequent sessions (16 comments) and that some lectures cover content covered by another recent lecture (7 comments). Example comments include: **"Many different clinical academics teaching into the program, and indeed on the same topics/areas results in lots of teaching overlap, but even more concerning, in large holes in teaching topics"** and **"The most common start to a lecture is 'let me know if you have already covered this' or words to that effect".** Other predominant themes included that there is large variability in quality and depth of lectures, with some being quite specialised (9 comments). However, 8 responses indicated a positive opinion with students expressing that Year 6 TTIP lectures have been very useful (3 comments).

Students were equivocal in regards to how well-informed clinical supervisors and preceptors were in guiding students on their clinical placement to the required level of knowledge while taking into account their prior knowledge. Students were equivocal that clinical supervisors were well-informed regarding learning objectives (mode [41%]: +1 | mean: +0.3 | range: -2 to +2 | n = 230), depth of prior knowledge of students (mode [47%]: +1 | mean: +0.1 | range: -2 to +2 | n = 230) and required knowledge of students (mode [48%]: +1 | mean: 0.0 | range: -2 to +2 | n = 229).

Figure 14: Clinical supervisors are well-informed (clinical)



However, the 62 free-text responses suggested a more negative opinion (23 from Year 4 students, 19 from Year 5 students, and 20 from Year 6 students). The most common view was that there was a high degree of variability with some supervisors having no idea of the expectations of students or the level of knowledge required (11 comments) but others being well informed (6 comments). Furthermore, several students suggested that the lack of clear objectives for students makes asking supervisors to be aware of objectives impossible, as well as suggestions that supervisors were unlikely to have read/received course objectives from the Adelaide Medical School (4 comments). Example comments include: **"Clinical supervisors are almost never aware of what we are expected to know before the rotation, and what knowledge we are expected to acquire on the rotation. This raises difficulties when doctors are exceptionally disappointed in our lack of knowledge, or when they show no interest in engaging us in a way that is relevant to our learning objectives."** and **"There still seems to be quite a lot of variability in terms of [supervisors'] understanding of our objectives. It would be very useful for them to have a list of objectives… However, it feels quite demanding for us as**

students to impose those objectives on them – much more something the university [should] provide." and **"[my preceptor] has no information about my course, and doesn't know what prior experience and teaching I've had (or haven't had)… [and] doesn't seem to know the required knowledge or learning objectives as he always asks us to come up with the topics for tutorials or write our own practice exam questions.**" and **"Even consultants have mentioned (multiple times!) that they have no idea what they're supposed to teach us"** and **"Although I've often had good supervisors, I wouldn't say they usually know what I need to know or what my learning objectives are… They don't really seem that informed about what we need to do.".** Finally, one student summarised the difficulty of lecturer's knowing the objectives was also present for students: **"We as students are not even informed about the faculty's learning objectives for most components of the course because they either a) Don't exist or b) Written by the students themselves"**. Another predominant theme was that many supervisors prioritise more 'specialised' knowledge over awareness of broader content (4 comments).

Conclusion of Standard 3.4

The Adelaide Medical School **does not meet** the sub-point under Standard 3.4 regarding the communication of curriculum objectives to lecturers, tutors and clinical supervisors. Given students experience teaching from a wide range of clinicians who are otherwise not involved with the medical program, it is imperative that specific learning objectives and outcomes are communicated to lecturers and clinical supervisors. Furthermore, lecturers must be given access to objectives of other lecturers in order to streamline lecture delivery and avoid unnecessary repetition. **Unfortunately, the communication of this information is variable and thus remains an area for improvement.** This issue has been previously identified as an area for improvement in the 2017 and 2018 AMC student submissions, and has been escalated by student representatives to several Course Coordinators and at both Year 1-3 and Year 4-6 Course Committees in the past, yet no progress has occurred. However, the AMSS believes that student-staff collaborations aimed at addressing these issues (e.g. student-staff co-created learning objectives and the 2018 Year 1-3 Lecture Review) are encouraging, despite being heavily reliant on student time, effort and leadership. In particular, the 2018 Lecture Review is crucial to this process. This was a student-led project that aimed to map every lecture given to preclinical students across Years 1-3, identify unnecessary repetition and poorly performing lectures, and create a more streamlined and cohesive lecture timetable that allowed lectures to work synergistically in a linked manner, rather than as stand-alone teaching items. Students are hopeful that some suggestions will be implemented in Semester 2 2019, however the outcome of this remains unclear.

Furthermore, the underlying cause of this ongoing issue and **a major concern of students is the lack of a clear, well-documented curriculum *(standard 3.2, standard 3.3, & standard 3.4)***. This was not directly explored in the survey as it is already a condition for AMC accreditation which students have seen no progress on in the past three years. **The AMSS maintains that it is unacceptable for a medical program to lack a clearly defined curriculum. A thorough, transparent curriculum that guides all teaching and learning activities is a basic expectation of modern tertiary education, and even more so in in an area as multifaceted and complex as medical education.** While the AMSS acknowledges the benefits of self-directed learning, it remains inappropriate to request that students accept responsibility for identifying the focus of the medical program and deciding for themselves what should be learnt. **Furthermore, the AMSS believes it is unacceptable for the Adelaide Medical School to have continued delaying mapping the curriculum for the past three years, despite it being a condition for AMC**

accreditation. Students are consistently told that 'the curriculum is being mapped' or 'the curriculum is being documented' or 'It's done, just not accessible in a user friendly format' or 'It's done, we just need different software'. Despite this, over the last three years, students have seen no evidence of such a curriculum. After review of the Adelaide Medical School staff submission to the AMC for 2019, including associated appendices, the AMSS remains sceptical that meaningful progress on curriculum mapping is being made. The AMSS is unable to comment on what curriculum documentation has been previously sent to the AMC as this is the first time we have received the AMC staff submission. The AMSS is certain there has been no curriculum map provided to students, nor any statement as to how such a map would be developed into something useful for students. The example curriculum map does not inspire confidence that any significant progress has been made towards the promised "comprehensive and detailed repository" nor provides any insight into whether it will be able to be converted to a "user-friendly searchable" format through the proposed E-lumen program. It is apparent that the individual reviewing aspects of each course has done so in a superficial manner from a seemingly non-clinical standpoint. The AMSS fears that this process has failed to identify duplication or omission of core learning materials, and has instead collated individual points (e.g. lecturer's objectives) rather than identifying concepts and underlying learning themes in the mapping process. **Furthermore, considering the current inactivity of the Adelaide Medical School on this issue, students are worried that with the new BMD medical program being implemented as a 'Minor Change' rather than a 'Major Change' as per AMC accreditation, that there will be no accountability for staff to ensure the new BMD medical program has a curriculum by the start date (planned 2021).**

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'

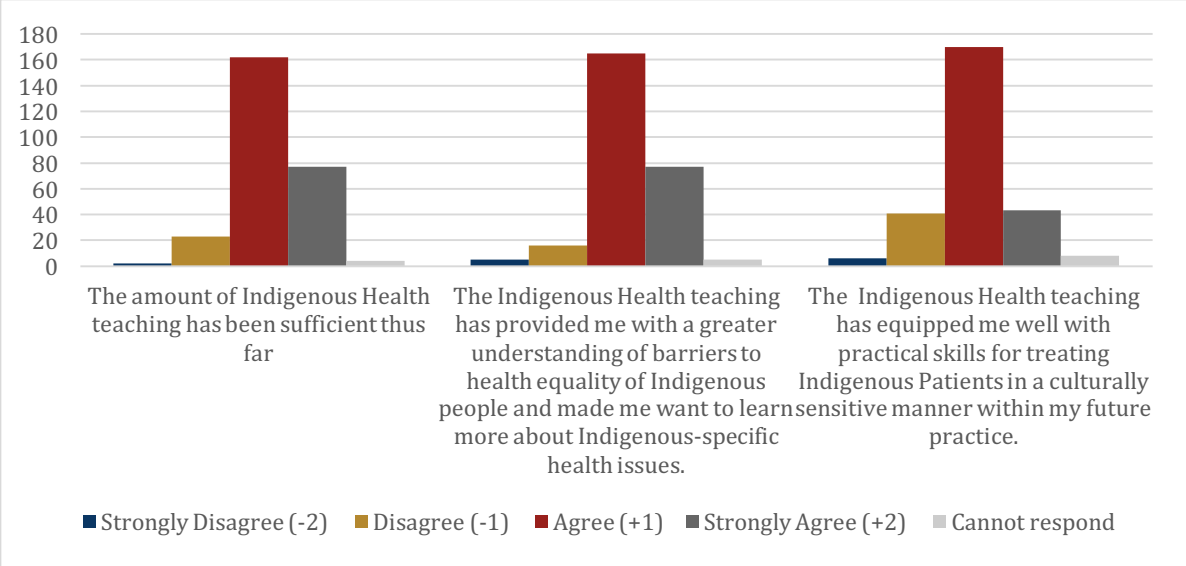
Method

Students in all year levels were asked to evaluate the efficacy of the current teaching of Indigenous Health by rating their level of agreement based on the following three 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"** and **"The Indigenous Health teaching has equipped me well with practical skills for treating Indigenous Patients in a culturally sensitive manner within my future practice".** 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 free-text field.

Preclinical Results

Students agreed that the new method of teaching Indigenous Health has been sufficient thus far (mode [60%]: +1 | mean: +1.1 | range: -2 to +2 | n = 268), that it had provided them with an understanding of barriers to health equality (mode [62%]: +1 | mean: +1.1 | range: -2 to +2 | n = 268), and given them practical skills for treating Indigenous Patients in a culturally sensitive manner (mode [63%]: +1 | mean: +0.8 | range: -2 to +2 | n = 268).

Figure 15: Indigenous Health (preclinical)



Interestingly, from the 38 free-text responses, there were 15 positive responses and 12 negative responses (10 from Year 1 students, 11 from Year 2 students, and 17 from Year 3 students). Year 1 students maintained their positive opinion, whereas Year 3 students demonstrated a more negative opinion.

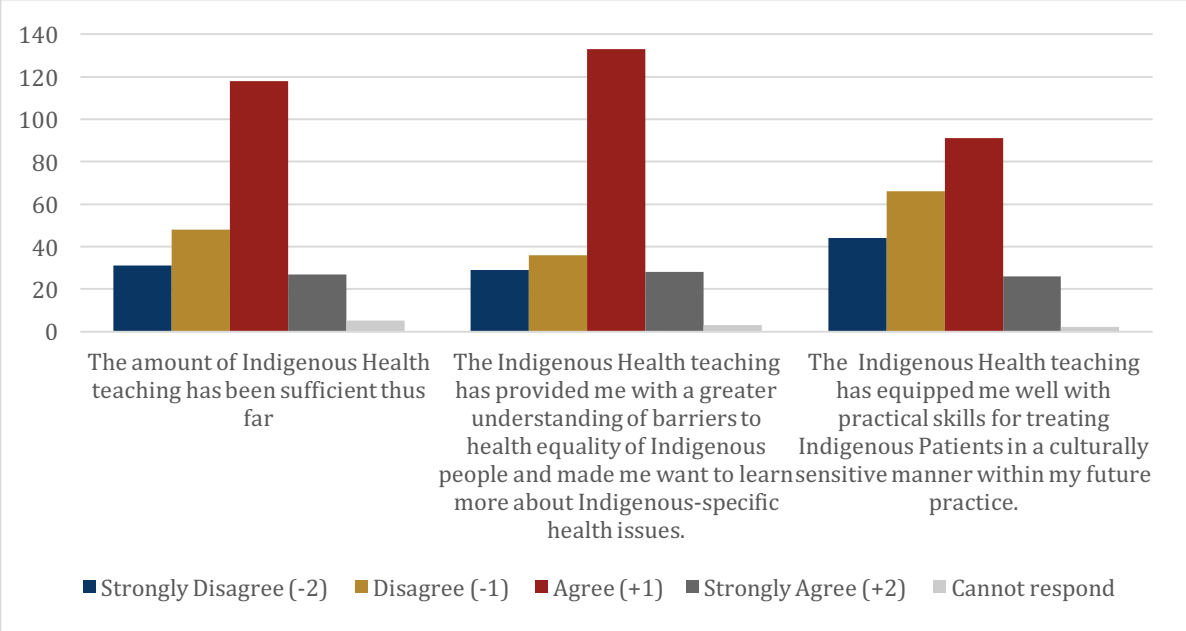
Pleasingly 15 responses indicated a positive opinion, with students expressing the teaching was sufficient (9 comments) and insightful (4 comments). These opinions were predominantly held by Year 1 students (7 comments). One Year 1 student commented: **"The sessions this year were insightful and I loved the chance we were given with the 'Circles of Knowledge' to talk with Aboriginal elders and senior members of the Aboriginal communities for their insights on the health system".**

The negative responses were predominantly from Year 3 students (9 comments) and Year 2 students (6 comments). The most common negative view was the teaching of Indigenous Health did not provide sufficient practical exposure to Indigenous patients (19 comments). One student commented: **"The dedicated sessions of Indigenous Health teaching have exposed the equality issues and disadvantages faced by Indigenous populations. However, I feel that practical skills to communicate with Indigenous patients have not been taught well, with only a set of inflexible rules on things to avoid being provided. I feel these rules would not work in a practical setting, especially considering the cultural diversity of Indigenous populations."** Other predominant negative themes included the teaching being repetitive (3 comments) and not providing new insight into Indigenous Health (4 comments).

Clinical Results

Students were equivocal that the current teaching of Indigenous Health has been sufficient thus far (mode [52%]: +1 | mean: +0.3 | range: -2 to +2 | n = 229) and that it had given them practical skills for treating Indigenous Patients in a culturally sensitive manner (mode [40%]: +1 | mean: 0.0 | range: -2 to +2 | n = 229). However, students agreed that it had provided them with an understanding of barriers to health equality (mode [58%]: +1 | mean: +0.4 | range: -2 to +2 | n = 229). Indeed, one of the most common themes raised in the free-text responses was that the curriculum focused too much on the barriers to health equality, and did not explain enough regarding practical skills to tackle these issues.

Figure 16: Indigenous Health (clinical)



Overall, 70 of the 72 free-text responses were of a negative opinion (27 from Year 4 students, 19 from Year 5 students, and 26 from Year 6 students). The most common view was that more practical advice on culturally sensitive practice and practical exposure was necessary, and that current teaching lacked a clinical focus on practical skills (60 comments). Example comments include: **"Whilst I am increasingly aware of the health disparities of Indigenous Australians and the cultural barriers to [accessing] healthcare, after 6 years of medical school I still do not have an effective understanding of how to navigate those cultural barriers or specific strategies I can use to help close the gap in Indigenous healthcare."** and **"Teaching of Indigenous Health is insufficient. We are taught about gaps in health and healthcare but we are not taught how to approach communicating with an Aboriginal patient and [are] not given any way to practice outside of the hospital setting, where the patients are ill."** and **"… There should be a greater focus on practical skills and actually seeing Indigenous patients rather than researching theoretical information on a computer and presenting it..."** and **"Most of the teaching is not terribly applicable [but] rather conceptual and when placed in Indigenous health settings I have realised how deficient it is – needs to be much more pragmatic and clinically applicable."** and **"Much more Indigenous health education required! Needs to be engaging and practical rather than purely theoretical."** and **"All teaching has been theoretical. Most clinicians I have observed do not follow [the] culturally sensitive clinical skills I have been taught so it is not possible to learn these on placement. I think medical students should do a day/sessions working with Aboriginal Health Workers to learn**

from them clinically." and **"The amount of time dedicated to Indigenous Health teaching is adequate, however the quality of that teaching is poor. I have learnt a lot about the discrimination faced by our Indigenous Australians and their disadvantage and barriers to healthcare, however I feel no more well-equipped to appropriately treat/encounter Indigenous patients now than I did prior to completing 3 years of the medical curriculum. The assignments we have in clinical years, when done poorly, would almost create more of a separation and negative experience for Indigenous patients. Furthermore, there are great services offered… such as cultural communication workshops run by [student groups] and the language workshops taught by the mobile language team, which I have been to that provide a much more hands-on, relevant educational sessions that have provided me with better skills and knowledge in this area."**. Other predominant themes included dissatisfaction with the assignments, specifically that the Indigenous Journey mapping assignment was intrusive or not appropriately supported (20 comments).

Conclusion of Standard 3.5

The Adelaide Medical School **does not currently meet** the sub-point under Standard 3.5 regarding Indigenous Health, however **is making promising progress in this area**. Indigenous Health teaching was previously identified as an area for improvement in the 2017 and 2018 AMC student submissions. The AMSS acknowledges that **efforts have gotten underway to reinvigorate the teaching in this area**, especially for preclinical students. This is reflected in the survey data, with Year 1 students being most positive, specifically in relation to the 'Circles of Knowledge' session. Therefore, the findings of this submission regarding Indigenous Health are **positive and optimistic for Indigenous Health teaching continuing to improve**. **It is likely that if the changes made in preclinical Indigenous Health teaching were also made to clinical Indigenous Health teaching that the opinions of clinical students would be more positive.** It is also important to note that this is an excellent example of staff listening to and implementing student feedback, with positive outcomes. Students would appreciate a directive to ensure there are confirmed plans for the 'Circles of Knowledge' session to be replicated for Year 4 students. Clinical students have also expressed a desire to have dedicated time assigned to work with, and learn from and about, Aboriginal Liaison Officers while participating in their clinical placements. The AMSS hopes that Indigenous Health teaching will continue to have a more seamless and thorough integration throughout the medical program to increase relevance and provide a more practical focus. This is demonstrated by one student: **"While the information given means we now have a good understanding of issues facing Indigenous Health, the 'one lecture and assignment a year' format means it often feels disjointed and something we need to complete to just tick a box"**.

Standard 4 | Learning and Teaching

Standard 4.1 | Range of Learning and Teaching Methods

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

Preclinical Course Components

Method

Students in preclinical year levels were asked to evaluate the efficacy of various course components by rating **the quality and delivery of Anatomy, Histology, Pathology, Physiology, Pharmacology, Public Health, Law and Ethics, Clinical Reasoning and Research Skills.** 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 free-text field.

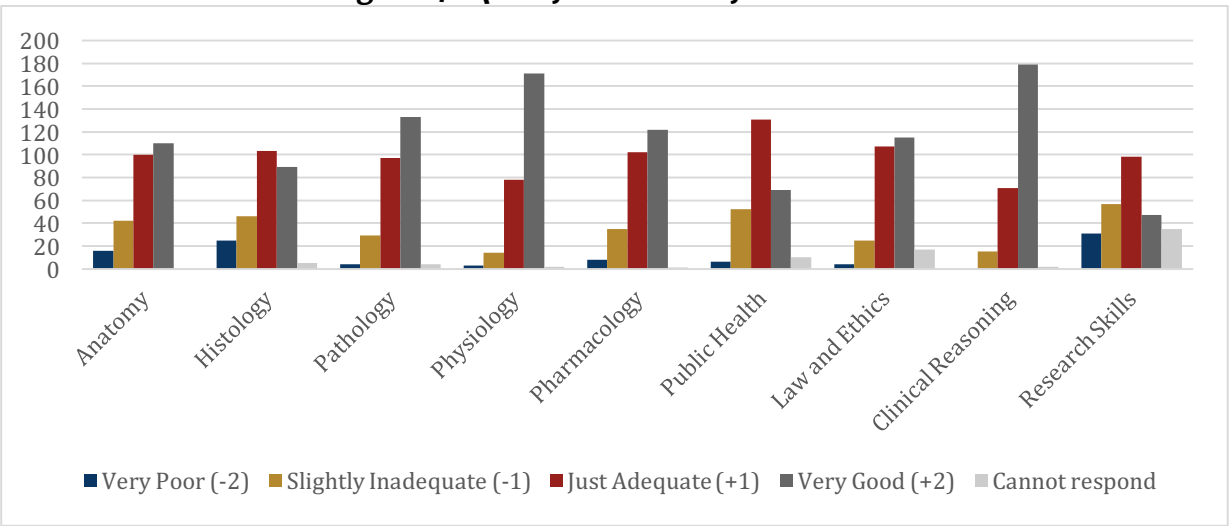
Results

Students agreed that all courses were just adequate in quality and delivery, with the exception of "Research Skills", which students felt was slightly inadequate. Students were most positive about Physiology and Clinical Reasoning. Students were least positive regarding Research Skills and Public Health.

The values for categories pertaining to all preclinical year levels were:

- Anatomy (mode [41%]: +2 | mean: +0.9 | range: -2 to +2 | n = 268)
- Histology (mode [38%]: +1 | mean: +0.7 | range: -2 to +2 | n = 268)
- Pathology (mode [50%]: +2 | mean: +1.2 | range: -2 to +2 | n = 267)
- Physiology (mode [64%]: +2 | mean: +1.5 | range: -2 to +2 | n = 268)
- Pharmacology (mode [46%]: +2 | mean: +1.1 | range: -2 to +2 | n = 268)
- Public Health (mode [49%]: +1 | mean: +0.8 | range: -2 to +2 | n = 268)
- Law and Ethics (mode [43%]: +2 | mean: +1.2 | range: -2 to +2 | n = 267)
- Clinical Reasoning (mode [67%]: +2 | mean: +1.6 | range: -2 to +2 | n = 267)
- Research Skills (mode [37%]: +1 | mean: +0.3 | range: -2 to +2 | n = 268)

Figure 17: Quality and Delivery of Courses



However, the 29 free-text responses suggested a more negative opinion, with 26 responses representing a negative view (2 from Year 1 students, 10 from Year 2 students, and 17 from Year 3 students). In particular, Year 3 students had significant concerns about anatomy, and felt that anatomy groups do not facilitate adequate teaching of students and are too large (7 comments). For example, **"Anatomy is not run well, the notes are often very difficult to follow, the groups are too big… The presents often only know their station so if you ask them other anatomy related questions they cannot answer you… The questions in the [pre-session] anatomy notes are almost never covered in the [session] and rarely uploaded after so you are left with heaps of uncertainty…"** Despite exposure to research ideally being integrated and occurring in every year of the medical program, some students indicated that they had not received any teaching on Research Skills (4 comments).

School of Medicine Teaching Series (SMTS)

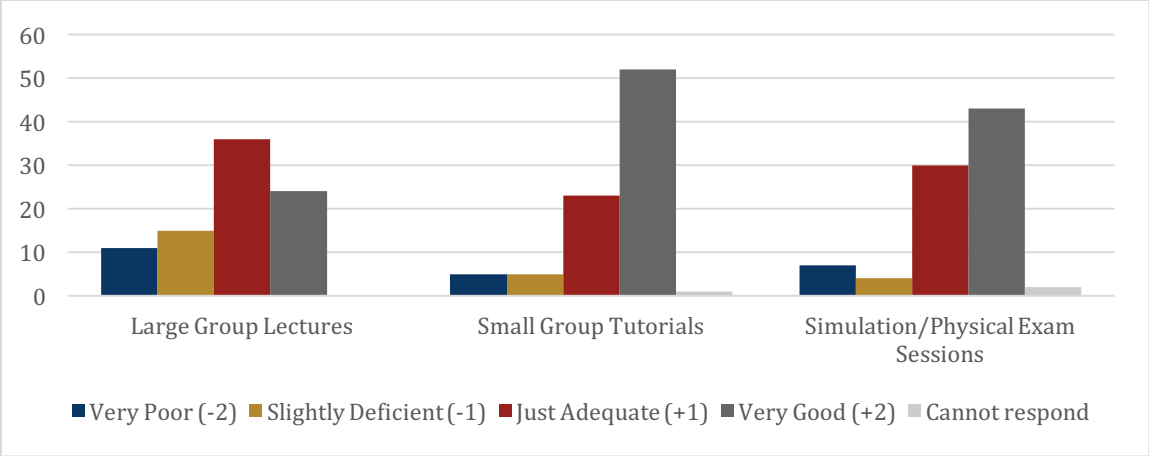
Method

Year 4 and Year 5 students were asked to rate the effectiveness of SMTS in helping to cover expected learning objectives. Students were asked to rate their level of agreement based on the following statement **"How effective is the School of Medicine Teaching Series (SMTS) in helping you to cover the expected learning objectives"** in three subparts **"large group lectures", "small group tutorials" and "simulation/physical exam 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 free-text field.

Results

Year 4 students overall agreed that SMTS was effective at covering the learning objectives through whole group lectures (mode [42%]: +1 | mean: +0.5 | range: -2 to +2 | n = 86), small group lectures/tutorials (mode [60%]: +2 | mean: +1.3 | range: -2 to +2 | n = 86) and simulation/physical exam sessions (mode [50%]: +2 | mean: +1.2 | range: -2 to +2 | n = 86).

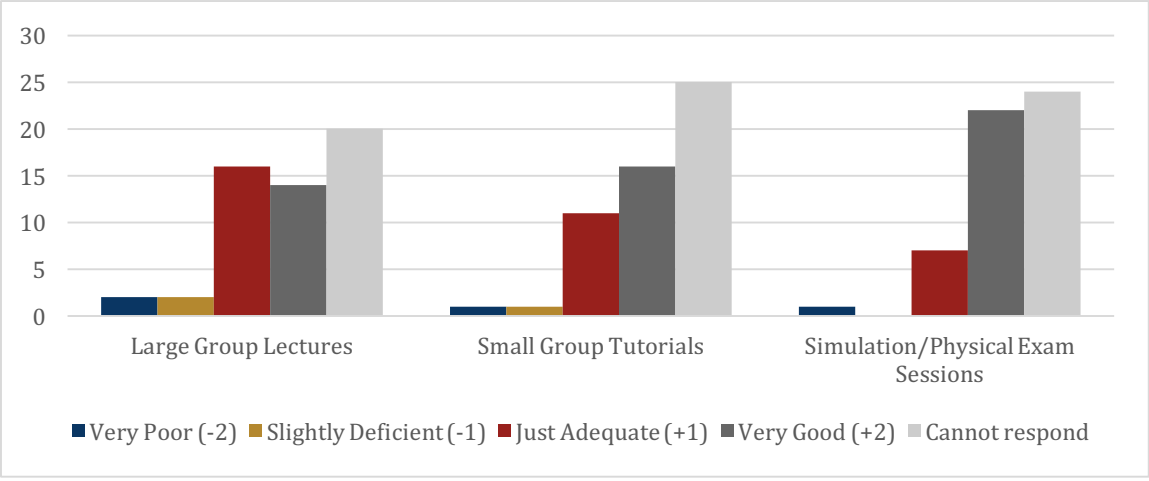
Figure 18: Year 4 SMTS



However, 26 free-text responses suggested a more equivocal opinion, with 20 responses indicating a negative opinion. The most common view was that while students enjoy directed teaching, the format of having many lectures in a day without breaks leads to poor retention of knowledge. One student commented: **"An entire day of teaching is not an effective way to teach students. It is not possible to retain information after hours of lectures. The design of such a program is more consistent with what is convenient for lecturers, rather than what is an effective teachings strategy for students"**. Students suggested having SMTS more frequently but less dense (e.g. half-days frequently rather than full days fortnightly) (2 comments). Other predominant themes included lack of access for rural students (6 comments) and lack of access to slides (3 comments).

Year 5 students overall agreed that SMTS was effective at covering the learning objectives through whole group lectures (mode [30%] +1 | mean: +1.1 | range: -2 to +2 | n = 54), small group lectures/tutorials (mode [30%]: +2 | mean: +1.4 | range: -2 to +2 | n = 54) and simulation/physical exam sessions (mode [41%]: +2 | mean: +1.6 | range: -2 to +2 | n = 54).

Figure 19: Year 5 SMTS



Generally, of the 16 free-text responses, students responded positively, however some focused on the variable quality and relevance of the lectures, tutorials and simulation sessions (6 comments). One student commented: **"I would say they're hit and miss in terms of relevance and quality. Recent neurology and cardiology lectures 2 weeks ago were fantastic".**

Year 6 Transition to Internship Program (TTIP)

Method

Year 6 students were asked to evaluate the efficacy of TTIP teaching by rating their level of agreement based on the following statement **"In Transition to Internship Program, the quality of each of the following in assisting my learning was:"** with seven subparts "**Lecture days"** and **"Seminar days"** and **"Practical days"** and **"Online NPS Prescribing Modules"** and **"Online Radiology Modules"** and **"Online Quizzes"** and **"Essential Competencies Log Book**". 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 free-text field.

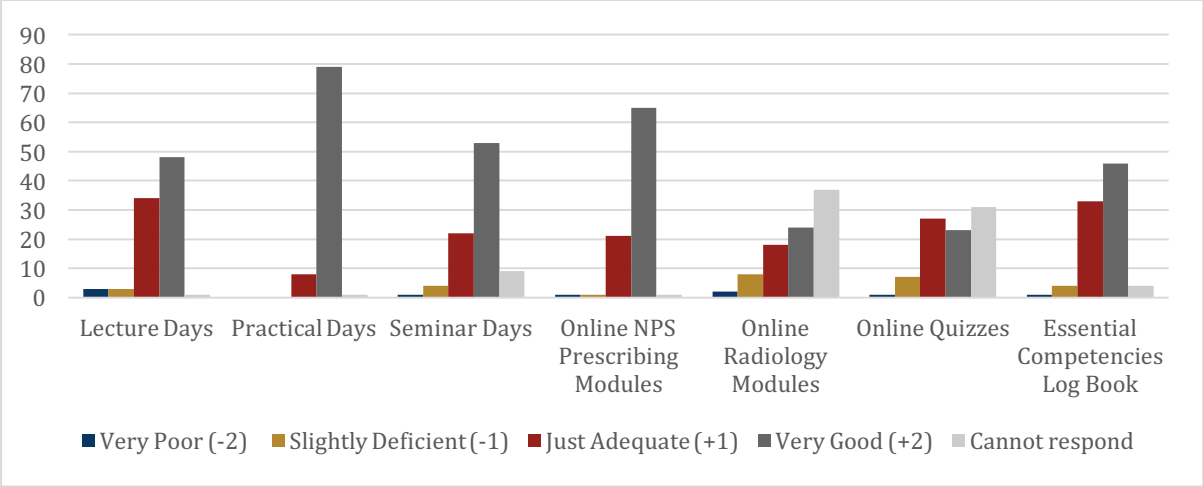
Results

Students agreed that the current teaching of TTIP was very good.

The values for each of the categories were:

- Lecture days (mode [54%]: +2 | mean: +1.4 | range: -2 to +2 | n = 89)
- Practical days (mode [90%]: +2 | mean: +1.9 | range: -2 to +2 | n = 88)
- Seminar days (mode [60%]: +2 | mean: +1.5 | range: -2 to +2 | n = 89)
- Online NPS prescribing modules (mode [73%]: +2 | mean: +1.7 | range: -2 to +2 | n = 89)
- Online Radiology Modules (mode [27%]: +2 | mean: +1.4 | range: -2 to +2 | n = 89)
- Online Quizzes (mode [30%]: +1 | mean: +1.1 | range: -2 to +2 | n = 89)
- Essential Competencies Log Book (mode [52%]: +2 | mean: +1.4 | range: -2 to +2 | n = 88)

Figure 20: Year 6 TTIP



Of the 15 free-text responses, the most common theme (10 comments) highlighted the efficacy of simulation sessions in preparing for internship in a safe and supportive environment. An example is: "**This has been some of the best teaching I have received in med school**" and **"TTIP is the best run program of the clinical years"** and **"Overall the TTIP program was very useful, in particular the [simulation] sessions and prescribing modules (I think a lot this is**

thanks to the consistency of these programs)" and **"Practical days were the best!! Learnt to so much. Lecture days were hit and miss. Some were great."**

Conclusion of Standard 4.1

This feedback **identifies highlights of the medical program** and that the Adelaide Medical School **clearly meets** this sub-point under Standard 4.1 regarding the range of teaching and learning methods.

Despite the lack of a clearly outlined curriculum, individual teaching components within the preclinical courses, the School of Medicine Teaching Series (SMTS), and the Transition to Internship Program (TTIP) are perceived overall by students as adequate.

1. Regarding preclinical course components, preclinical students consider the quality and delivery of all course components to be **just adequate**. In particular, it is pleasing to see that Histology has improved (having been previously identified as an area of concern in the 2017 AMC student submission) and that the teaching of Clinical Reasoning continues to be highly valued by students. The AMSS hopes to see Research Skills ideally being integrated and occurring in every year of the medical program from Year 1.
2. Regarding SMTS, clinical students were **generally satisfied** with the quality and delivery of SMTS in Year 4 and Year 5. However, students maintain that they find long continuous lecture days are ineffective for learning and do not encourage knowledge retention. Students suggest that the SMTS program is delivered more frequently with shorter sessions (e.g. half days weekly rather than full days fortnightly). This would bring the SMTS program in line with its rural equivalent, the Peer Assisted Learning in Medicine and Surgery (PALMS) program. Moreover, it is likely that the SMTS program would benefit from a similar review process to the 2018 Lecture Review of the preclinical lectures, and that this would be assist to increase the quality and relevance of the SMTS program.
3. Regarding TTIP, Year 6 students were **particularly pleased** with TTIP and found the quality and delivery to be **very good.** In particular, students found the Practical Days and Prescribing Sessions (including the online NPS prescribing modules) to be of most benefit. **It is clear that this is the best aspect of the medical program and the leader deserves to be commended**.

It is important to note that due to the scope of this submission, the AMSS is unable to comment on clinical placements in 2019. However, these have been extensively reported on in the 2017 and 2018 AMC student submissions and remain largely unchanged.

Standard 4.3 | Core Skills

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

Efficacy of Core Skills Teaching

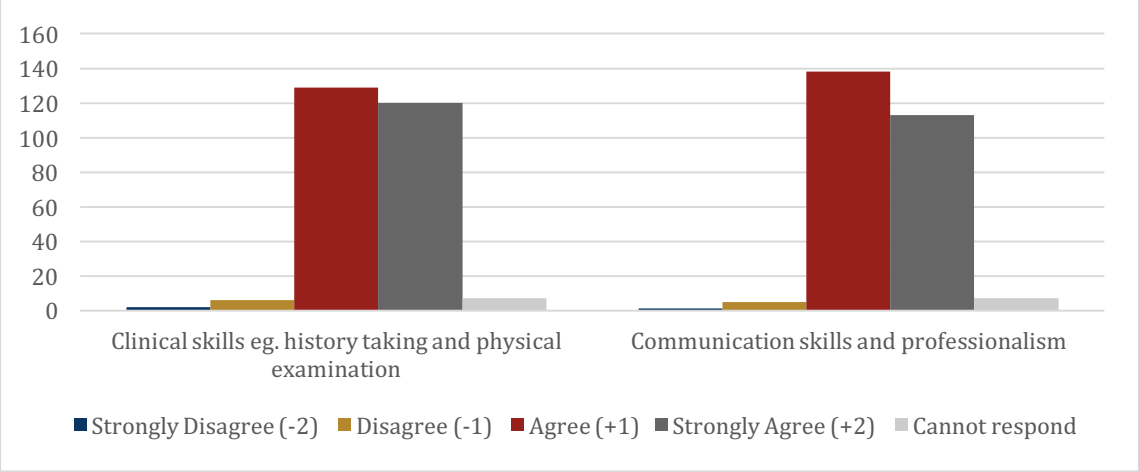
Method

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: **"The medical program has equipped me with these core skills that can be applied in a clinical setting:"** divided into four subparts **"Clinical Skills (e.g. history taking and physical examination)"** and **"Communication skills and Professionalism'** and **'Procedural skills (e.g. venepuncture, cannulation)"** and **"Management Plans and Prescribing skills". Preclinical students were only asked to evaluate "Clinical Skills (e.g. history taking and physical examination)" and "Communication skills and Professionalism".** 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 free-text field.

Preclinical Results

Students agreed that the medical program had equipped them with both core clinical skills (mode [49%]: +1 | mean: +1.4 | range: -2 to +2 | n = 264) as well as communication skills and professionalism (mode [52%]: +1 | mean: +1.4 | range: -2 to +2 | n = 264).

Figure 21: The Medical Program has equipped me with Core Skills (preclinical)



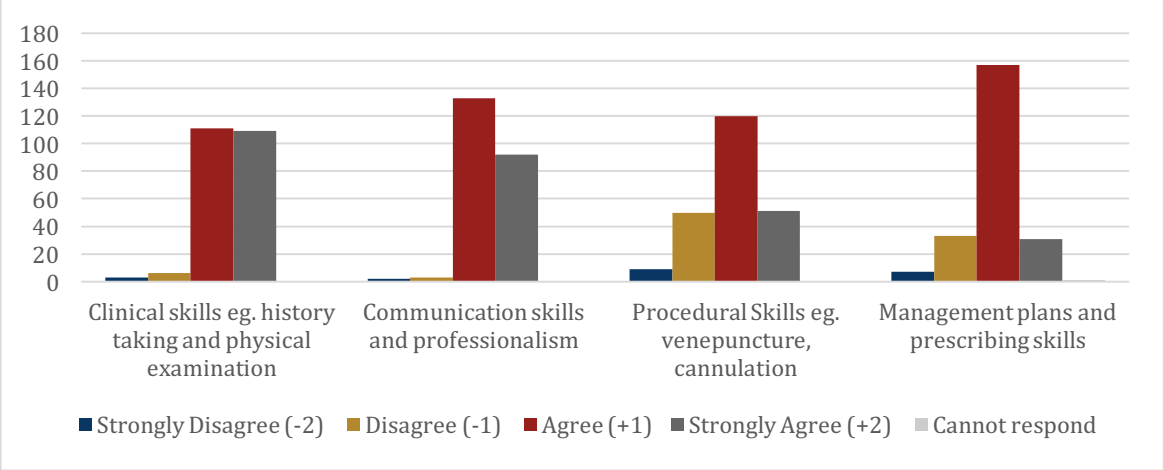
However, the 14 free-text responses suggested a more negative opinion, particularly from Year 3 students (2 from Year 1 students, 3 from Year 2 students, and 9 from Year 3 students). The most common view among Year 3 students was that they did not feel adequately supported in

learning new physical examination techniques and received little to no feedback (6 comments). Example comments include: **"… There are no video examples [or] feedback for [physical examinations] and histories in Year 3. We have no idea what the new [physical examinations] are meant to look like and not many tips for techniques used in [physical examinations]."** and **"It would be great if students could be informed of what level their practical clinical skills are expected to be at. Because we are in hospitals for Clinical Skills, there is no longer any standardised teaching for history and [physical] examination so we do not know what level of depth or breadth we are expected to cover in our end-of-year OSCEs. There is a clinical examination checklist, but that does not help clarify [physical] examination techniques, procedures or history taking details.".** Other themes included some students from Year 1 and 2 feeling adequately prepared (3 comments), while some students felt that there was not enough direct teaching of communication skills (2 comments).

Clinical Results

Students agreed that the medical program had equipped them with all core skills: Clinical Skills (mode [48%]: +1 | mean: +1.4 | range: -2 to +2 | n = 229), Communication and Professionalism (mode [58%]: +1 | mean: +1.3 | range: -2 to +2 | n = 230), Procedural Skills (mode [52%]: +1 | mean: +0.7 | range -2 to +2 | n = 230), and Management Plans and Prescribing Skills (mode [68%]: +1 | mean: +0.8 | range -2 to +2 | n = 228). Year 6 students were more likely to agree than Year 4 or Year 5 students in all categories.

Figure 22: The Medical Program has equipped me with Core Skills (clinical)



However, 47 free-text responses suggested a more negative opinion, with 39 responses indicating a negative opinion (21 from Year 4 students, 13 from Year 5 students, and 13 from Year 6 students). The most prominent themes were requests for greater exposure to formal teaching of procedural skills (14 comments), with multiple students noting lack of direct teaching or supervision for these skills on the wards. Example comments include: **"More simulation sessions on less common procedural techniques e.g. NGT and catheters would be useful."** and **"We had one, 1 hour session in 3rd year, to learn and practice procedural skills in a safe environment which is absolutely not sufficient at all."** and **"Procedural skills are poorly taught by the university – it is really up to you to learn in a clinical setting."** and **"Very minimal teaching for procedures skills, almost entirely requires a clinician to take time out of their day to teach you"**. Other predominant themes included teaching regarding management plans was poor (7 comments). Example comments include: **"Clinical skills in years 1/2 set me up well for history taking, physical exam, etc. The medical school has had very little input into teaching**

me how to do procedural skills or develop management plans" and **"I [agree] with the heavy caveat that these [skills] were either self-taught through my own study or taught 'on the go' by junior doctors. I would say the best thing they've taught us is history taking and examination in Clin Skills – that is a really good program that should continue**".

Preparedness for Internship

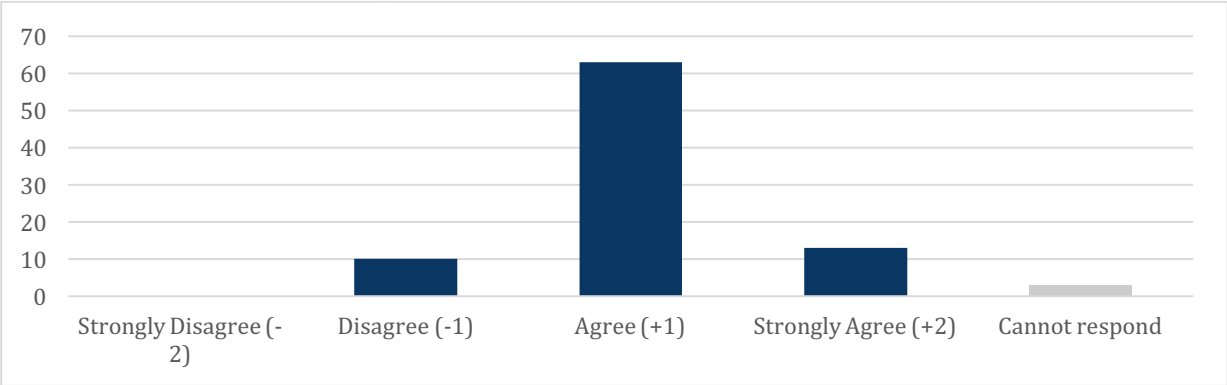
Method

Year 6 students were asked to evaluate the statement **"As I now approach the end of medical school, I would consider myself prepared for internship".** 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 free-text field.

Results

Students agreed that they considered themselves prepared for medical internship (mode [71%]: +1 | mean: +0.9 | range: -2 to +2 | n = 89).

Figure 23: Preparedness for Internship



There were 12 free-text responses with the most common theme stating that TTIP was beneficial (5 comments). Example comments include: **"The TTIP program has been the key to making me feel prepared"** and **"Overall I have felt that 6th year is an excellently run year which has really consolidated my learning and also taught a whole lot of practical skills [that] I think will really prepare me for life on the wards, and I really appreciate it as an opportunity for learning.".**

Conclusion of Standard 4.3

This feedback **identifies highlights of the medical program** and the Adelaide Medical School **clearly meets** this sub-point under Standard 4.3 regarding teaching of core skills for clinical practice and the quality of preparation provided for internship.

Students agree overall that the medical program had equipped them with all four core skills (as identified by the AMC standards) needed for clinical practice. In particular, the Year 1 and Year 2 Clinical Practice programs are rated highly by students for being an excellent method of teaching history taking and physical examination skills. Students value these sessions and would like them to continue. However, Year 3 students did not feel adequately supported in their Year 3 Clinical Practice program, and were unable to refine their physical examination techniques due to receiving limited supervision and feedback. This has been an ongoing issue since 2016 for Year 3 students, and has been escalated by student representatives to the Clinical Practice Course Coordinator, the Year 3 Year Level Advisor, the Year 1-3 Course Committee, the MBBS Programs Coordinator, and the Dean. Students appreciate efforts in standardising teaching across hospital sites, as well as the opportunity to receive feedback. Unfortunately, this important concept has been poorly implemented in 2019 with the newly centralised Clinical Practice Lectures. These were created to ensure all students received the same teaching in a standardised manner and to ensure all students had the opportunity to ask questions of an expert clinician. However, the Adelaide Medical School has refused to record these lectures (despite this being the policy of the University of Adelaide) and has poorly communicated attendance requirements. In addition, the current simulation sessions teaching of procedural skills are highly valued and students would like the number of these sessions to be increased, as there is a lack of direct teaching or supervision for these skills on the wards. The AMSS hopes that more formal and directed teaching of procedural skills using simulation will be incorporated into the medical program in the future. It is also important to note that while students feel confident in these core skills, students continue to question whether this has been achieved predominantly through self-directed learning rather than via support or direction from the Adelaide Medical School. Example comments include: **"[Core skills] were either self-taught through my own study or taught 'on the go' by junior doctors"** and **"I feel equipped but [I am] unsure if the medical program equipped me or I just had to pick up the slack".**

Regarding how students perceive their preparedness for internship, it is clear that students find the TTIP program valuable in preparing them for internship.

Standard 4.7 | Interprofessional Learning

'The medical program ensures that students work with, and learn from and about other health professionals'

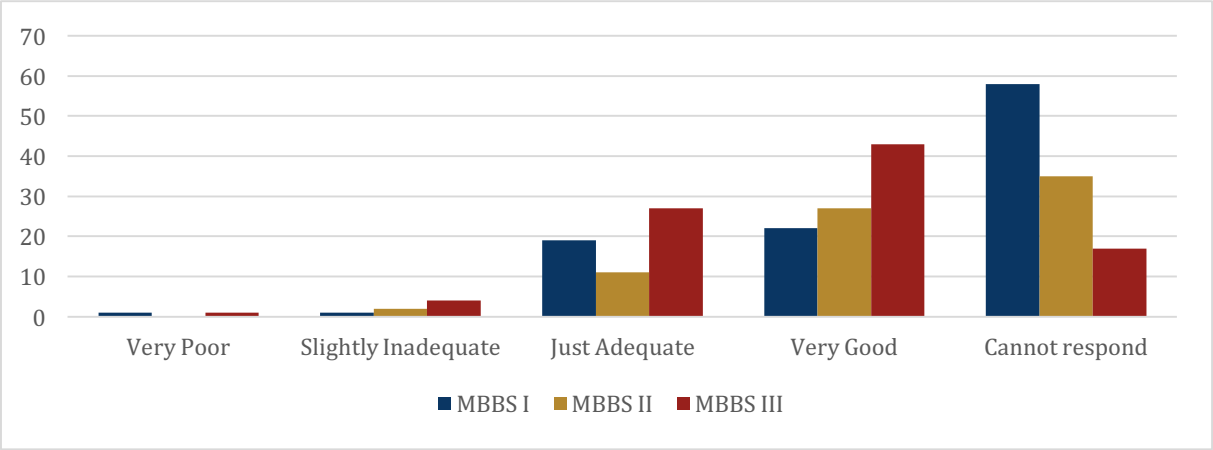
Method

Students in all year levels were asked to evaluate the efficacy of current Interprofessional Learning based on the following statement **"Please comment on the quality and delivery of Interprofessional Learning (IPL) in 2019"**. 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 free-text field.

Preclinical Results

Students agreed that the quality and delivery of Interprofessional Learning was absent (mode [41%]: 'cannot respond' | mean: +1.5 | range: -2 to +2 | n = 268).

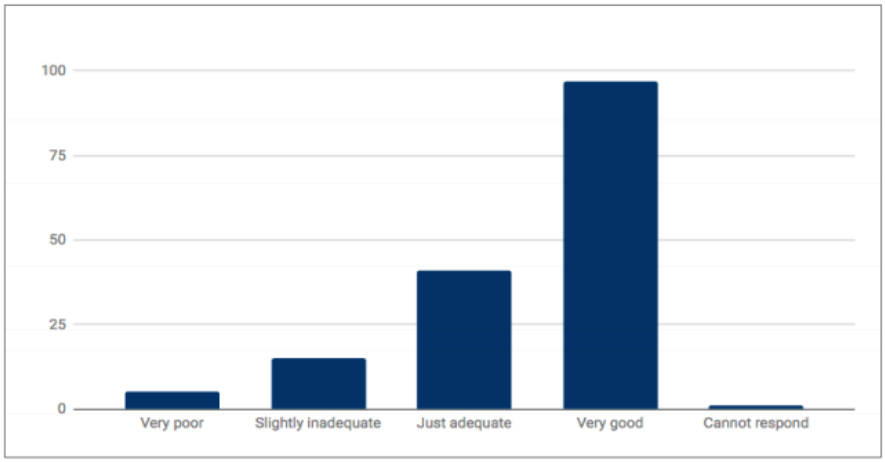
Figure 24: Interprofessional Learning (preclinical)



Furthermore, 37 free-text responses demonstrated that IPL was notably absent across all years in 2019 (8 from Year 1 students, 13 from Year 2 students, and 16 from Year 3 students). Many students confirmed that they had not received any IPL teaching (20 comments), and some Year 1 students stated that they were not aware that IPL was a component of their course (3 comments). This is consistent with a large proportion of students choosing 'cannot respond' due to not experiencing IPL. Despite this, many students explained that in sessions they had received previously, they found IPL to be beneficial (11 comments). One student commented: **"We had no IPL because the med school decided to cancel it! Our cohort is very disappointed and after discussion with the simulation centre staff we still want IPL opportunities.".**

This is in stark contrast to 2018, where students responded positively to the program (mode: [61.4%] +2 | mean: +1.33 | range: -2 to +2 | n = 158 from 159) (see graph below).

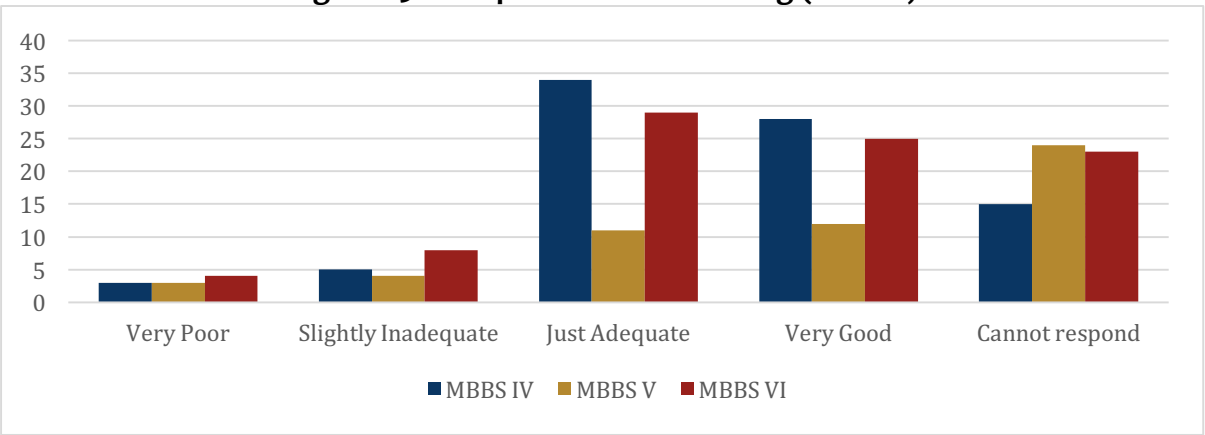
2018: IPL (preclinical)



Clinical Results

Students agreed that the quality and delivery of Interprofessional Learning was just adequate (mode [32%]: +1 | mean: +1.0 | range: -2 to +2 | n = 228).

Figure 25: Interprofessional Learning (clinical)



However, 40 of the 46 free-text responses suggested a more negative opinion (16 from Year 4 students, 16 from Year 5 students, and 14 from Year 6 students). The most common view was that students had not received formal IPL teaching (29 comments). This is consistent with a large proportion of students choosing 'cannot respond' due to not experiencing IPL. Other predominant themes included that Year 4 teaching with pharmacy students was poorly attended by pharmacy students, reducing the usefulness of the sessions (5 comments). One student commented: **"IPL with pharmacy students was good but last year's [simulation] sessions [with nursing students] were much more engaging".** However, 6 responses indicated a positive opinion with students expressing they found the Year 4 program enjoyable (4 comments) and that the Year 6 medicolegal afternoon was useful (2 comments). One student commented: **"I would have liked to have more interaction with nursing staff within a simulation setting that more closely approximated the real world. Whilst our prior IPL teaching with pharmacy and law students were interesting, they were a little too far removed from daily practice to be immediately useful".** Comments from Year 5 students focused on the absence of formal IPL sessions, but discussed that IPL was integrated with clinical placements.

Conclusion of Standard 4.7

The Adelaide Medical School **does not meet** the sub-point under Standard 4.7 regarding Interprofessional Learning (IPL). **It is concerning that many students have not had access to IPL in 2019.** This is in stark contrast to 2018, where students responded positively to the program. IPL in 2018 offered opportunities for medical (Year 1-3) and nursing (Year 1-3) students to work together in the simulation centre solving team-based emergency care scenarios. These were perceived by students as realistic and relevant clinical experiences that improved their awareness of each other's roles and facilitated both groups to learn from and with each other. Clinical students have also reported that these simulated experiences have been valuable in preparing for the hospital environment, as well as being the catalyst for continuing professional relationships. **It is unfortunate that this program has been removed in 2019 and that no replacement activities have been provided.** The AMSS maintains that being able to work in an interprofessional team is a basic expectation of any clinical medical student, therefore developing these skills must begin in the preclinical years.

Standard 5.3| Assessment feedback

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

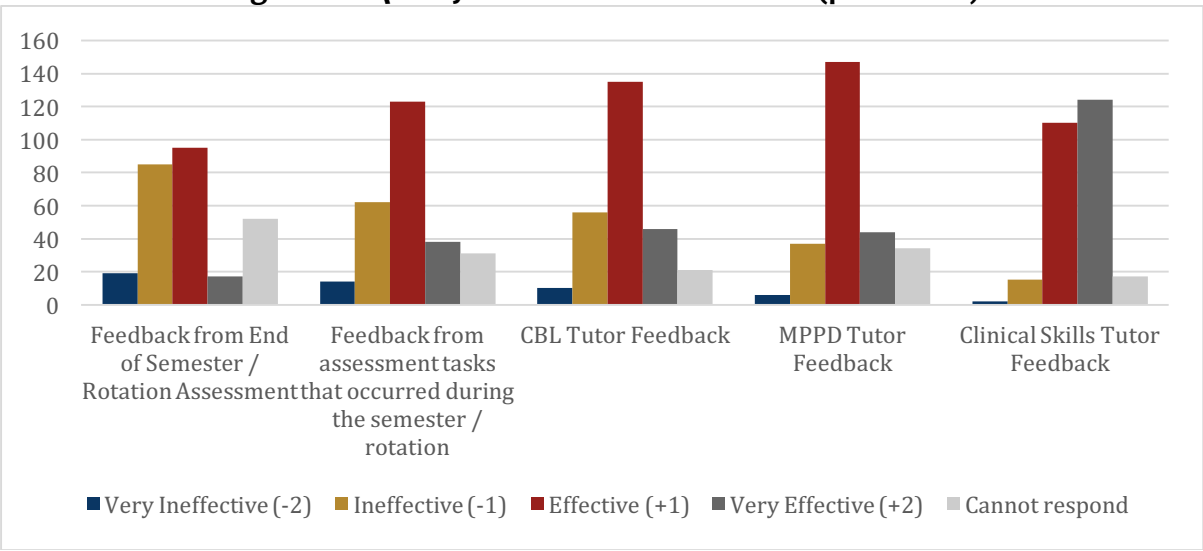
Method

Students in all year levels were asked to evaluate the feedback they received based on the following statement: **"How effective was the following feedback provided by the Adelaide Medical School in enabling you to focus your study on specific areas of weakness?"** The specific modes of feedback evaluated varied with each year level. All preclinical year levels were asked to evaluate **"Feedback from End of Semester Assessment"** and **"Feedback from assessment tasks that occurred during the semester"** and **"CBL Tutor Feedback"** and **"MPPD Tutor Feedback"** and **"Clinical Skills Tutor Feedback".** All clinical year levels were asked to evaluate **"Feedback from End-of-Placement / End of Semester assessment"** and **"Feedback from assessment tasks that occurred during the clinical placement"** and **"Consultant/Team feedback during the clinical placement".** 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 free-text field.

Preclinical Results

Students were positive about CBL tutor feedback (mode [50%]: +1 | mean: +0.6 | range: -2 to +2 | n = 268), MPPD tutor feedback (mode [55%]: +1 | mean: +0.8 | range: -2 to +2 | n = 268), Clinical Skills tutor feedback (mode [46%]: +2 | mean: +1.4 | range: -2 to +2 | n = 268) and Feedback from Assessment Tasks that Occurred During the Semester (mode [54%]: +1 | mean: +0.6 | range: -2 to +2 | n = 267). Students were equivocal regarding the effectiveness of End of Semester Assessment feedback (mode [35%]: +1 | mean: 0.0 | range: -2 to +2 | n = 268).

Figure 26: Quality of Assessment Feedback (preclinical)

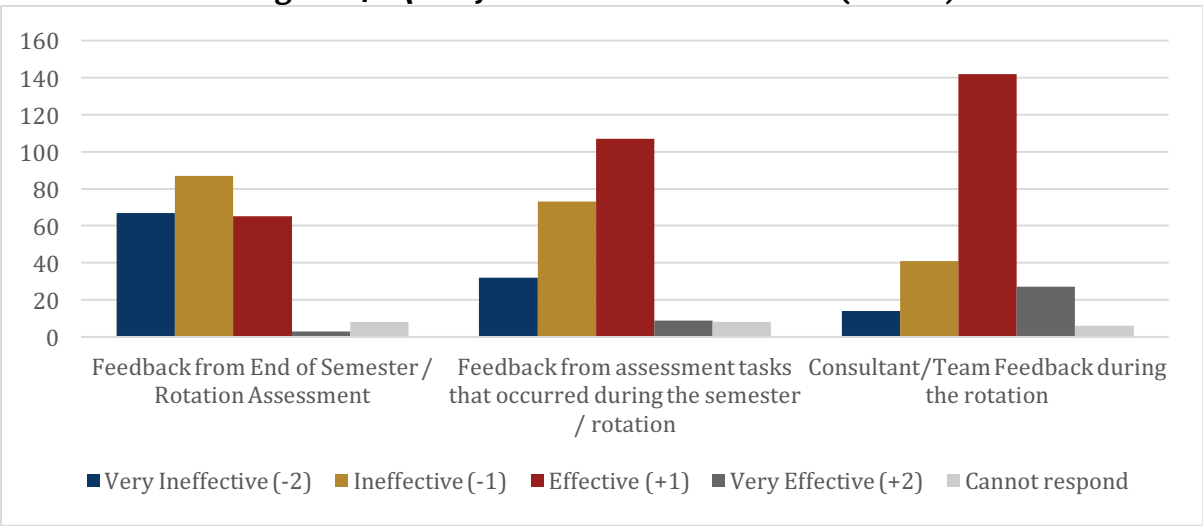


Furthermore, 43 free-text responses were of a negative opinion, with 34 responses indicating that feedback was insufficient (7 from Year 1 students, 17 from Year 2 students, and 19 from Year 3 students). Students emphasised the importance of feedback, best summarised by the following two comments: **"Feedback from the medical school about assessments is inadequate overall, as it is not made clear to individual students where they went wrong and how they could improve in the future."** and **"Tutors should be aware that feedback is the best way of learning. It is only through trying and making mistakes [that] we will grow in this course.".** Students suggested that more specific feedback rather a general area of study would be more effective (5 comments). In particular, students were most negative about OSCE feedback (11 comments), with one student commenting: **"Raw scores from end of semester OSCE tell you nought about how one can improve for next time".** Additionally, students expressed a negative opinion about CBL feedback (10 comments), MKE feedback (4 comments), and MPPD feedback (3 comments).

Clinical Results

Students disagreed that End of Placement/End of Semester Assessment feedback enabled them to focus their study on specific areas of weakness and believed it to be ineffective (mode [38%]: -1 | mean: -0.7 | range: -2 to +2 | n = 230). Students were equivocal that feedback from assessment tasks that occurred during the clinical placement was effective in enabling them to focus their study on specific areas of weakness (mode [47%]: +1 | mean: -0.1 | range: -2 to +2 | n = 229). Students agreed that the current Consultant/Team feedback during the clinical placement provided was effective in enabling them to focus their study on specific areas of weakness: (mode [62%]: +1 | mean: +0.6 | range: -2 to +2 | n = 230).

Figure 27: Quality of Assessment Feedback (clinical)



However, 78 free-text responses suggested a more negative opinion, with 66 responses indicating a negative opinion (40 from Year 4 students, 17 from Year 5 students, and 21 from Year 6 students). The most common view was the End of Placement/End of Semester feedback, particularly OSCE marks, was delivered late (28 comments) and provided insufficient detail (26 comments). Example comments include: **"We should be getting exam feedback and OSCE feedback fast and in more depth. If we don't understand the mistakes we are making in our OSCEs, how are we able to ever improve. The released results from third year OSCEs (which were released very late) were also quite confusing to interpret."** and **"I think there has been some improvement over the years regarding examination feedback but going from none to minimal is not particularly commendable. A mark for an OSCE never tells you what aspect you need to improve on, and self-reflection can only get you so far. The advent of the recording of OSCEs should have heralded improved feedback but this has been stymied and not rolled out for reasons that are not clear."** and **"In regards to assessments I still haven't received my OSCE grades and MSK quiz, both of which are hurdles now for me to pass. I don't know whether or not I passed these assessments so have no way to guide my study going forward if I am not reaching my goals."** and **"Receiving exam feedback from last year months into this year is an appalling embarrassment on behalf of the medical school – it's impossible to learn from our mistakes/well doings if we don't have the feedback, and we only get it after we've forgotten how we did, and lost the ability to reflect. There is no excuse (and if there is, as usual the medical school lacks accountability and transparency)."** and **"My one biggest wish would be to get more feedback from our OSCEs and exams"**. Other predominant themes included that the feedback was often generic and not helpful (17 comments), and often poorly reflective of effort (6 comments). Another predominant theme was that feedback from the Consultant/Teams was often given by consultants with whom students had little contact (14 comments). However, some students described instances of positive Consultant/Team feedback (6 comments).

Conclusion of Standard 5.3

The Adelaide Medical School **does not meet** the sub-point under Standard 5.3 regarding the provision of regular feedback to guide students' learning. **Students do not find the feedback provided by the Adelaide Medical School to be helpful in focusing on improving their individual areas of weakness.**

Students continue to maintain negative opinions regarding assessment feedback, in particular relating to the timeliness and level of detail provided. Despite student representatives continually escalating the inadequacy of feedback, at the Year 1-3 and Year 4-6 Course Committees respectively, as well as to the MBBS Program Coordinator and the Dean, **staff continue to explain that the reason for lack of improvement in this area is insufficient staff**. The AMSS maintains that the provision of feedback should be given higher priority so that there are adequate resources to provide feedback for medical students, as this is a core requirement in the delivery of the medical program. **The AMSS maintains that it is unacceptable for a lack of staff to result in students receiving inadequate feedback. Delivery of timely, relevant feedback is a basic expectation of modern tertiary education, and particularly important for medical students who will be caring for patients in the future. Furthermore, as the new BMD medical program will use a graded system of assessment, feedback for students must available and transparent assessment methods must be used. Unfortunately, if this does not improve there is a danger that the Adelaide Medical School's commitment to provide an excellent education will be seen to lack credibility.** Measures to provide prompt feedback, including individualised communication with students, are strongly encouraged.

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 (Evaluation of Student Experience of Learning and Teaching) Feedback

Method

Students in all year levels were asked to evaluate the efficacy of the use of **eSELTs (Evaluation of Student Experience of Learning and Teaching – the standardised mode of gathering student feedback, used across all courses at the University of Adelaide)** as a form of feedback by rating their level of agreement based on the following statement **"eSELTs are an effective means by which medical students may convey feedback about their courses and about their clinical tutors/supervisors"**. 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 free-text field.

Preclinical Results

Students agreed that eSELTs are an effective means by which students may convey feedback about the course and about tutors (mode [62%]: +1 | mean: +1.1 | range: -2 to +2 | n = 268).

However, 13 of the 18 free-text responses described a more negative opinion (3 from Year 1 students, 8 from Year 2 students, 7 from Year 3 students). The most common view was that eSELTs are tedious to complete, taking >20 minutes on average (8 comments). Another predominant theme was that students never receive information as to how their feedback is acted upon (7 comments) and that there is a lack of implementation of the student feedback (4 comments). Examples of this frustration include: **"[eSELTs] are good for conveying feedback, but what is the point if this feedback is never acted upon?"** and **"[Students] convey feedback, but the university makes no effort making the requested changes. They make excuses as to why they cannot implement changes.".** Additionally, a common view was that the inconvenient timing of the eSELTs resulted in low student participation, due to only being open in the exam period (4 comments). Examples of this frustration include: **"[eSELTs are] effective, however I strongly disagree with the timing wherein they're released. Unfortunately, it**

always coincides with SWOTVAC and I've often heard students comment that they were unable to find the time to complete them due to exam stress." and **"I think they're an effective way to give feedback but I think a lot of people are put off by the timing around exams and the length of the surveys"** and **"eSELTs are due the day before the exam season starts, so students are not focused on providing feedback but rather passing their exams".** Finally, one student commented **"There [needs] to be a [clearer] way of providing feedback to different departments (e.g. Anatomy) in the eSELTs as opposed to only being able to provide feedback for individual tutors e.g. the disorganised nature of the anatomy program isn't just one anatomy tutor's fault – so I feel bad giving them a bad rating. There [needs] to be an umbrella area where we could provide feedback for the entire course."**

Clinical Results

Students were equivocal regarding the efficacy of eSELTs as a means by which students may convey feedback about the course and about clinical supervisors (mode [48%]: +1 | mean: +0.1 | range: -2 to +2 | n = 229).

However, all of the 44 free-text responses described a negative opinion (20 from Year 4 students, 13 from Year 5 students, 11 from Year 6 students). The most common view was that that students never receive information as to how their feedback is acted upon, and therefore do not feel as if any positive changes have resulted due to their feedback in the eSELTs (19 comments). Examples of this frustration include: **"Have never been told by the faculty that this feedback has even been read let alone considered"** and **"I don't think anything has ever come of eSELTs despite yearly feedback – does anyone even read it?"** and **"[It is only useful] if the medical school listens though which I don't think they do most of the time, because we give them the same feedback each year and there are still big recurring issues"** and **"We don't get an answer and there are no changes"** and **"I think they could be useful, however we never see the results or any changes based on what we say so I have no idea whether it's actually making any difference or not. It would be great to see a summary of the feedback given so that we know we're being heard at least".** Students also expressed that the eSELTs are not appropriately set up for clinical medicine courses, as the eSELTs require students to select from a predetermined list of supervisors, many of which are staff that the student has not interacted with before, reducing the usefulness of the feedback (18 comments). Examples of this frustration include: **"I had actually never met/seen/had anything to do with most of the clinical tutors/supervisors that were listed… so I found the eSELTs quite hard to fill out."** and **"… they have not provided accurate tutors for the classes, [and I] could not honestly complete the eSELT as I could not proceed without selecting the wrong person. Little things like this are riddled throughout the course."** and **"[eSELTs] often ask questions about individuals we have minimal contact with and doesn't provide an option to provide feedback on people we actually interact with."** and **"Relevant tutors/supervisors are rarely if ever included in eSELTs. i.e. the coordinator of a course might be listed in the eSELT but the site supervisor is not. Therefore, when most-to-all interaction is with the site supervisor, and there is no section to give feedback about them, this makes the eSELT redundant."** and **"The lack of consistent lecturers in the course makes eSELTs an inaccurate representation of overall teaching. Also, I often would prefer to give more general course feedback. Whilst the teachers are generally wonderful, I feel that the overall structure of the course is where the most improvement could be made."** Students also explained that the eSELTs had a large number of questions and were too time consuming to complete (8 comments). Example comments include: **"... I feel the sheer depth of the number of questions being asked is a bit overwhelming and might**

discourage [students].” and **“[eSELTs are] so lengthy and you’re expected to comment on people you’ve never even seen before or had one lecture from.”**. Students also mentioned that the eSELTs were released too late in the year for meaningful feedback (4 comments). One student commented: **“They come out too late – no way to provide ongoing feedback in a way that is listened to.”.**

Conclusion of Standard 6.1

The Adelaide Medical School **does not meet** the sub-point under Standard 6.1 regarding monitoring of its medical program. **The Adelaide Medical School does not respond quickly or effectively to concerns about the quality of any aspect of the medical program**.

It is clear that students are dissatisfied with eSELTs (Evaluation of Student Experience of Learning and Teaching – the standardised mode of gathering student feedback, used across all courses at the University of Adelaide) as a means of providing feedback due to:

1. Students never receiving information as to how their feedback is acted upon
2. Students being unable to give feedback for the correct staff member
3. Issues relating to timing (as eSELTs are only open in the examination period)
4. Issues relating to the length (students desire more concise eSELTs)

Furthermore, as eSELTs are not anonymous, students are fearful of the repercussions of providing honest feedback. This final quote summarises the student opinion well: **“eSELTs are poorly timed, organised, and do not allow feedback on the main areas I would like to provide feedback on. They are generic and do not fit the structure of the medical course.”.**

Despite the above four issues being escalated to the MBBS Program Coordinator, the Dean and AMS Programs Board several times, this has never been resolved. Instead staff steadfastly agree that medical students must use the same form for feedback as all other university courses, despite acknowledging eSELTs are inadequate and poorly suited to the medical program structure. Staff also acknowledge the response rate to the eSELTs is poor, yet refuse to provide alternative channels for feedback, and actively discredit other established feedback pathways, including student representation on committees and results from the AMSS’ larger, more informed and more targeted surveys. As the AMSS demonstrates, it is possible to gather student opinion in a robust manner, with this survey garnering a response rate of (59%). **The AMSS maintains that it is unacceptable for the Adelaide Medical School to continue to use an inadequate method for collecting student feedback. Collecting and considering student feedback is a basic expectation of modern tertiary education. Unfortunately, there is a danger that the Adelaide Medical School’s commitment to responding to student concerns will be seen to lack credibility.** It is clear medical students require a tailored solution to accommodate the unique aspects of the medical program, which include:

1. Many teachers are involved in the medical program (over 100 staff members requiring individual review by specific students).
2. The addition of an option to give feedback regarding each course (separate to the enrolled courses), as opposed to only providing feedback on staff members. (This is necessary because the enrolled courses do not reflect reality as the medical program is an integrated rather than enrolled course-based program.)

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.'

Absences related to Mental Health

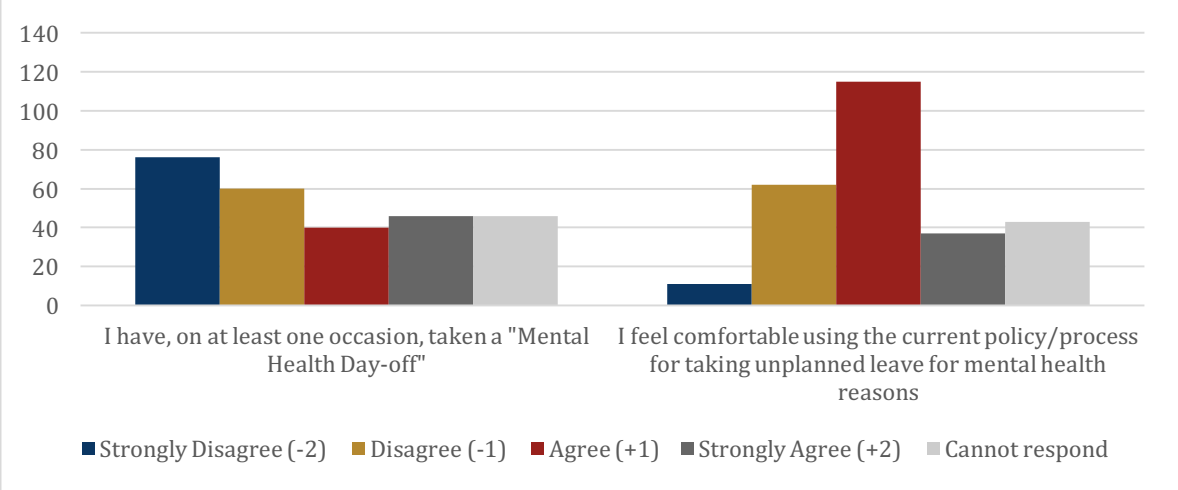
Method

Students in all year levels were asked to evaluate the policy permitting students to take unplanned leave as required for mental health reasons (colloquially referred to as "Mental Health Days-off") by rating their level of agreement with the following statements **"I have, on at least one occasion, taken a "Mental Health day-off"** and **"I feel comfortable using 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 free-text field.

Preclinical Results

Students were equivocal about having used the current Mental Health day-off policy (mode [28%]: -2 | mean: -0.4 | range: -2 to +2 | n = 268). However, students agreed they felt comfortable with using the current process for taking Mental Health days-off (mode [43%]: +1 | mean: +0.5 | range: -2 to +2 | n = 268).

Figure 28: "Mental Health days-off" (preclinical)

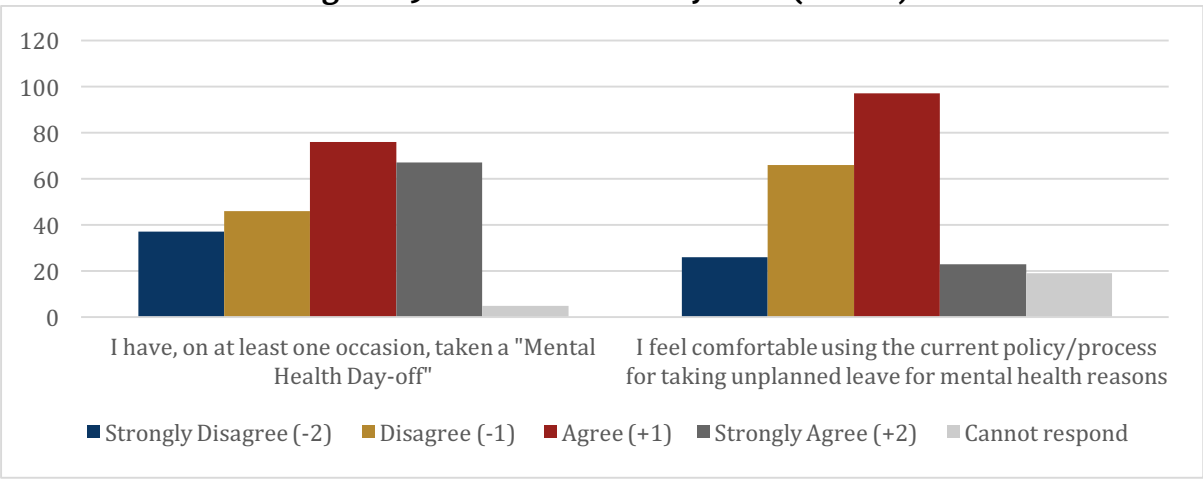


However, of the 50 free-text responses, 38 responses indicated a more negative opinion (17 from Year 1 students, 16 from Year 2 students, and 17 from Year 3 students). The most common view was that students were not made aware of such processes, or the process was confusing to follow (23 comments). Other predominant themes included being penalised due to attendance forming a summative assessment component (17 comments) and feeling the need to use another reason for the absence due to the stigma associated with mental health (2 comments). One comment that summarised the overall sentiment was: **"Attendance affects our marks, so as someone who struggles to contribute in stressful, group environments I cannot afford to take extra days off uni just for mental health reasons."** And **"Marks allocated for [CBL] is centred around attendance. Personally, I have never had to take a mental health day off but I feel if I did, I would be discouraged to as not attending a [CBL] session would result in a 0% [mark] for the session. I believe if there is a valid reason, we should not be penalised for an absence"** and **"Every time we miss a CBL session we get a 0% [mark for the session], I had influenza A with a medical certificate and I still came to uni because I would have got a 0% [mark] for that session"** and **"A tutor reduced my grade purely due to missing 2-3 CBL sessions due to medical reasons and made that very clear with their written assessment of me. I'm now afraid to skip any CBL tutorials."** and **"I think that yes mental health days are possible. But if you miss [CBL] sessions, you run the risk of falling behind. In previous years when I have taken a mental health day and a medical leave (surgery) day, it was noted in my [CBL] tutor's feedback that I had poor attendance which affected my performance and thus grades"** and **"I feel as though the implication [is] that taking a mental health day will [affect] their grades [and] can cause stress and anxiety"** and **"Leave of any kind affects your grades – even when physically sick I am reluctant to take a day off"** and **"The current process penalises students through a reduction in grades for absences unless they provide supporting documentation. Providing supporting documentation would defeat the purpose of a mental health day, as students would need to go to a doctor and request a medical certificate on the day of the absence. Therefore, students are placed in a difficult position where even if they take a mental health day they feel as if they cannot do so without reprisal"** and **"Recent mental health struggles and adjustment to new medications caused me to require more than the one designated mental health day off, and I was too unwell/unable on some occasions to make a [doctor] appointment to get a medical certificate/documentation required."**. However, 6 responses indicated that while some students had not personally used such procedures, they were glad they existed (6 comments). One student commented: **"I still went to uni when I was stressed but would still feel comfortable taking time out if I needed or was feeling overwhelmed"**.

Clinical Results

Students were equivocal that they have taken, at least on one occasion, a "Mental Health Day-off" (mode [33%]: +1 | mean: +0.4 | range: -2 to +2 | n = 231) and were also equivocal that they feel comfortable using the current process for taking unplanned leave for mental health reasons (mode [42%]: +1 | mean: +0.1 | range: -2 to +2 | n = 231). Interestingly, Year 5 students were most likely to disagree (mode [40%]: -1 | mean: -0.45 | range: -2 to +2 | n = 51).

Figure 29: "Mental Health days-off" (clinical)



However, 78 of 83 free-text responses suggested a more negative opinion (28 from Year 4 students, 26 from Year 5 students, and 29 from Year 6 students). The most common view was that there was stigma attached to taking a mental health day off (16 comments), resulting in several students telling their supervisor they are 'sick' with a physical illness (10 comments). Example comments include: **"I honestly have never actually told a team that I have taken a mental health day, but rather said I have been sick because of the fear of the implications of stating explicitly that I have taken a mental health day. I have longstanding mental health issues and it is much easier to say that I have the cold or flu or something like that because it's seen as more acceptable"** and **"[I] have been told multiple times by different members of staff over the years that taking a day off for mental health was not acceptable and if one was to take one day off for mental health it means that person needed to see someone because they weren't well"**. Other predominant themes included supervisors being unaware of the policy (10 comments) and the process being too difficult (8 comments). Example comments include: **"I think if I was to take a mental health day off or unplanned day off, by the time I found the paper work, filled it out and submitted it, I would have been better off going in for the day"** and **"All the documentation required makes it excessively difficult and I feel it is not private as I may want it to be if I want a mental health day"** and **"It is not listed as an option/example on the leave form. Furthermore, I feel like there is a stigma associated with taking time off for mental health related reasons – [especially] if we need to ask our supervisors for leave"** and **"It still seems like an invasion of privacy and a patronising dynamic for me to tell the uni when I am having a mental health day off. In the instances where I have done this, I have just communicated directly with my team that I am taking a day off. This seems like a much more adult way of managing things i.e. in the workplace if you needed a day off for personal reasons you would just tell your boss, not submit a form to the head of the company. I feel that enforcing this dynamic of recording everything at the highest level turns people away from feeling like they can be honest if they need a day off for mental health reasons"** and **"Still feel there is stigma associated with taking mental health days – the university's response to students having more than a day of absence can be quite stress-inducing, making it more difficult to report."** and **"[The mental health day] policy doesn't seem to have been conveyed to our rotation supervisors who are disgruntled or do not approve of mental health days for some reason"** and **"I agree with taking [a] mental health day-off, however, the university should have a clear announcement to the different hospitals that students are allowed to take [a] mental health day off as the hospitals might not be aware of it."** and **"Whilst through AMSS channels it has now been made clear how to apply for a mental health day off, it has not been made nearly as clear through faculty channels**

(with good support from the Dean but most course-coordinators etc. not being aware or supportive of the idea, or thinking this is only for individuals with documented mental health conditions and not as prophylaxis for the general student body who is needing a day to get back on top of their mental health). It is also not clear around the threshold for leave requirements, and hence I still fear repercussions of taking a day off e.g. on my ED term, I would assume I'd have to find time to make up the ED shift I missed, which adds further stress to the thought of taking a day off, because now I would have to find a time I am able to do this.". Furthermore, additional themes included the requirements on attendance being unclear (6 comments), and that the medical school is not supportive of mental health days (5 comments). Example comments include: **"Many [clinical placements] quote requiring 95% attendance to pass, but most rotations don't even have 20 days working ergo you can't miss a single day without fear of failing the rotation/repercussions"** and **"Although I've taken these days off, I don't feel like the medical school emphasises that these are allowed. The impression I've always gotten from the faculty is that we're discouraged from taking them"** and **"I do not feel comfortable taking [off] days for mental health as from my understanding we are only allowed 5 days of unplanned leave for the entire year including non-mental health reasons. Therefore, I would be inclined to just push through on days of poor mental health just in case I need the 5 other days for physical sickness. I am also unsure of what the actual process is for taking a mental health day"** and **"I've previously wished to take a Mental Health Day (on multiple occasions) however have feared that the faculty would not take it seriously. Given their general 'tough luck' policy (plus Dean Symonds' recent statement effective to 'you should put clinical learning opportunities above all else' at SMTS) I don't trust them to stand by their word to be honest."**. However, 4 free-text responses were of a positive nature, with one example stating: **"Leave requests [online] seem to remain unapproved and unnoticed (I still have planned leave requests from 2018 which are yet to be approved) so I feel comfortable submitting leave requests and having days off for mental health reasons as it seems unlikely these are followed up overly promptly".**

Access to Student Support Services

Method

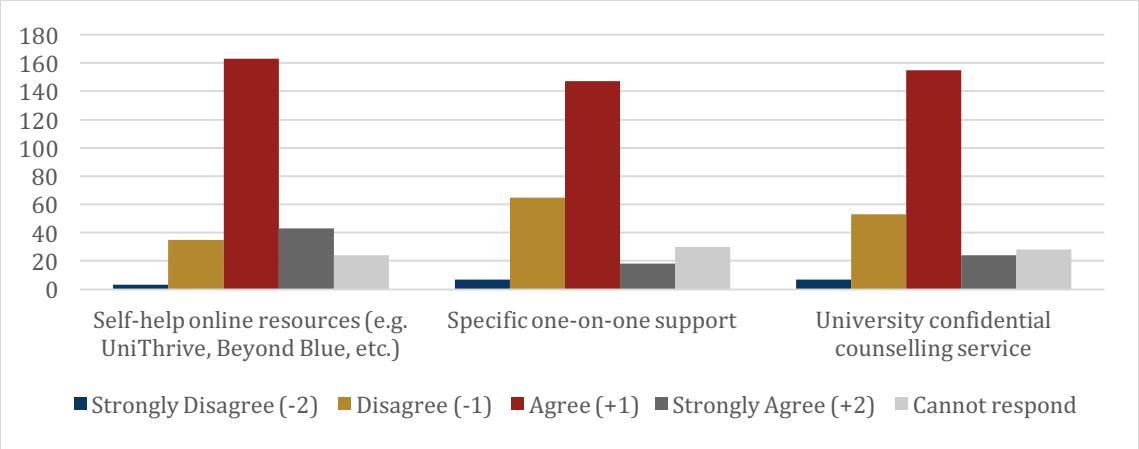
Students in all year levels were asked to evaluate current access to student support services by rating their level of agreement with the following statement: **"Many students can experience difficulty during their time in medical school with maintaining academic progress, good health and wellbeing, financial security and work-life balance. If I need to, I feel confident and comfortable accessing the following student support services:"** with three subparts **"self-help online resources"** and **"specific one-on-one support"** and **"university confidential counselling service".** 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 free-text field.

Preclinical Results

Students agreed that student support services are accessible: self-help online resources (mode [61%]: +1 | mean: +0.9 | range: -2 to +2 | n = 268), specific one-on-one support (mode [55%]: +1|

mean: +0.4 | range: -2 to +2 | n = 267) and the university confidential counselling service (mode [58%]: +1 | mean: +0.6 | range: -2 to +2 | n = 267).

Figure 30: Accessibility of Student Support Services (preclinical)
"I feel confident and comfortable accessing the following student support services"

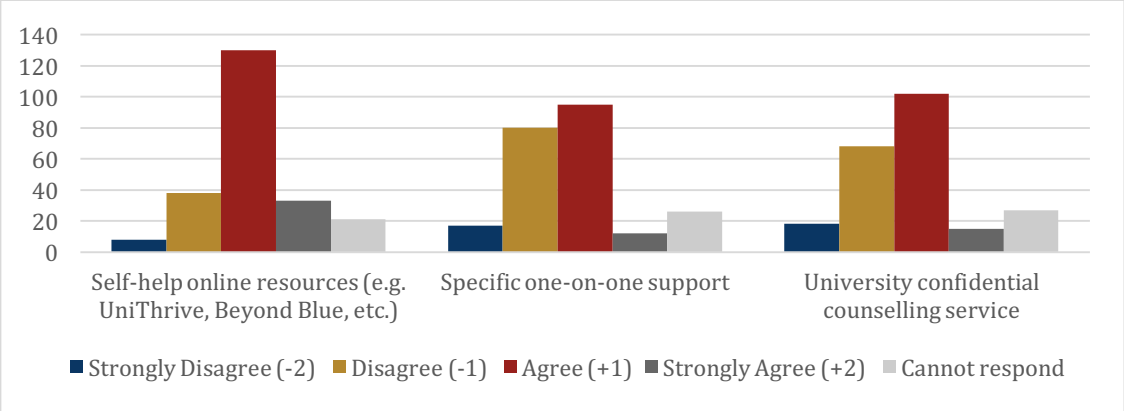


However, 21 of the 31 free-text responses indicated a more negative opinion (12 from Year 1 students, 9 from Year 2 students, and 10 from Year 3 students). The most common view was that students were not made aware of such services (10 comments). Example comments include: **"I would feel comfortable seeking such support, but would like more information regarding how I can access it."** and "… **I'm sure I would feel comfortable in using self-help online resources if I knew what they were and a bit more about them – before now I was not aware that these resources existed."** and **"… With the counselling service, we were told of it but I couldn't find it…"** and **"I think there could be more flyers up around [the AHMS Building] reminding students where they can get support if they need it.".** Other predominant themes included difficulty in booking timely appointments as services are overbooked (5 comments), services were not adequate and referred students to an external psychologist or did not have one available (4 comments) and were not appropriate for discussing finances or work-life balance (2 comments). Example comments include: **"Extremely difficult to get appointments with counselling services"** and **"The counselling service at uni is incredible (mostly for just existing) however waiting times are long (had to book an appointment 6 weeks in advance)"** and **"I don't know [that there is] anyone appropriate to speak to about financial circumstances and work-life balance at Uni".**

Clinical Results

Students agreed that they feel comfortable and confident accessing self-help online resources (mode [57%]: +1 | mean: +0.7 | range: -2 to +2 | n = 230). However, students were equivocal regarding both being comfortable and confident in accessing specific one-on-one support (mode [41%]: +1 | mean: 0.0 | range: -2 to +2 | n = 230), and in accessing the university confidential counselling service (mode [44%]: +1 | mean: +0.1 | range: -2 to +2 | n=230).

Figure 31: Accessibility of Student Support Services (clinical)
"I feel confident and comfortable accessing the following student support services"



However, 50 of the 60 free-text responses suggested a more negative opinion (22 from Year 4 students, 12 from Year 5 students, and 26 from Year 6 students). The most common view was that university counselling services were too difficult to access due to limited out-of-hour services, which did not accommodate clinical students with hospital responsibilities (9 comments), as well as it not being located nearby (7 comments). Example comments include: **"Stringent attendance requirements (8am-5pm, Mon-Fri) and inflexible leave allowances (approximately one per term, less for certain courses i.e. compulsory teaching days, rostered ED terms) make seeking in-person services almost impossible."** and **"Too hard with placement and being off campus to access services, never free in business hours"** and **"Medical students are very separated from the main uni especially in clinical years. I don't feel like we have support services offered to use when we're at placement at different hospitals all the time."** and **"The counselling services are often quite difficult to access while on placement hours and they have a very long waiting list for non-emergency appointments"** and **"It's hard to access the uni one-on-one counselling when [the] majority of the time in the clinical years I'm at hospital and not based on campus. I feel comfortable accessing the service, but it is hard to be able to get to the service when I'm based out in the Lyell McEwin [Hospital] and I have heard wait times are sometimes long and there are only specific times available and then you have to work out leave from placement.".** Other predominant themes included that students were unaware of the services available (11 comments), that university counsellors are unaware of the requirements of the medical program (5 comments), and that non-emergency services from the university service have long wait times (5 comments).

Bullying and Sexual Harassment

Method

Students in all year levels were asked to evaluate the presence of bullying and sexual harassment within the Adelaide Medical School by rating their level of agreement based on the following two statements. Firstly, **"In 2019, how often have you experienced any form of bullying OR sexual harassment at medical school (including clinical placements)?"** in five subparts **"I experienced it from an administrative staff member"** and **"I experienced it from an academic staff member"** and "**I experienced it from a clinical supervisor**" and "**I experienced it from another medical student"** and "**I experienced it from a patient**". Secondly **"In 2019, how often have you witnessed another medical student experiencing any form of bullying OR sexual harassment at medical school (including clinical placements)?"** in five

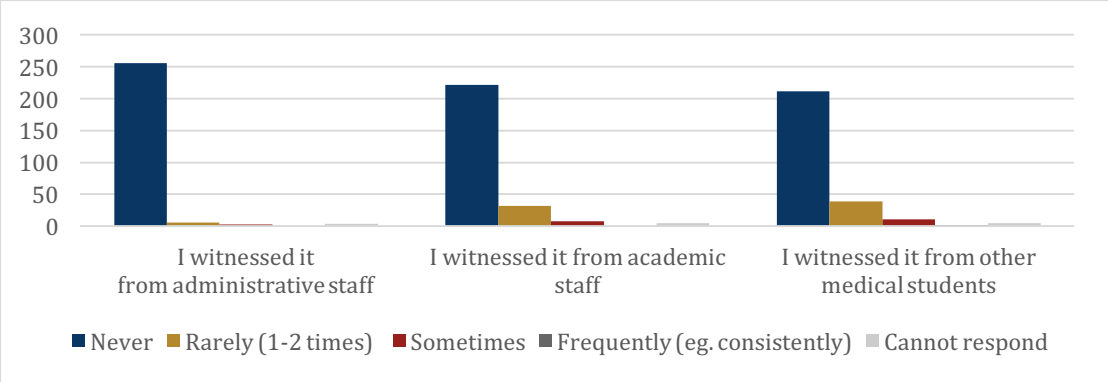
subparts **"I witnessed it from an administrative staff member"** and **"I witnessed it from an academic staff member"** and "**I witnessed it from a clinical supervisor**" and "**I witnessed it from another medical student"** and "**I witnessed it from a patient**". For both statements answers were obtained via Likert scale from -2 (representing never) to +2 (representing frequently). For both statements no equivocal midpoint was provided to attempt to reduce central tendency bias. For both statements a "cannot respond" category was included to avoid forcing students to make statements that they did not agree with. Students in all year levels were also asked whether they had made any reports: **"In 2019, have you ever reported any form of bullying OR sexual harassment at medical school?"**. Answers were obtained via yes or no categories. 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 free-text field.

It is important to note that definitions for bullying and sexual harassment were provided. **Bullying was defined as** "unwanted and unwarranted behaviour that a person finds offensive, intimidating or humiliating and is repeated so as to have a detrimental effect upon a person's dignity, safety, and well-being". **Sexual harassment was defined as** "unwanted, unwelcome or uninvited behaviour of a sexual nature that results in a person feeling humiliated, intimidated or offended".

Preclinical Results

Students had mostly never encountered bullying or sexual harassment personally (mode [87%]: -2 | mean: -1.8 | range: -2 to +2 | n = 267) nor witnessed bullying or sexual harassment of other medical students (mode [83%]: -2 | mean: -1.8 | range: -2 to +2 | n = 266). Students had never reported bullying or sexual harassment.

Figure 32: Witnessing Bullying or Sexual Harassment (preclinical)
"In 2019, how often have you witnessed another medical student experiencing any form of bullying OR sexual harassment at medical school (including clinical placements)?"



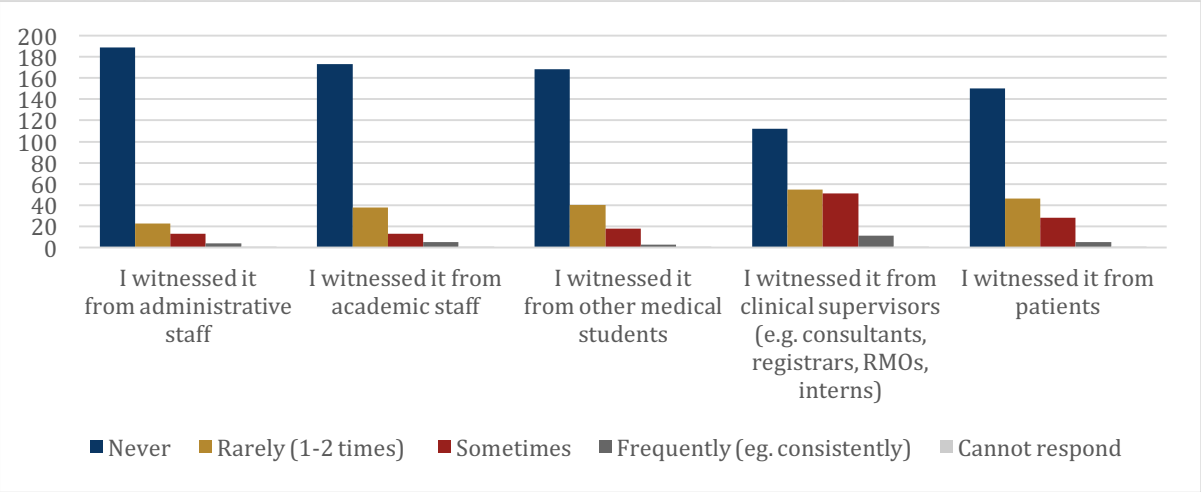
However, 33 free-text responses suggested a more negative opinion (10 from Year 1 students, 7 from Year 2 students, and 16 from Year 3 students). The most concerning view was regarding the way an incident that occurred in a Year 3 lecture was handled, and this will be used as an illustrative example. Example comments include: **"There was one incident during a lecture in which a staff member was questioned by students on a topic which was perceived as sexist (however the lecturer showed clear peer-reviewed evidence for the content they shared). This was not the issue… [The issue was that] the group of students were called immature for their comments. [The group of students] reported it to Course Coordinators and after a**

couple of months of silence [all Year 3 students] received an announcement from the Dean (Prof Ian Symonds) which I found overly harsh, inappropriate and somewhat threatening. I believe this to be a form of bullying against the group of students who complained." and **"During one Year 3 lecture, the cohort (as a whole) was very uncomfortable with the conduct of the lecturer. He made the students feel very uncomfortable when asking questions about the topic being taught, using sexist remarks as it was only females who were asking questions. The lecturer was reported to the medicine faculty, however, the faculty responded saying the students were behaving inappropriately."** and **"A lecturer was sexist and when we gave feedback, the Dean of Medicine took this man's side without fully acknowledging students' views. We were not made to feel heard or made to feel like we could follow up the matter safely."** and **"[There was] an escalation of a discussion between a lecturer and several students, where the lecturer became extremely agitated, rude and unpleasant. The lecturer in question [had] been rude on previous occasions."** and **"One lecturer acted very rudely and condescendingly when his point of view was challenged by multiple students"** and "**A lecturer made multiple sexist comments about woman, belittling their motivations in life as simply to make friends"** and **"We had one particular lecture in which the conduct was rude and misogynistic"**. Additionally, in the survey clinical students continued to mention the poor behaviour of this specific lecturer, and stated that this issue had been reported annually since 2015 with no action being taken. Example comments include: **"[He] is deliberately mean to the medical students and should be sacked from the university… We would rather someone who cares for our wellbeing and respects us."** and **"I've overhead [him] absolutely rip into a student (far beyond what could have been reasonable constructive criticism). These comments seemed intentionally destructive and hurtful and it was really uncomfortable"**. Furthermore, it should be noted that preclinical students also have wider concerns, including: **"I've been subject to belittling comments/jokes on a couple of occasions when I've been made to feel that I am somehow worth of less respect because I am a woman"**. It is unfortunate students perceive the main issue to be not these incidents themselves, but more so how their reports of incidents are dealt with.

Clinical Results

Students had mostly never encountered bullying or sexual harassment personally nor witnessed bullying or sexual harassment of other medical students. The majority of students had never reported bullying or sexual harassment.

Figure 33: Witnessing Bullying or Sexual Harassment (clinical)
"In 2019, how often have you witnessed another medical student experiencing any form of bullying OR sexual harassment at medical school (including clinical placements)?"



However, 110 free-text responses suggested a more negative opinion (38 from Year 4 students, 35 from Year 5 students, and 37 from Year 6 students). The most common view was that despite many students experiencing bullying, it is the way in which these incidents are dealt with by the Adelaide Medical School that is most upsetting for students. Example comments include: **"I have been very disappointed with my [peers'] comments on how the medical school has responded to their complaints against staff, supervisors and other medical students. I have repeatedly heard stories of clinical bullying (in the form of abusive feedback from supervisors etc.) or even sexual harassment [not being] escalated by the medical school after complaints have been lodged. Many clinical supervisors are known as bullies and unpleasant by students but despite multiple complaints have continued to hold prestigious roles which I find disappointing. I have also heard of complaints of medical students harassing other medical students (both emotionally and sexually) which have been escalated but without any clear action made (e.g. students being placed together on a [clinical placement] despite one student having emailed [the medical school] regarding the sexual harassment)."** and **"As a young female I have had sexually aggressive comments made knowingly and directly at me by a middle-aged male surgeon in the middle of a theatre staff by all female nurses, and not one person stepped in or offered support afterwards. This has completely changed my career direction and I now no longer consider surgery a desirable working environment. I have never experienced bullying or sexual harassment outside of surgical rotations. At times patients with frontal dementia can be inappropriate however we are well-trained by medical school on how to deal with this. Sexual harassment by senior surgeons however – no training on how to deal with it at all."** and **"Worst situation I'd experienced was being regularly yelled at and slapped on the arm/hand on multiple occasions in theatre by an orthopaedic consultant on Surgical Home Unit in Mount Gambier. Despite this consultant REGULARLY being brought up, nothing has been done."** and **"I have had several experiences that left me feeling uncomfortable. I have had RMOs get my number from other students and contact me after hours. I have had others find me on Facebook and send me private messages asking me out or commenting on my [Facebook] wall inappropriately. On one occasion it was quite bad and when I notified my placement supervisor I was told to let him know it if it got worse and nothing was done."** and **"A female RMO got my number from another student and started messaging me after hours. She then found me on Facebook and started commenting on things. While on placement she refused to let me see patients or talk to other doctors, had**

me write all of her notes and tried to get me to write medication charts despite me telling her I legally couldn't. I was made to stay longer than required on placement and was given breaks at times different to other medical students. I felt she was isolating me from others and cyber-stalking me after house. I reported this to my supervisor and was told to tell him if it got worse by which time the placement was almost over." and "**Reported an RMO in 4th year to my registrar at the end of my rotation, but as far as I'm aware nothing came of this."** and **"Have been harassed by academic staff previously via email and it was only because he accidently cc'ed in another member of staff that he apologised."** and **"I reported the bullying to the supervisor of the rotation, but would have no idea who to report it to within the medical school"** and **"There is no well-established avenue in the hospital system [or] the university to report this. And when it has been reported, little has been done about it"** and **"No idea how to report a staff member! There is no clear proforma or guideline easily accessible to students (I even looked for one)"** and **"… Having better reporting systems when sexual harassment occurs and to take students reporting bullying seriously. I am happy to be leaving the medical school as I am just tired of dealing with them over the years."** and **"I don't know who to report it to and don't believe there would be any sort of outcome anyway"**. Another common theme was regarding bullying by administrative staff. Example comments include: **"Administrative staff, specifically the Student Engagement Team for the Faculty of Health and Medical Sciences have been extremely condescending, rude and dismissive over the past two years that I have worked closely with them. As students… little to no weight [is] given to our opinion, however we are then also expected to run activities FOR the Student Engagement Team with no credit… Even after this, they have been incredibly rude to myself and other students and no taken on any feedback despite us constantly asking to reach a fair compromise… This has led to significant burnout… and despite escalation to higher up staff members we have no received [an] adequate response."** and "**The Student Engagement Team had our students run an educational orientation even for first year students and we were abused on how we went about it despite spending a lot of our own free time to do so.**" and **"I experienced a disregard for student support and very detrimental input from members of the Student and Program Support Team. [I have] consistently felt unsupported by them and incredibly poor/rude communication with them has made contacting them very disheartening. While they were sent emails regarding better communication and relationship with student societies, the emails fell to silent ears and ideas put forth were rebuffed time and time again."**

Separation of student support and academic progression decision making

Method

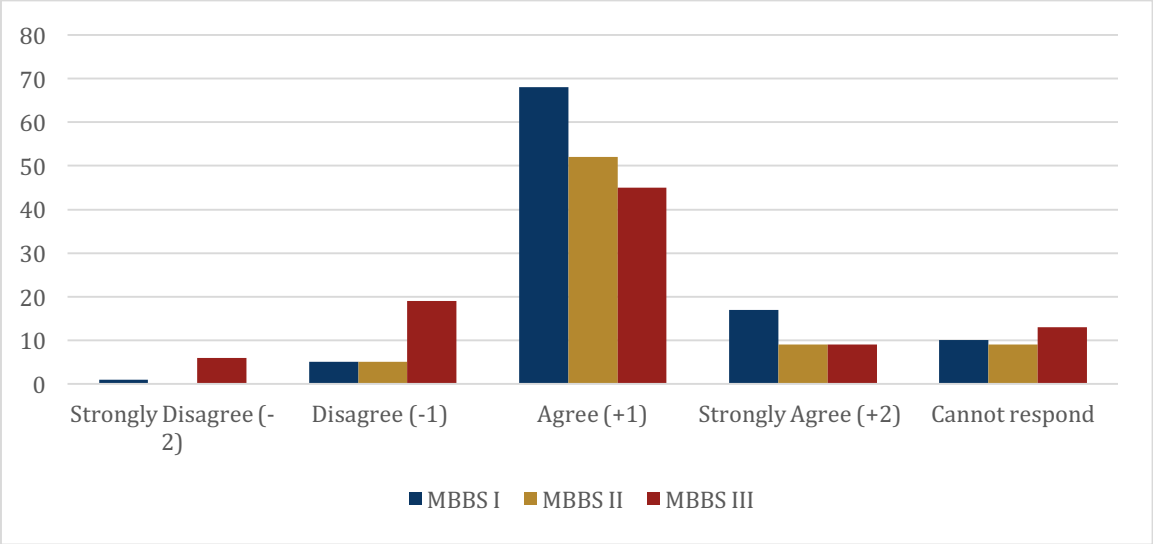
Students in all year levels were asked to rate their level of agreement with the following statement: **"As a medical student, I am able to get support and accurate advice on any issues arising from medical school (including clinical placement) from an individual I trust in a way that makes me feel safe, without fear of risking my academic progression"**. 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 free-text field.

Preclinical Results

Students agreed that they were able to get support and accurate advice without risking their academic progression (mode [62%]: +1 | mean: +0.8 | range: -2 to +2 | n = 268).

Figure 34: Student support and academic progression (preclinical)
"I am able to get support and accurate advice without risking my academic progression"

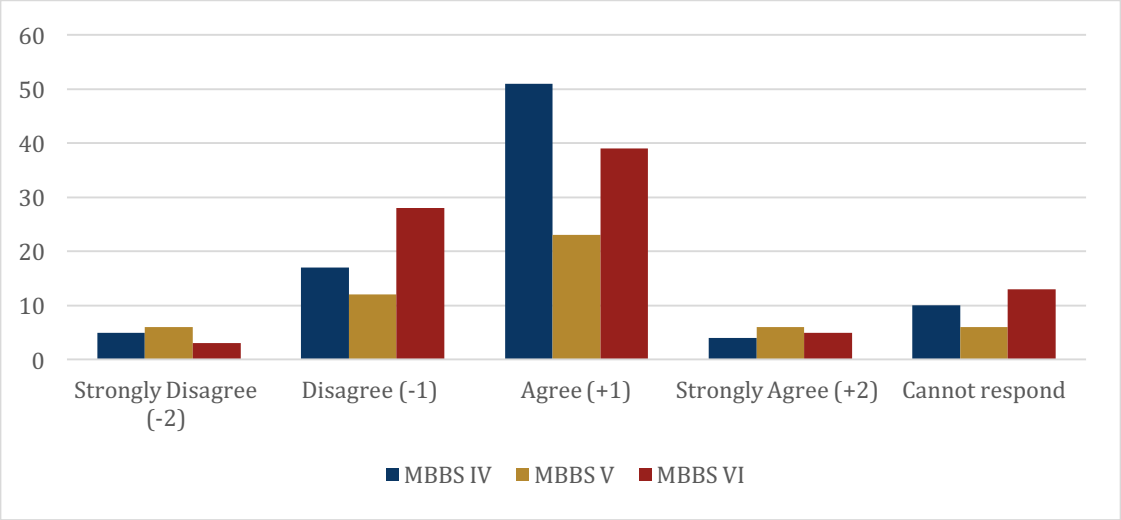


However, 14 free-text responses suggested a more negative opinion (4 from Year 1, students, 1 from Year 2 students, and 9 from Year 3 students). The most common view was that students have significant concerns about their academic progression when seeking help from staff at the Adelaide Medical School (9 comments). Example comments include: **"I think there is still [a] culture of fear and apprehensiveness surrounding how the medical school might respond to individuals raising concerns about tutors, other students, etc. Whether or not this is justified, I think that it is difficult to change this belief without changing some of the systems available for reporting concerns (e.g. would an anonymous reporting system be possible/does one already exist?)"** and **"I am fearful of being blacklisted or dropped from the course"** and **"… Seeking one-on-one support within the medical school is often a daunting task for preclinical students, who associate the medical school faculty staff as the body who passes/fails students, and I have known a number of preclinical students who did not want to risk their 'reputations' with the medical school teaching staff by revealing they were stressed/unwell"** and **"If an issue is raised, it cannot be guaranteed that a student will stay anonymous. It cannot be promised that a student will be protected when a university staff member is involved. Students' don't feel comfortable raising issues when their academic progress is [likely] threatened."** and **"Due to the way that a certain issue was handled this year regarding the behaviour of a lecturer, [including the] a lack of transparency in the process and no review by an impartial/external third party, I would not feel safe reporting any [future] issues that may arise".**

Clinical Results

Students were equivocal that they were able to get support and accurate advice without risking their academic progression (mode [50%]: +1 | mean: +0.3 | range: -2 to +2 | n = 228).

Figure 35: Student support and academic progression (clinical)
"I am able to get support and accurate advice without risking my academic progression"



However, 29 free-text responses suggested a more negative opinion (10 from Year 4 students, 16 from Year 5 students, and 12 from Year 6 students). The most common view was that students have significant concerns about their academic progression when seeking help from staff at the Adelaide Medical School (21 comments). Example comments include: **"I wouldn't even know who to talk to as I don't feel like I trust the medical school"** and **"I would not have any idea who to go to for this advice. Also I would have significant concerns for my academic progression."** and **"I personally would not feel comfortable approaching some of the faculty's senior staff to make a complaint out of fear of damaging my reputation/progression"** and **"[Staff] seem to be judgemental in the name of 'professionalism' and I would not trust them to support me without risking my academic progression"** and **"I would not know which individuals I would confide in that would be detached from the medical school or the hospital. I would not trust that there was [no] conflict of interest."** and **"I felt completely fine in preclinical years, but uncomfortable in clinical years due to most of the supervisors being future bosses"** and **"Being on rural placement, it can be difficult when the person who is bullying students is the person who we need to report bullying to."** and **"When you are bullied by a relatively senior doctor [and] member of academic staff in the med school you are too afraid to speak out or report to them, much [less be] able to talk to someone else in the medical school (least they find out and make life harder for you). Plus there is no easily identified process on how to make a complaint."** And **"I never complain about anything before the end of [the clinical placement] in case my examiner is the person to or about whom I complained. Our [assessment] is subjective enough as it is so I would rather avoid that."** and **"I think if I expressed displeasure to most staff they would be defensive and unhelpful…"** and **"Even if you try to tell people about your issues they are always met with extreme defensiveness, and hesitancy to actually make any changes to help. There are a select few people (mostly clinicians volunteering within the medical school) who are actually on our side and understand what we are going through."** and **"Academic staff [say they] always want feedback but they never accept the**

feedback I give or take it seriously" and **"It is very difficult to know who to go to about these issues and I have experienced a level of disengagement from many staff members"** and **"One-on-one faculty support is non-existent as the general uni supports often don't know much about the [medical program] and can't give much help – the medical school or at bare minimum the [faculty of health and medical sciences] should have a separate student welfare person who is designated to be the STUDENT'S advocate, not taking the side of the university"** and **"There is no person available (outside of my own mentors) that is made clear to students as a person separate to your academic progress to discuss these issues [with] and provide accurate advice. Admin and central uni staff don't understand the medical course to provide information, and medicine staff available are entirely the ones involved in your assessment."** and **"Whilst there are specific academic staff that would offer one-on-one support, there lacks a 'go to' person for such concerns that is separate to my academic progress that actually knows the [medical program] well enough to provide accurate advice"** and **"Whilst I have frequently encountered staff (at tutorials and on clinical rotations) with whom I feel comfortable discussing my academic progress and areas of weakness, the lack of consistent and easily accessible support staff in the medical school makes this primarily a matter of chance rather than an indication of the advice available through the medical school. A list of contacts (who are not involved in the assessment process) and regularly contactable throughout the year may be useful in ensuring that those who are less fortunate in the clinical teams that they encounter feel comfortable in seeking advice"** and **"There doesn't seem to be an independent person within the medical school who would actually [be informed about] the medical school and hospital [requirements]"** and **"I feel like nothing much can be done so I don't seek help".** One student was more positive: **"I don't know any of the admin/academic staff well enough to say I could go to them. I honestly think I wouldn't fear risking my progression, but more that they would just do nothing at all".**

Conclusion of Standard 7.3

The Adelaide Medical School **does not meet** the sub-point under Standard 7.3 regarding student support services. This is because students have significant concerns that the Adelaide Medical School is unsupportive of absences related to mental health, does not provide easy access to student support services, does not adequately prevent bullying and sexual harassment, does not separate the provision of student support from academic progression decisions, and does not provide adequate support to Indigenous medical students. **Overall, the AMSS has significant concerns about student health and wellbeing. The AMSS remains worried that a lack of preventative action is leading to an inevitable crisis point that risks the safety of students in the medical program.**

<u>Absences related to mental health</u>

Students believe that the policy permitting students to take unplanned leave as required for mental health reasons (colloquially referred to as 'Mental Health Days-off') is unclear, inaccessible, and not supported by staff. This is true for both preclinical and clinical students, but for slightly different reasons:

1. Preclinical students continue to be obstructed from using the policy permitting students to take unplanned leave as required for mental health reasons due to their conflicting attendance policy. A summary from the online Course Outline (https://www.adelaide.edu.au/course-outlines/013241/1/sem-1/): **"Tutorial assessments: All tutorials are weighted equally. Tutor assessments are based on student**

demonstration of knowledge/reasoning/professional competence in tutorials. Students are unable to demonstrate competence if they are not present, therefore students will receive a zero grade for tutorials where they are not present unless there are exceptional medical, compassion or extenuating circumstances as defined by the Modified Arrangements for Coursework Assessment Policy.". This meant students who are absent will receive a zero for that tutorial unless their absence falls under the Modified Arrangements for Coursework Policy or an Access plan. This policy is one intended for planned examinations rather than ongoing coursework, meaning that even for legitimate unplanned absences (e.g. a medical certificate from a certified health professional), students would receive a zero grade for that session. It was only after extensive advocacy led by the AMSS that this was amended to: **"In response to student concerns expressed to the Dean, the decision is that occasional legitimate absences will not be penalised. Because it is a full year course, final adjustments to adjust for absences [will occur] at the end of the year when the following will happen:**

a. **The 'factor' for absence will be adjusted to allow for four unsubstantiated absences per year (average 1 per term). This will result in no penalty for students that have overall 95% attendance for Year 1 and Year 2 and 90% for Year 3.**
b. **The 'factor' will be further adjusted for absences that fit the Modified Arrangements for Coursework (MACA) policy (i.e. correctly documented absences) if overall attendance is >85%.**
c. **Students with >15% documented absence over the year that fits the MACA policy will be considered on a case-by-case basis. "**

However, the initial statement remains online and is easily accessible by students. The AMSS is severely disappointed that it was only following persistent student advocacy that staff decided that '**occasional legitimate absences will not be penalised**', which seems self-evident. **The AMSS maintains that it is not acceptable for students to remain unsupported and indeed actively penalised for choosing to look after themselves in a professional manner. Self-care and professionalism are closely intertwined and students should be encouraged to develop these skills, which are crucial for ensuring a fulfilling and safe career as a doctor.**

2. Clinical students at clinical placements continue to note a lack of awareness and enactment of the policy permitting students to take unplanned leave as required for mental health reasons, due to clinical supervisors remaining unaware and questioning the legitimacy of "Mental Health days-off." This is a significant issue not just in terms of lack of support, but also for the potential for harm. Measures to ensure clinical staff receive communication regarding the policy is strongly encouraged. Furthermore, while clinical students understand the rationale for monitoring attendance, the requirement to provide written justification for an absence is a barrier, because it suggests that the reason will be closely scrutinised. This means students feel concerned that they will not be supported by staff in taking leave for mental health reasons. This is further compounded by the fact that the categories for which students may apply for leave do not even mention the words 'mental health', nor indicate that it is an acceptable reason. Likewise, it is important to acknowledge that this is often an area that is personal and can (unfortunately) be associated with a degree of stigma. **Requiring that students openly acknowledge taking 'mental health days', to an organisation that is responsible for assessing competency and has previously conveyed a 'push through it' attitude (and who are not actively communicating otherwise), is a strong deterrent to students**.

Access to student support services

Students are generally unaware of the support services (including counselling, wellbeing and academic advisory services) available to them and are equivocal regarding the effectiveness of these services. Particular concerns regarding the university confidential counselling service included difficulty in booking accessing appointments promptly (as services are overbooked and have long wait times), difficulty accessing limited out-of-hours appointments (as clinical students have clinical responsibilities during business hours), and that the services were not informed regarding the requirements of the medical program.

Bullying and sexual harassment

While it is difficult for the Adelaide Medical School to address the wider culture of bullying and harassment in medicine, what is relevant to their duty of care to students is responding to and adequately addressing student complaints of verbal, physical and sexual harassment and abuse experienced from clinical supervisors, academic and administrative staff. **The AMSS has grave concerns regarding the welfare of Adelaide medical students and the grossly inadequate processes currently in place for incident reporting.** It is clear that despite many incidents being reported, there is no staff response and no visible outcomes are achieved. Sadly, it seems in some cases students are even actively penalised. These factors together have understandably led to a strong sense of futility and fear in the student cohort. Many students believe there is currently no value in reporting incidents, and doing so may in fact be to their own detriment. On student summarised the situation: **"Due to the way that a certain issue was handled this year regarding the behaviour of a lecturer, [including the] a lack of transparency in the process and no review by an impartial/external third party, I would not feel safe reporting any [future] issues that may arise".** This report contains the example of preclinical students being bullied by a lecture, which lacked a transparent and professional response. This is not an isolated instance, but has been chosen to exemplify a wider systemic issue that bullying has become accepted and ingrained in the Adelaide Medical School culture, and student experience suggests current staff responses are actively detrimental to progress.

Separation of student support and academic progression decision making

The Adelaide Medical School does not separate student support from academic progression decision making. It should be noted that students are concerned about raising issues with staff due to their role in decisions regarding academic progression. Students continue to emphasise that there is a lack of support from the Adelaide Medical School, and that there appears to be no one who is both aware of the requirements of the medical program and whose role is to support medical students. **There is a disconnect between the Adelaide Medical School's stated importance of students taking care of their own mental and physical wellbeing and the student experience of accessing support. Unfortunately, there is a danger that the Adelaide Medical School's commitment to supporting student mental health and wellbeing will be seen as tokenistic and lacking credibility.** One student's comment is insightful: **"Many members of the Faculty of Health and Medical Sciences seem to preach student engagement and [wellbeing] but rarely put this into practice. On regular occasions this year it seems that the faculty put priority on their staff and their own interests rather than prioritising our education."**. Finally, one student summarised the issue as: **"It feels like there is no one from the Medical School who is there to support us. Supports are almost exclusively from our own friends, family and organisations like the AMSS who make themselves visible and work hard to ensure that we are aware of the little support structures and people in the institution that**

exist to help us. There NEEDS to be a better student support structure. Running a breakfast once/twice a semester is not enough."

Inadequate support for Indigenous students

Unfortunately, the Adelaide Medical School is not providing adequate support to Indigenous medical students. This was not directly explored in the survey because there are fewer than ten Indigenous students in the medical program, and this issue has instead been identified through direct discussion with Indigenous students. **One Indigenous student stated that they feel they have seen a decline in services provided over the course of their five years of medical school: "My general thoughts at the moment are that there is little support for the [Indigenous] students, having declined from what it was previously when I started. I wouldn't be here if it weren't for the support I received. I'm trying what I can individually [they are currently tutoring all the younger Indigenous Students remotely from their rural site] but I worry about [preclinical students]".** The main issues identified are:

1. Lack of a dedicated Indigenous Student Study Space at the AHMS building (discussed in Standard 8.1)
2. Lack of access to ITAS tutoring

   The University of Adelaide is meant to offer free tutoring for Indigenous students through ITAS. Unfortunately, despite repeated requests, no Year 1 Indigenous medical students have access to ITAS tutoring. They are still waiting to hear back about this, despite having already had to sit their first set of summative examinations.
3. Lack of a dedicated orientation for Year 1 Indigenous medical students prior to O'Week

   One Indigenous student (the AIDA representative) tried to organise this in 2019 in conjunction with the Adelaide Medical School Indigenous Coordinator, however wider staff were not supportive in setting a date prior to O'Week for this to occur. While Indigenous students were eventually able to meet with this Indigenous staff member early in 2019, there was no opportunity for students to meet groups external to the Adelaide Medical School such as FAIMM (Flinders and Adelaide Indigenous Medical Mentoring).

The AMSS maintains that it is unacceptable for the current level of support to Indigenous medical students to continue. The AMSS is seriously concerned about the impact of these issues on Indigenous students, especially regarding long term retention rates, as well as in terms of wellbeing. Supporting Indigenous students is critical to improving health outcomes in the Indigenous population and is a basic expectation of medical education. Unfortunately, there is a danger that the Adelaide Medical School's commitment to supporting Indigenous medical students will be seen to lack credibility.

Standard 8 | The Learning Environment

Standard 8.1 | 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.'

Quiet Study Spaces for Preclinical Students

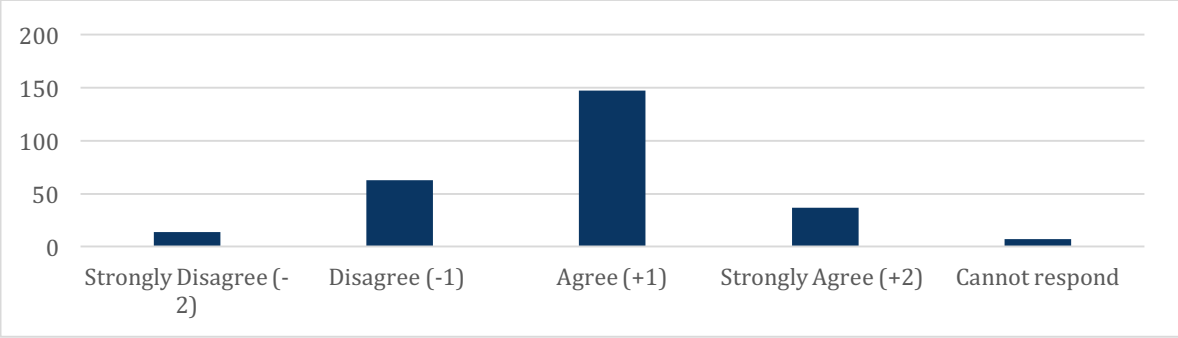
Method

Preclinical students were asked to evaluate the availability of quiet study spaces within the Adelaide Health and Medical Sciences (AHMS) building by rating their level of agreement based with the following statement **"Within the AHMS building, quiet study space is available during the university term (working hours)".** 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 free-text field.

Results

Students agreed that there was adequate quiet study spaces at the AHMS building during the term (mode [55%]: +1 | mean: +0.5 | range: -2 to +2 | n = 268).

Figure 36: Availability of Quiet Study Space at the AHMS Building
"Quiet study space is available during the university term"



However, of the 80 free-text responses, **every free-text response** focused on the lack of quiet study space (26 from Year 1 students, 18 from Year 2 students, 36 from Year 3 students). Students acknowledged that while there are dedicated areas, these are too small and fill up too quickly, forcing students to study in places which are busy, crowded, and too loud. The most common view was that there are not sufficient spaces for the number of people needing them (66 comments). Other predominant themes included the large amount of underused staff

space that students cannot access (8 comments). Example comments include: **"There are massive areas that are behind glass screen doors used as 'office space' for staff. It looks like a great area [but] we can't access it. It seems the staff assigned to work in those areas are never there… seems like a waste, especially when the staff then have meetings in our 'assigned study spaces'."** Students also complained about not enough chairs or workstations in the newly built quiet study room (5 comments). Example comments include: **"While the new Level 4 Quiet Study Area has been a very good decision, there is still a lack of quiet study space compared to the number of students. Especially around midday, it is difficult to find a quiet study area, and we often have to settle for areas with noise disturbance."** and **"There is not enough space despite new areas being allocated. There is constant overcrowding and many students stuggle to find places to study during the university term."** and **"There are some study spaces but more often than not they are all occupied and I struggle to study at uni due to how busy the communal areas are.".**

Conclusion of Standard 8.1

There are many positives of the physical infrastructure of the Adelaide Health and Medical Sciences (AHMS) Building, however there remain several issues regarding the allocation of space that means the Adelaide Medical School currently **does not meet** the sub-point under Standard 8.3 regarding satisfactory physical facilities. In 2017, the Adelaide Medical School moved from (the now) Helen Mayo Building on Frome Road to the Adelaide Health and Medical Sciences (AHMS) Building on North Terrace. The AMSS recognises it is difficult to give negative feedback about a new building, especially one that was costly to build and one that has won numerous architectural awards. However, the AMSS believes the concerns raised by students are valid and deserve to be considered. Staff are very proud of the new building, but unfortunately students have concerns that it is not fit-for-purpose based on three key factors, all of which represent simple alterations that would greatly improve student satisfaction.

1. The lack of quiet study space available for students

   In 2019, new areas (e.g. Level 4 Quiet Study Area) were converted to become quiet study spaces following student concerns raised in 2018, for which students are grateful. However, the availability of quiet study spaces remains one of the most common issues raised to student representatives, **and students feel their ongoing concerns are not heard.** The conversion of existing spaces into student study areas to accommodate more students is a priority.

2. The lack of private space available to be used for Student Counselling Services

   This was not directly explored in the survey but was identified as a common theme in the free-text comments. Previously in 2018, the university confidential counselling services were offered on trial at the AHMS building (rather than their nomal location of the central university campus). Unfortunately, students were not invited to provide input as to how the counselling service could best be implemented. The area chosen for this trial was some glass rooms in a public staff area (visible from a major student hub space), and hence lacked confidentiality so students did not feel comfortable attending. Furthermore, advertising and communication of the trial was limited, which meant the vast majority of students were not informed about this new option. Ultimatley, due to lack of attendance, the university confidential counselling services were withdrawn from the AHMS building following the three-month trial. To access counselling services now, students must either walk 20 minutes or use a tram to

get to the central university campus which remains a significant barrier to seeking help. **The AMSS believes this needs a more active effort with better student consultation as it could be a great success and a tangible way of improving mental health. Despite multiple requests and meetings, it has not been reinstated.**

3. The lack of safe space for Indigenous students
    a. This was not directly explored in the survey because there are fewer than ten Indigenous students in the medical program, and this issue has instead been identified through direct discussion with Indigenous students. **It is extremely disheartening that the Adelaide Medical School has not made a dedicated safe study space for Aboriginal and Torres Strait Islander medical students**. One Aboriginal student explained that with a large family and noisy house at home, they previously found having a dedicated place that they knew they could study in (with 24/7 access and mentors nearby) crucial. This student feels that the current setup of either needing to walk 20 minutes or use a tram to get to a different campus just to find a quiet study spot burdensome and a barrier to completing their studies. **"As far as specific resources go, Yaita Purruna was the best thing [Adelaide Medical School] did, but with the move to new AHMS [Building], this has been lost. Yaita Purruna was the Indigenous Health Sciences study space which was available 24/7 [in the old medical school]. It had 4 computers, 6 desks, a mini fridge [and a] microwave and was an awesome place to study quietly. In addition, it was a good meeting place to see some of the other older years (I met my mentor Dr Bodie Rodman there, as well as Rhodes scholar Claudia Paul) and get support/help if needed".** This space remains on the central university campus and has since been downsized.