



**MSaND**

**MEDICAL STUDENTS ASSOCIATION OF NOTRE DAME, FREMANTLE  
(MSAND)**

**STUDENT SUBMISSION TO THE AMC APRIL 2009**

**1. Introduction**

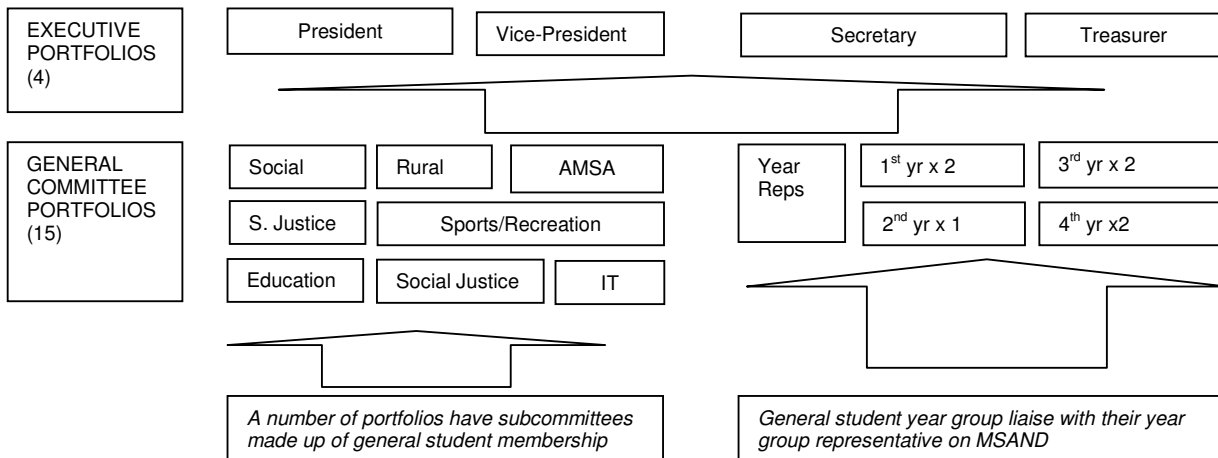
MSAND is the peak representative body of the Medical Students of Notre Dame, Fremantle. This submission has been prepared by the President and Education representative of MSAND, with input from the general committee and parties representing students on school committees. A brief overview of MSAND is provided along with a discussion of various aspects of the MBBS student experience at the University of Notre Dame, Fremantle. The intent is that this document provides a broad framework and background to facilitate further direct and specific student input to the AMC during their visit to the School of Medicine in June 2009.

**2. Objects of MSAND**

The objects of MSAND, a non-profit organization, shall be to

- i. promote the well being and interests of the students;
- ii. further the common interests of students;
- iii. provide for and encourage communication among students
- iv. provide extra-curricular activities for the general well-being of students;
- v. represent students whenever such representation is necessary or desirable, and to provide a recognised means of communication between the students and the school of medicine, university authorities and other relevant bodies;
- vi. assist and co-operate with any body or organisation having kindred aims;
- vii. provide, conduct or manage educational, cultural, sporting, welfare, recreational or commercial facilities or activities intended for the benefit directly or indirectly, of students and,
- viii. reach beyond the university boundaries and contribute effectively to the wider community

**3. MSAND Structure**



#### **4. The Context of the Medical School & Monitoring / Evaluation.**

- a) *Student representation and consultation within the School's governance structures, opportunities for student feedback about the course & mechanisms for student involvement in course development.*

MSAND provides an avenue for frequent and open consultation between the School of medicine and student body. The MSAND president and Education representative meet frequently with the Dean to discuss overarching issues and matters of interest, providing a frequent point of contact between the two parties. Further to this, each year group have representatives who liaise frequently with year coordinators, academic and administrative staff, in regards to matters arising within a particular year group.

The School of medicine encourages and requests student representation on each of the following committees: -

- i. Syllabus committee
- ii. Assessment committee
- iii. Selection committee
- iv. Evaluation committee
- v. Research committee

Student representatives also sit on the St John of God Medical Undergraduate oversight committee, which evaluate the quality of clinical placements in the private sector, particularly those placements at the St John of God hospital campuses.

In 2009 MSAND has arranged both preclinical and clinical representation on the appropriate committees, ensuring adequate representation across all four years. Student input is both welcomed and encouraged at the committee meetings. The representatives feel well supported to give meaningful contribution and that any input is both respected and considered.

Student representatives feed back to the student body, and are coordinated via the MSAND Education Representative.

There is a biannual student-staff liaison meeting between the members of MSAND and the relevant staff of the school of medicine. Students have the opportunity to appraise the course and feedback through a weekly teaching / lecture / PBL evaluation program in years Med 100 & 200, as well as end of semester evaluation of both domain areas and individual teaching staff.

For students in the clinical years feedback is delivered via online and paper rotational evaluation surveys with honest and constructive feedback immensely encouraged. Feedback is also asked for and delivered directly to Notre Dame hospital coordinators at weekly face to face tutorials.

- b) *Staff (academic, admin and technical available to support curriculum needs and the quality of teaching (either in general or with examples of strengths and weaknesses)*

University based academic staff are approachable and supportive to students in a general capacity, and in their specific academic areas. Academic staff, if not permanently based at the university are freely contactable by email, as are the staff involved from Curtin. If a problem is not resolvable via email, there will be a coordinated effort to meet face to face and resolve the issue.

In general, hospital based staff and clinicians, provide high quality structured and opportunistic clinical teaching as well as regular tutorial coordination at the respective hospital sites.

PBL tutors are well informed about the weekly problem and learning objectives and effectively facilitate the PBL process that is necessary for the development of clinical reasoning skills. There is however, variability of quality between tutors based upon their own clinical experience and personality.

Med 100 & 200 clinical skills have been an area identified as one that somewhat lacks in trained available staff to support optimal learning requirements. Clinical skills curriculum areas are being covered, however students feel that with an increase in specialised staffing there is potential for the current set up to be improved. The organisation of clinical skills sessions was also an area identified as lacking and has improved in the last year.

Communication between administrative staff and students about day-to-day issues, such as timetabling, cancelled and rescheduled lectures and lecture note availability is also an area identified by the students as one that could be improved, particularly in Med 200.

One of the great strengths of the integrated nature of the Notre Dame program is the lecture program delivered by consultant clinicians or field experts. Usually these lectures are pitched at the appropriate level of learning and cover the necessary learning objectives. There are however semi-regular occurrences of lecturers reporting that not enough time has been allocated for delivery of the required content, something that arouses student concern.

## **5. The Outcomes of the Medical Course**

### *a) The statement of outcomes for the medical course and their clarity to students*

The over arching outcomes and goals of the MBBS course are freely available to students and can be accessed through the student handbook and course guidelines link via the portal. Specific outcomes for each year are outlined through weekly learning objectives for MED 100 & 200, and in rotation study guides for MED 300 & 400. It is clear to all students that assessment and expectation of learning goals is firmly based upon the published learning objectives.

### *b) The relationship between the medical school and other agencies involved in the delivery of education.*

Curtin University of Technology – the Curtin program for students in Med 100 & 200 is well coordinated and offers an organised and comprehensive coverage of the necessary syllabus areas for the basic & clinical science domain. Students have commented that perhaps the amount of feedback that the Curtin lecturers and teaching staff receive from the Notre Dame based student feedback is limited.

Clinical teaching in the hospitals is perceived by students to be well coordinated. Some concern had been raised about cross-site teaching with students expected to attend tutorials / teaching at different hospital campuses in one day. The primary concern here is one of travel time, fatigue and personal financial cost. This issue has already been somewhat addressed with the proposed change of the ophthalmology rotation from the 4<sup>th</sup> to 3<sup>rd</sup> year curriculum.

Hospital based Notre Dame administrative staff are a valued point of student contact and provide an organisational focus, thus contributing to positive learning experiences on clinical placements.

## 6. The Medical Curriculum

### *a) The School's information concerning course content, sequencing and clarity of the curriculum*

Information regarding the course content is difficult to comment on. In the PBL format of the curriculum, learning objectives and course content is not released ahead of the allocated week so as not to impede the PBL process of hypothesis generation, subsequent testing and generation of learning objectives. This format can be difficult for students to initially grasp, especially for those from traditionally arranged undergraduate degrees. After an initial adjustment, however, students do adapt to the new style of learning especially after gaining an appreciation of the purpose of the PBL process.

The sequencing of the curriculum is that of a spiral process, by the end of the preclinical years, students generally feel prepared and confident to progress to the clinical years.

In the clinical years, all course content (clinical expectations, learning objectives and yearly objectives) are made clear in the rotational study guides and year handbook publications.

### *b) Components of the course that students consider highlights and components that could be improved*

Clinical exposure starts within the first semester of the MED 100 course with GP placements and continues into MED 200. Despite being relatively short placements, students generally embrace the exposure to clinical practice and many consider this exposure to be a highlight of the preclinical years.

It has been brought to the School of Medicines attention by MSAND that formative quizzes in MED 200 are lacking content from all domain areas, with the exception of pharmacology and population and preventative health. This is an area identified for improvement.

### *c) Perceived gaps in the course and areas of repetition*

The learning objectives and structured teaching provide a comprehensive coverage of required content to fulfil both the yearly and MBBS course objectives. Any perceived gaps in learning may stem from the nature of self-directed learning and not the course per se. It is acknowledged that one aspect of the post-graduate course is the theme of student reflection and identification of their own learning 'gaps' to guide self directed study.

Pharmacology was an area of the course that was highlighted as deficient at the last AMC review. Students in the foundation years now receive frequent pharmacology lectures and formative quizzes that form the important basis for further pharmacological based learning objectives in the clinical years.

## 7. The Curriculum – Teaching and Learning

### *a) Formal teaching - Strengths and Improvements*

The students feel one of the strengths of the formal pre-clinical teaching is that consultant clinicians often present lectures, thereby maintaining a consistent clinical perspective to learning. As previously mentioned the delivery of clinical skills in MED100 and 200 has been identified as an area for improvement, however MSAND recognizes through discussion with the school that this is more of a staffing than curriculum issue.

Overall the clinical experience of students has been overwhelmingly positive. Specifically MSAND has received positive comment regarding private sector experiences and communication processes. Hospital coordinators are open to feedback and any deficits in clinical experiences are quickly rectified, for example bedside teaching and tutorials programs have been expanded at many of the sites. Students feel that any potential lack in the spectrum of patient exposure is more than made up for by one-on-one consultant contact and teaching.

It is noted that many of the private sector sites are employing more registrars and residents, so exposure to more junior medical staff is also on the increase.

Feedback from students who spent 2008 on at the Rural Clinical School (RCS) has been overwhelmingly positive. Consistent with feedback in previous years there was reported variation in teaching and clinical exposure, with each site having differing strengths and weaknesses. However, the general view of returning students has been that they had a valuable experience that has prepared them well for their final year's study and internship. Students valued the opportunity to study jointly with UWA students, their future colleagues, and no issue with knowledge incompatibility was perceived. Currently there is no formal assimilation process for RCS students returning back into the metropolitan course and some students feel there is potentially benefit from such a process. The issue of communication deficits between the RCS, university and students, raised in early 2008, has significantly improved and the role of the university rural liaison, Marianna Erkens, in facilitating this is valued.

It is noted that positive feedback has been received on involvement in the 4<sup>th</sup> year honours program. This aspect of the student experience, namely exposure to research activities, is one identified by student comment for further integration throughout the four years.

*b) Preparation of students for self-directed learning.*

Students do feel well prepared for self-directed learning. Weekly resource lists from both in hardcopy and electronically, are made available to students at the commencement of the weekly problem. Lectures, clinical skills tutorials, laboratories and expert tutorials are focussed towards the weekly problem and cover many of the outlined learning objectives. They provide a solid foundation of teaching from which further personal study can be explored. It is clear to the students that self-directed learning is a major element of the MBBS course and essential to cover all the outlined learning objectives.

*c) Information Technology and other communication technologies in teaching and learning*

Weekly PBL cases are delivered via the student portal. All other resources are stated or the links provided via the student portal, under the appropriate tabs. Portal function is now essentially problem free, in regards to access, speed and reliability. There may be some delay in the provision of lecture notes prior to the commencement of lectures, however this is mostly infrequent and often involves guest lecturers. This issue has been addressed in the majority of cases, however some outstanding issues in obtaining lecture notes continues to exist in Med 200.

Students in the clinical years believe that audio recordings of back to base lectures available on the portal would be of benefit. This is particularly relevant with MED 400 students away on rural GP placement at staggered intervals throughout the year. Such a service would also allow Notre Dame students on RCS to access MED 300 lectures if desired. MSAND does recognise, however, that such a service may have an averse effect on back to base lecture attendance.

Students regard the completion of the IPE database as immensely time consuming and of no educational benefit. MSAND query the purpose and relevance of such a requirement.

## 8. The Curriculum - Assessment of Student Learning

### a) *The University's assessment, grading and progression rules (including clarity)*

The University's rules are clear and freely available. The School's policy differs slightly from the universities – primarily by excluding the offer of supplementary examinations in the first three years of the course and offering in their place a moderating exam. The definition of this process is currently being finalized and will be ready prior to the AMC visit. The students feel this process should have been clear from the start of the year and formed part of the unit outline provided at the commencement of the units. Student representatives have direct input via the assessment committee into the formulation of the policy regarding this assessment.

### b) *Practice and formative assessments preparing students for the graded (summative) assessments*

In pre-clinical years, the self-directed formative assessments (i.e. weekly quizzes) provide some insight into the summative assessments. There are some inconsistencies (in the minority) as some questions are derived from external sources and do not reflect a level of knowledge required to be demonstrated for the examination. In the majority, they are helpful. Formative feedback is provided to students in both formal and informal settings throughout the year.

### c) *Assessment components that could be improved*

Clarity over the grading and standards applied to the professional portfolio would be useful. The School provides a detailed handbook that gives directions on format, content and provides model answers but no marking guides. Marking is currently subjective, however it is difficult to comment if an objective marking guide would be of benefit for a pass / fail requirement of the course.

It is felt that the professional portfolio in the clinical years requires a disproportionate amount of work for the educational benefit derived as well as the relatively small percentage of marks the portfolio contributes to the final grade.

The assessment impost from university core units (specifically the Med 200 Ethics unit offered in 2009) seems to have an unfairly large amount of assessment associated with it, and this together with the delivery, disengages many students so lecture attendance is poor. This issue has been raised with the School of Medicine Dean who has endeavored to assist in this issue.

### d) *The feedback available to students on their performance*

If anything, gaining the opportunity to review our papers – particularly the summative MSATs would be a useful opportunity for feedback. We understand the invigilation impost this incurs but believe it would be a useful opportunity to identify deficits in one's own learning.

More formative feedback in clinical skills during pre-clinical years would be useful.

The mini-CEX (includes both formative and summative mini examinations for each rotation) is a tool available to students in the clinical years to receive feedback on their clinical performance throughout the term. Such a tool attempts to allocate a proportion of the overall mark to the clinical experience itself. By allocating a proportion of the overall marks to this form of assessment adds the imperative for the student to perform it correctly. The clinical experience will always differ between each student and each placement, so there will never be a standardized experience available. When completed correctly, they are extremely useful in identifying areas of deficit and strength. It is felt that the current mini-CEX is the best tool practically available, and provides an acceptable balance between the disparity of individual experiences and the justice in assigning some of the overall mark to the students' clinical performance. Clinicians', in the majority, are aware of the mini-CEX process and are willing to provide constructive feedback and fair assessment.

## 9. Implementing the Curriculum – Students

a) *The nature and clarity of the students' admission process.*

The university provides clear and detailed (where possible) information regarding the required steps and criteria that need to be fulfilled in order to be a successful applicant. Prerequisite and exclusion criteria are well understood by most. With 100% of successful applicants being entirely commonwealth supported places from 2009 onward, this provided potential students with even greater clarity as to the potential outcome of application. Students feel that providing the school of medicine with a personal statement of interest and curriculum vitae, as well as the interview process, allows for well-rounded applicants with diverse educational and vocational backgrounds that further strengthens the cohort of medical students.

b) *The services available to support students, including counseling, health, academic advisory services.*

The school of medicine provides support to students via:

- Medical Student liaison officer (Susie Stewart). Students are aware of her capacity as a clinical psychologist, and her availability for students to seek advice and assistance for issues impacting on their studies.
- Weekly clinical debriefing sessions as part of the Personal/Professional Development.
- There is an awareness that all senior academic staff are approachable and are available to meet with individual students in a non-threatening or intimidating environment.
- The School of medicine encourages and supports the ongoing work of MSAND. MSAND provides a strong and well-rounded supportive structure for fellow students. Some of MSAND's initiatives include; a peer mentoring scheme for new students joining Med 100, special interest education sessions, peer support and representation, social and sporting / recreation events, and advice on social justice opportunities.

c) *The services available to support students from under-represented groups & those with special needs.*

In general the university is effective in response to any specific special needs of students. It is noted that the campus does not have any facilities (structural or otherwise) to support students with young children, but it is acknowledged services are available in the local area.

## 10. Implementing the Curriculum – Educational Resources

a) *The adequacy of the School's physical facilities for teaching.*

The schools tutorial and clinical skills rooms are well equipped with the relevant books and equipment to facilitate learning. They are generally clean and tidy, and overcrowding is seldom a problem.

Laboratory style learning occurs through Curtin University of Technology, predominantly on Mondays. The laboratories and anatomy labs have excellent resources available to students in allocated times. There is an anatomy model room located at Notre Dame, attached to the library, as an adjunct to the exposure students receive during Monday teaching sessions. Revision laboratory sessions are arranged by Curtin in the lead up to exams, to allow increased exposure to resources, and tutors are usually available intermittently throughout such sessions.

As students are enrolled at both campuses – students have dual access to both Notre Dame and Curtin libraries in Med 100 & 200. The University of Notre Dame website allows library and online journal access from any computer. The portal access is now running smoothly and provides access from any computer to the posted information and links. Similarly, students have access to resources and information via the Curtin platform.

At all private sector clinical sites tutorial and common rooms are well set up with computers exclusively for student use and direct logon access is provided. Students in the majority of public sector sites are not provided with student logon rights. This seems to be standard for all students, regardless of which university they attended. Computer access is therefore usually obtained through junior medical officers of the attached team. The tertiary teaching hospitals often also do not have common rooms or exclusive computer access available to Notre Dame students. MSAND recognizes that this is not entirely within the control of the school of medicine but highlights the issue for advocacy and as a contrast to the private sector experience.

## **11. Conclusion**

MSAND and the student body look forward to the opportunity to provide further specific feedback to the AMC during their visit in June 2009. As previously discussed student working groups will be organised to meet with the AMC team at both the university campus and at various clinical placement sites.

In summary the feedback to MSAND following the last AMC review process is that the issues identified for management via this process have generally improved. This document does highlight further issues for improvement however it is important to note general comment to MSAND is that the student experience at the university is a positive one and that channels for student feedback function effectively.