



THE SECRETARY OF EDUCATION

WASHINGTON, D.C. 20202

APR 30 2001

SENT BY FACSIMILE TRANSMISSION

Professor Ian Simpson
Chairman, Accreditation Committee
Australian Medical Council
13 Napier Close
Deakin ACT 2600
Australia

Dear Professor Simpson:

In February 1995, the National Committee on Foreign Medical Education and Accreditation (NCFMEA) determined that the medical accreditation standards used by Australia were comparable to the standards used to evaluate programs leading to the M.D. degree in the United States. On March 9, 2001, the NCFMEA reviewed the information recently provided by the Australian Medical Council (AMC) on its current medical accreditation standards to reassess the comparability of those standards.

I am pleased to inform you that the NCFMEA, at its March meeting, determined that the current accreditation standards used by the AMC to evaluate medical schools in Australia and New Zealand are comparable to the standards used to evaluate programs leading to the M.D. degree in the United States. This determination of comparability by the NCFMEA has a maximum duration of six years from the date of this letter, unless the Committee withdraws, extends or renews its determination prior to that date. Before expiration of the six-year period, the NCFMEA will seek to confirm that your standards and procedures for accrediting medical schools in Australia and New Zealand are still comparable to the accreditation standards applied to medical schools in the United States. If so, its previous determination of comparability will be extended for another period.

In an effort to keep apprised of the accreditation activities of the AMC, the NCFMEA has requested that the AMC submit annual reports to the NCFMEA, with the first report scheduled for review at the March 2002 NCFMEA meeting. The purpose of the annual report is to provide the NCFMEA with a summary of accreditation activities, including the following information:

- *Overview of accreditation activities:* A summary of key activities by the AMC during the past year (January 2001-December 2001), such as accreditation reviews conducted, accreditation decisions reached, accreditation conferences or training sessions held.

- *Summary of any changes or developments in the following areas:*
 - *Laws and Regulations:* Any changes in your country's laws or regulations affecting the accreditation of your medical schools.
 - *Standards, Processes and Procedures:* Any changes in the accreditation standards, processes or procedures that the AMC uses to evaluate and accredit medical schools.
- *Schedule of upcoming accreditation activities:* A listing of accreditation meetings and listing of on-site visits to medical schools planned for January 2002 - December 2002.

Please send the annual report by January 7, 2002, to the Executive Director of the NCFMEA at the address below:

Bonnie L. LeBold
Executive Director, NCFMEA
U.S. Department of Education
1990 K Street, NW - Room 7007
Washington, D.C. 20006-7563
U.S.A.

If you have any questions, please do not hesitate to contact Ms. LeBold at (202) 219-7009 (telephone), (202) 219-7008 (fax), or Bonnie_LeBold@ed.gov (e-mail).

As a result of the determination of continued comparability by the NCFMEA, any medical school in Australia or New Zealand that is accredited or approved by the AMC may apply to the U.S. Department of Education to participate in the Federal Family Education Loan (FFEL) program. If a medical school's application is approved, otherwise eligible students enrolled in the school who are either U.S. citizens or permanent residents of the U.S. may receive loans to finance their medical education through the FFEL program. Medical schools that wish to participate in the FFEL program may obtain the proper application forms from the Foreign Schools Team at the following address:

Foreign Schools Team
U.S. Department of Education
Room 3674, ROB-3
7th & D Streets, S.W.
Washington, D.C. 20407
U.S.A.

Please note that it is not necessary for medical schools that are currently participating in the FFEL program to contact the Foreign Schools Team at this time; the status of those schools remains unchanged by the NCFMEA's decision of continued comparability.

Page 3 - Professor Ian Simpson

I want to thank you for taking the time to respond to our requests for information about your standards and processes for accreditation of medical schools. I very much appreciate the interest you have taken in this matter.

Sincerely,

Rod Paige

U.S. Department of Education



**Staff Analysis
of the
Standards Used by**

Australia/New Zealand

For the Evaluation of Medical Schools

March 9, 2001

U.S. Department of Education

Staff Analysis
of the Standards Used by
Australia/New Zealand
for the Evaluation of Medical Schools

Prepared February 2001

Background

During its February 1995 meeting, the National Committee on Foreign Medical Education Accreditation (NCFMEA) determined the Australian Medical Council (AMC) accreditation standards and processes to be comparable to the standards of accreditation applied to M.D. programs in the United States. Accordingly, the NCFMEA formally deemed Australia a country whose standards for accreditation were comparable to those in the United States. The NCFMEA reviews the comparability of countries' standards on a periodic basis, and in June 2000, Australia was provided a copy of the NCFMEA's new guidelines and requested to provide information to demonstrate compliance with those guidelines. The information provided by the country in response to that request is the subject of this analysis.

In developing its initial guidelines for accreditation, the AMC relied heavily on the recommendations and conclusions of two Australian groups: the Doherty Committee of Inquiry into Medical Education and Medical Workforce and the Project Panel on General Professional Education of the Physician. It also drew extensively from the recommendations of the Education Committee of the General Medical Council of the United Kingdom and the standards of the Liaison Committee on Medical Education (LCME).

The philosophy of the AMC is that its guidelines should emphasize the general principles it regards as essential requirements for basic medical education. Thus, its objectives for medical education are defined in very general terms, and the curriculum is defined only in broad outline. This is consistent with the belief of the Doherty Committee that "a diversity between medical schools in the approach to undergraduate curriculum is desirable."

Australia's response to this request for information documents certain key events and continued improvements to the AMC accreditation process. By December 1995, the AMC had visited and accredited both New Zealand medical schools. Furthermore, the Medical Council of New Zealand has endorsed the AMC's accreditation reports.

In addition, a special working group, convened by the Accreditation Committee Chair, reviewed the administrative procedures and the educational guidelines of the AMC during 1996-97. The review, which incorporated the views of the various stakeholders in the process, was done "in the light both of the AMC's experience over the last decade and of developments in medical education worldwide." The outcomes of the review were incorporated in the AMC's revised "Guidelines for the Assessment and Accreditation of Medical Schools."

The AMC summarizes the key improvements as follows: an examination of the value of the accreditation process is included in Part I of the "Guidelines;" more explicit and flexible procedures for assessing existing medical courses, major course changes and new medical schools are included in Part 2; and updated educational guidelines for the design and delivery of curricula are included in Part 3.

Summary of Findings

Department staff has reviewed the AMC standards and processes and concludes that they remain comparable to the standards currently used to accredit medical schools in the United States.

Note: As the Australian accreditation standards and processes are used to assess medical schools in both Australia and New Zealand, acceptance of these standards means that medical schools in both countries may qualify as institutions of higher education under 34 CFR 600.55.

Staff Analysis

The National Committee on Foreign Medical Education and Accreditation is charged with determining whether the standards of accreditation used by a foreign country to accredit medical schools offering programs leading to the M.D. (or equivalent) degree are comparable to standards of accreditation applied to M.D. programs in the United States.

In making this determination, the Committee uses the following guidelines which it has determined provide an appropriate framework for the thorough evaluation of medical schools offering programs leading to the M.D. (or equivalent) degree.

The Committee wishes to make it clear that these are in fact guidelines and that a foreign country's review and approval process can differ substantially from these guidelines and still be determined to be comparable to the standards used in the United States, provided the foreign country can demonstrate that its standards and processes of evaluation are effective alternatives to those used in the United States.

PART I: The Entity Responsible for the Accreditation/Approval of Medical Schools

There should be a clearly designated body responsible for evaluating the quality of medical education in the foreign country, and that body should have clear authority to accredit/approve medical schools in the country that offer educational programs leading to the M.D. (or equivalent) degree.

The recognized body accrediting schools offering programs leading to Australia's first professional medical degree is the Australian Medical Council (AMC). The Australian Health Ministers established the Australian Medical Council (AMC) in 1985 as the national standards body for basic medical education in Australia and reports annually to the Health Ministers. In 1991, the Ministers decided to require medical practitioners in Australia (excluding overseas trained specialists) to be graduates of Australian or New Zealand medical schools or to hold an AMC certificate before they could be granted unconditional registration in any state or territory of the Commonwealth. This decision led to negotiations between the AMC and the Medical Council of New Zealand, which resulted in New Zealand medical schools becoming subject to the AMC accreditation process. Thus, the AMC guidelines are used to assess medical schools in both countries.

The AMC has a standing committee, called the Accreditation Committee, responsible for evaluating medical schools. The Accreditation Committee consists of 11 members and has representatives from the medical schools, the Australian Medical Council itself, the specialist medical colleges, and the Medical Council of New Zealand. The Australian Medical Council consists of 17 members who were nominated by the medical schools, the specialist postgraduate medical colleges, the Australian Medical Association, the Australian Health Ministers Advisory Council, and the state and territory medical registration boards. Of the 17 members on the Council, eight are presidents of the state medical registration boards, and 16 are medically qualified. At least two members of the Council are also members of the Accreditation Committee.

The AMC derives its authority not only from its own constitution, but also from the legislation of the individual Australian States and Territories. The response notes that all the States and Territories have adopted uniform minimum requirements for initial registration as a medical practitioner. Those requirements "limit entitlement to general or full registration to graduates of Australian and New Zealand medical schools accredited by the AMC and overseas trained doctors who hold the AMC examination certificate." One of the principal tasks of the AMC, as specified in its charter, is "to advise and make recommendations to the State and Territory Medical Boards in relation to the accreditation of Australian and New Zealand medical schools and of courses conducted by the schools leading to basic medical qualifications." The AMC has established a standing

committee, called the Accreditation Committee, which is responsible for (1) advising the AMC on accreditation matters, including the criteria for accreditation; (2) recommending assessors to visit and assess the medical schools; and (3) reporting annually to the AMC on its activities.”

The AMC’s response of August 31, 2000 to the Department of Education documented the fact that it is Australia’s national standards body for basic medical education.

Documentation:

Constitution of the Australian Medical Council.

Extracts from the Medical Practice Acts of two of the Australian State and Territories concerning the AMC’s authority to accredit medical schools.

PART II: Accreditation/Approval Standards

The entity within the foreign country that is responsible for evaluating the quality of medical education in the country and has authority to accredit/approve medical schools should have standards comparable to the following:

1. Mission and Objectives

(a) The educational mission of the medical school must serve the general public interest, and its educational objectives must support the mission. The medical school’s educational program must be appropriate in light of the mission and objectives of the school.

(b) An essential objective of a program of medical education leading to the M.D. (or equivalent) degree must be to prepare graduates to enter and complete graduate medical education, qualify for licensure, provide competent medical care, and have the educational background necessary for continued learning.

The AMC’s “Guidelines for the Assessment and Accreditation of Medical Schools” emphasize the essential requirements for basic medical education. The Guidelines have objectives for how to produce broadly educated medical graduates. The objectives are generally stated in terms of educational outcomes, i.e. the knowledge, skills, and attitudes that graduates of the basic medical education course are expected to have.

The AMC’s response notes that with regard to the general public interest, the Guidelines indicate that medical schools must respond to the evolution of health needs in the communities they serve, have methods for communication with the recipients of health care, and respond appropriately to that community. Each

school is responsible for putting in place an assessment system that tests the required knowledge, skills, and, where possible, attitudes that AMC believes are fundamental to sound medical education. The stated purpose of AMC accreditation is to ensure that new medical graduates are so prepared that at registration they are competent and responsive to the health needs of both individual citizens and communities.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools –
p. 5 - aims of the accreditation process,
pp. 23-24 – concerning the objectives of medical education,
p. 38 - responses by medical schools to the health care needs of the community,
pp. 40-41 – concerning preparation for internship.

2. Governance

- (a) The medical school must be legally authorized to provide a program of medical education in the country in which it is located.
- (b) There must be an appropriate accountability of the management of the medical school to an ultimate responsible authority external to and independent of the institution's administration. The external authority must have sufficient understanding of the medical program to develop policies in the interest of both the medical school and the public.

In Australia the system ensures that there is an appropriate accountability to an authority external to and independent of the institution's administration. As the AMC's response notes, all of the medical schools are located in publicly funded universities. Furthermore, their authorization comes from two sources: the State and Commonwealth (or Federal) Governments. This being the case, the AMC's Guidelines do not impose or prescribe any specific mechanism for accountability to an authority external to and independent of the institution's administration.

Nevertheless, the AMC's response notes that there is a range of controls to ensure the proper operation of the universities, including requirements for annual external audits and annual reports to State Parliament. At the Federal level, the performance of universities is reviewed annually in educational profile discussions, and against Commonwealth performance indicators. The AMC obtains details on school and course governance through its visiting teams when they examine the university structure and organization and by interviewing key university personnel.

Documentation:

Guide to the Preparation of an Accreditation Submission, Section 2.
Letter from the Commonwealth Education Minister to the Vice-Chancellor of Australia's newest medical school at James Cook University demonstrating the requirement of both Commonwealth and State approval of medical schools.

3. Administration

- (a) The administration of the medical school must be effective and appropriate in light of the school's mission and objectives.**
 - (i) There must be sufficient administrative personnel to ensure the effective administration of admissions, student affairs, academic affairs, hospital and other health facility relationships, business and planning, and other administrative functions that the medical school performs.**
 - (ii) The chief academic officer of the medical school must have sufficient authority provided by the institution to administer the educational program. That individual must also have ready access to the university president or other university official charged with final responsibility for the school, and to other university officials as are necessary to fulfill the responsibilities of the chief academic officer's office.**
 - (iii) In affiliated institutions, the medical school's department heads and senior clinical faculty members must have authority consistent with their responsibility for the instruction of students.**

The AMC's Accreditation Guidelines outline a framework for both the administration and the administrative structure of a medical school. They also describe a philosophy for the medical school's relationships with the State Health Department and with associated institutions (i.e., hospitals, research institutes, and community health centers) and the community.

The requirements regarding the administration and management of medical schools cover the autonomy of the medical school, the school's control of the curriculum, the administrative support and infrastructure facility to support academic staff, and the role of medical school academic staff in teaching hospitals and affiliated institutions.

The AMC ensures that the school meets the requirements by requesting that the information be provided in the questionnaire that the school completes in preparation for accreditation, and then verified on-site by the visiting team.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools – pp. 36-38 – concerning management of the medical school, p. 39 – concerning academic staff.

- (b) The chief academic official of the medical school must be qualified by education and experience to provide leadership in medical education.**

The general requirements for the senior academic faculty in the Australian system are determined by the statutes and policies of the university that contains the medical school. The AMC guidelines do not specify any additional requirements for the chief academic officer of a medical school.

There is a general expectation that the leadership of the medical school is entrusted to an individual whose knowledge, experience, and interest in medical education is sufficient to lead the faculty in developing the overall curriculum, evaluating its appropriateness and effectiveness through the quality of the graduates, and making changes as necessary to keep the curriculum current and of high quality.

During the accreditation process, the AMC obtains information on the terms of office of the Senior Medical School Officers, and the university's policy and practice concerning the appointment and promotion of staff. As a senior member of the faculty, the chief academic officer would be expected to meet all the customary requirements in terms of academic credentials and experience that are requisite to that level of appointment.

Documentation:

Guide to the Preparation of an Accreditation Submission, Sections 3 and 11.

- (c) The medical school may determine the administrative structure that best suits its mission and objectives, but that structure must ensure that the faculty is appropriately involved in decisions related to –**
 - (i) Admissions**
 - (ii) Hiring, retention, promotion, and discipline of faculty; and**

(iii) All phases of the curriculum, including the clinical education portion;

The AMC reports that it imposes no uniform structure but requires medical schools and their faculty to have sufficient autonomy over admissions and curricula to achieve their stated objectives. In addition, this would include direct responsibility for resources.

The faculty ensures that the medical school has the necessary autonomy over curriculum that is necessary to achieve the stated program objectives. A curriculum committee, or its equivalent, is expected to exist and be responsible for developing overall curricular design and recommending changes that reflect altered requirements, educational techniques, or demonstrated deficiencies in the overall course or aspects of it.

The AMC also notes that the statutes and policies of the university that contains the medical school will determine the general requirements for hiring, retention; promotion and discipline of the faculty. In addition, the AMC requires information on the measures that are taken to recruit and support high quality staff. Furthermore, the AMC requires an explicit policy for development including mentoring and specific courses in teaching, assessment, evaluation, grant-writing, management and information technology.

Documentation:

AMC's August 2000 Response to the NCFMEA, p. 4.

(d) If some components of the educational program are conducted at sites that are geographically separated from the main campus of the medical school, the school must have appropriate mechanisms in place to ensure that –

- (i) The educational experiences at all geographically separated sites are comparable in quality to those at the main campus; and**
- (ii) There is consistency in student evaluations at all sites.**

The AMC notes that its Accreditation Guidelines includes expectations that medical schools have processes in place that allow the overall content and balance of the curriculum and its assessment to be defined. Furthermore, the schools must be able to implement and change the curriculum according to these overall requirements and have mechanisms to ensure that all clinical placements in hospitals and communities are supervised and well-organized with clearly defined objectives with assessments.

Most importantly, the schools must make special efforts to monitor the educational experiences of the clinical attachments outside the main teaching hospitals. All teaching sites must have sufficient resources, including appropriate support services and facilities.

When the medical schools prepare for accreditation, they are asked to provide specific information on the resources for all teaching sites, but especially how assessment is made consistent across teaching sites and how coordination is maintained in remote attachments. The AMC's visiting team visits all of the medical school's teaching sites to inspect the library and facilities firsthand and to meet with the students and interns and all the appropriate staff.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, p. 31.
Guide to the Preparation of an Accreditation Submission, Sections 12 and 13.
Model Schedule for an Assessment Visit

4. Educational Program

- (a) *Duration:*** The program of education leading to the M.D. (or equivalent) degree must include at least 130 weeks of instruction, scheduled over a minimum of four calendar years.

Completion of the Australian medical courses requires a minimum of four years of study for graduate students, and five or six years for courses that generally admit students directly from secondary school. In addition, the AMC guidelines require "a significant period of time devoted to students' personal contact with patients." That period of time would normally entail the equivalent of at least two years spent primarily in direct contact with patients, as well as in contact with patients during other parts of the course.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, p. 27.
Accreditation Register – shows the length of the Australian and New Zealand accredited medical courses.

- (b) *Curricular Content:*** The medical school's curriculum must provide students with general professional education, i.e. the knowledge and skills necessary to become a qualified physician. At a minimum, the curriculum must provide education in the following:

- (i) The sciences basic to medicine, including--**

(A) The contemporary content of those expanded disciplines that have traditionally been titled anatomy, biochemistry, physiology, microbiology and immunology, pathology, pharmacology and therapeutics, and preventive medicine; and

(B) Laboratory or other practical exercises that facilitate the ability to make accurate quantitative observations of biomedical phenomena and critical analyses of data.

(ii) A variety of clinical subjects, including at least the core subjects of internal medicine, obstetrics and gynecology, pediatrics, surgery, and psychiatry and, preferably, family medicine.

Note 1: Medical schools that do not require clinical experience in one or another of the above disciplines must ensure that their students possess the knowledge and clinical abilities to enter any field of graduate medical education.

Note 2: Clinical instruction must cover all organ systems and include aspects of acute, chronic, continuing, preventive, and rehabilitative care.

Note 3: The medical school's program of clinical instruction must be designed to equip students with the knowledge, skills, attitudes, and behaviors necessary for further training in the practice of medicine.

Note 4: Instruction and experience in patient care must be provided in both ambulatory and hospital settings.

Note 5: Each required clinical clerkship (or equivalent) must allow the student to undertake thorough study of a series of selected patients having the major and common types of disease problems represented in the clerkship

(iii) Disciplines that support the fundamental clinical subjects, such as diagnostic imaging and pathology.

(iv) Ethical, behavioral, and socioeconomic subjects pertinent to medicine.

- (v) **Communications skills integral to the education and function of physicians, including communication with patients, families, colleagues, and other health professionals.**

The AMC's response notes that there are specified "requirements relating to the basic sciences, clinical sciences component, fundamental clinical subjects, ethical, behavioral, and socio-economic subjects and communications skills in the form of objectives relating to the knowledge and understanding, skills and attitudes expected of medical graduates."

Each medical school is responsible for developing its objectives for its medical course and having a curriculum that achieves those objectives. However, they must be in agreement with the broad outline of the medical curriculum outlined in the AMC's guidelines.

The AMC has several specific objectives for how the overall goal of basic medical education to produce broadly educated medical graduates should be achieved. All of these objectives are stated in terms of educational outcomes, i.e. the knowledge, skills, and attitudes that graduates of the basic medical education course are expected to have.

Objectives related to knowledge and understanding:

"Graduates completing basic medical education should have knowledge and understanding of:

- (i) Scientific method relevant to biological, behavioral and social sciences at a level adequate to provide a rational basis for present medical practice, to assimilate the advances in knowledge that will occur over their working life.
- (ii) The normal structure, function and development of the human body and mind at all stages of life, the interactions between body and mind, the factors which may disturb these.
- (iii) The aetiology, pathology, symptoms and signs, natural history, and prognosis of common mental and physical ailments in children, adolescents, adults and the aged. A more detailed knowledge is required of those conditions that require urgent assessment and treatment.
- (iv) Common diagnostic procedures, their uses and limitations.
- (v) Management of common conditions including pharmacological, physical, nutritional and psychological therapies.

(vi) Normal pregnancy and childbirth, the more common obstetrical emergencies, the principles of antenatal and postnatal care, and medical aspects of family planning.

(vii) The principles of health education, disease prevention, amelioration of suffering and disability, rehabilitation, and the care of the dying.

(viii) Factors affecting human relationships, the psychological well-being of patients and their families and the interactions between humans and their social and physical environment.

(ix) Systems of provision of health care including their advantages and limitations, the costs associated with health care, the principles of efficient and equitable allocation and use of finite resources, and methods of meeting the health care needs of disadvantaged groups within the community.

(x) The principles of ethics related to health care and the legal responsibilities of the medical profession.”

Objectives related to skills:

"Graduates completing basic medical education should have developed the following skills to an appropriate level for their stage of training:

(i) The ability to take a tactful, accurate, organized, and problem-focused medical history.

(ii) The ability to perform an accurate physical and mental state examination.

(iii) The ability to choose, from the repertoire of clinical skills, those which it is appropriate and practical to apply in a given situation.

(iv) The ability to interpret and integrate the history and physical examination findings to arrive at an appropriate diagnosis or differential diagnosis.

(v) The ability to select the most appropriate and cost effective diagnostic procedures.

(vi) The ability to formulate a management plan and to plan management in concert with the patient.

(vii) The ability to communicate clearly, considerately and sensitively with patients, relatives, doctors, nurses, other health professionals and the general public.

(viii) The ability to counsel sensitively and effectively, and to provide information in a manner that ensures patients and families can be truly informed when consenting to any procedure.

(ix) The ability to recognize serious illness and to perform common emergency and life-saving procedures such as caring for the unconscious patient and cardiopulmonary resuscitation.

(x) The ability to interpret medical evidence in a critical and scientific manner, and to libraries and other information resources to pursue independent inquiry relating to medical problems."

Objectives relating to attitudes as they affect professional behavior:

"During basic medical education, students should acquire the following professional attitudes which are regarded as fundamental to medical practice:

(i) Respect for every human being, with an appreciation of the diversity of human background and cultural values.

(ii) An appreciation of the complexity of ethical issues related to human life and death including the allocation of scarce resources.

(iii) A desire to ease pain and suffering.

(iv) An awareness of the need to communicate with patients and their families, and to involve them fully in planning management.

(v) A desire to achieve the optimal patient care for the least cost, with an awareness of the need for cost-effectiveness to allow maximum benefit from the available resources.

(vi) Recognition that the health interests of the patient and the community are paramount.

(vii) A willingness to work effectively in a team with other health care professionals.

(viii) An appreciation of the responsibility to maintain standards of medical practice at the highest possible level throughout a professional career.

(ix) An appreciation of the need to recognize when a clinical problem exceeds their capacity to deal with it safely and efficiently and of the need to refer the patient for help from others when this occurs.

(x) A realization that it is not always in the interests of patients or their families to do everything which is technically possible to make a precise diagnosis or to attempt to modify the course of an illness."

In addition to its expectation regarding the general structure of the curriculum, the AMC expects each medical school to have in place effective mechanisms for evaluating and changing the curriculum, for monitoring the curriculum, and for the integration of the curriculum. A curriculum committee, or its equivalent, is expected to exist and be responsible for developing overall curricular design and recommending changes that reflect altered requirements, educational techniques, or demonstrated deficiencies in the overall course or aspects of it.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, pp. 23-31.

(c) Design, Implementation, and Evaluation

- (i) There must be integrated responsibility by faculty within the medical school for the design, implementation, and periodic evaluation of all aspects of the curriculum, including both basic sciences and clinical education.**
- (ii) The medical school must regularly evaluate the effectiveness of its medical program by documenting the achievement of its students and graduates in verifiable ways that show the extent to which institutional and program purposes are met. The school should use a variety of measures to evaluate program quality, such as data on student performance, academic progress and graduation, acceptance into residency programs, and postgraduate performance; the licensure of graduates, particularly in relation to any national norms; and any other measures that are appropriate and valid in light of the school's mission and objectives.**

The AMC's Accreditation Guidelines specify that the medical schools have processes that define the overall content and balance of the curriculum and its assessment. The schools must be able to implement and change the curriculum gradually according to the overall requirements. The schools must have mechanisms to recognize emergent topics and themes that should be incorporated into the curriculum. Furthermore, the schools must have a process

for evaluating, reviewing and changing the curriculum. The process can include student questionnaires, and student representation on the curriculum committees. The range of evaluation measures also includes an examination of pass rates in individual course components, and an examination of the quality of the graduates.

The faculty ensures that the medical school has the necessary autonomy over curriculum that is necessary to achieve the stated objectives. This is done through the medical curriculum committee that develops the overall curriculum design, implementation and student assessment. The membership includes the basic and clinical sciences.

When the medical school submits its accreditation request, it is required to provide information that will allow the accrediting team to judge the extent of faculty participation in the life and decision-making process of the school. During the actual accreditation visit, the AMC's team meets with the faculty from all the levels, departments and units that contribute to the medical course.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools --
pp. 28 and 29 – concerning the design and organization of the curriculum,
pp. 32 and 33 – concerning monitoring and evaluating the curriculum.
Guide to the Preparation of an Accreditation Submission, Sections 3 to 5.
Model Schedule for an Assessment Visit.

5. Medical Students

(a) Admissions, Recruiting, and Publications

(i) The medical school must admit only those new and transfer students who possess the intelligence, integrity, and personal and emotional characteristics that are generally perceived as necessary to become effective physicians.

(ii) A medical school's publications, advertising, and student recruitment must present a balanced and accurate representation of the mission and objectives of its educational program. Its catalog (or equivalent document) must provide an accurate description of the school, its educational program, its admissions requirements for students (both new and transfer), the criteria it uses to determine that a student is making satisfactory academic progress in the medical program, and its requirements for the award of the M.D. degree (or equivalent).

(iii) Unless prohibited by law, student records must be available for review by the student and an opportunity provided to challenge their accuracy. Applicable law must govern the confidentiality of student records

The AMC Accreditation Guidelines set forth the general requirements that schools must meet when designing their own admission requirements. The Guidelines indicate "that certain standards of literacy, numeracy, aptitude and scientific knowledge are required for successful completion of a medical course, and that admission requirements must be clearly defined, defensible and free of discrimination or bias, and that medical schools are expected to have a mechanism for student appeal against admission decisions."

The AMC Guidelines for the Assessment and Accreditation of Medical Schools does not specifically address the medical school's publications including its school catalog, advertising, and student recruitment practices in terms of the program's mission and goals. It does, however, state that the school's selection process should be published and made available to potential students. In addition, the Australian Vice-Chancellor's Committee has established guidelines that outline the university's responsibility to provide students with access to current and accurate information about the educational program, application and entry procedures, credit transfer policies, selection processes, financial implications, course formats, assessment procedures, attendance requirements, etc.

Furthermore, as part of its accreditation process, the AMC requires medical schools to submit copies of their policies and procedures for student selection, including copies of any publications that explain the selection process to potential students and information on the process for appeals against admission decisions.

Regarding student records and confidentiality, the AMC's response notes that each Australian State has Freedom of Information and privacy legislation that governs access to documents held by state authorities. Furthermore, the Australian Vice-Chancellors' Committee has produced a statement on the relationship between universities and students that discusses both expectations and responsibilities. Finally, the AMC's response notes that each university sets its own detailed rules and regulations concerning student access to and confidentiality of records. However, those rules and regulations must be in accord with State legislation and the Vice-Chancellors' statement.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools,
p. 33 – concerning student admission.
Guide to the Preparation of an Accreditation Submission, Section 10.
Universities and their Students: Expectations and Responsibilities,

(Official Statement of the Australian Chancellors' Committee),
A2 – concerning admission requirements, A8 – concerning student review of
results, A11 – concerning confidentiality of information.

(b) Evaluation of Student Achievement

(i) The medical school faculty must establish principles and methods for the evaluation of student achievement, including the criteria for satisfactory academic progress and the requirements for graduation.

(ii) The medical school's evaluation of student achievement must employ a variety of measures of student knowledge, competence, and performance, systematically and sequentially applied throughout the medical program, including the clinical clerkships.

(iii) The medical school must carefully monitor the progress of students throughout their educational program, including each course and clinical clerkship, must promote only those who make satisfactory academic progress, and must graduate only those students who successfully complete the program.

The Accreditation Guidelines suggest a range of assessment methods but each school is free to establish their own methods to evaluate student achievement. The Guidelines on student assessment cover the following areas: the need for explicit assessment criteria; the requirement for summative, or barrier, assessment and formative assessment; the encouragement to medical schools to develop valid and reliable assessment instruments for all specific educational objectives, including attitudinal objectives; and monitoring by the curriculum committee of the pass rates in the individual components of the course.

In the Australian system, student assessment and examination is a major topic in each AMC accreditation report on a medical school. The on-site evaluation team conducts interviews with those individuals and/or committees specifically charged with the evaluation of student performance. In addition, the team often reviews samples of student work, computer-administered formative tests, and examination papers and reports used in the assessment process.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, pp. 31-32.

Guide to the Preparation of an Accreditation Submission, Section 7.

Topics Covered in an AMC Accreditation Report.

(c) Student Services

Students must have access to preventive and therapeutic health services, including confidential mental health counseling. Policies must include education, prevention, and management of exposure to infectious diseases during the course of the educational program.

The AMC's Accreditation Guidelines contain specific requirements concerning the medical school's physical facilities including those used for student study and recreation. There must be adequate lounge, locker and food service areas for the students. In addition, there are requirements for student support such as counseling services, student academic advisors and student health services to deal with student illness, impairment and disability. The accreditation submission must include the specific information regarding the school's facilities and student support services.

The materials originally provided with the AMC's submission did not include any requirement that schools must have policies regarding the education, prevention, and management of exposure to infectious diseases during the course of the educational program. However, the AMC subsequently provided a separate document in which it emphasizes the importance of informing medical students about the following areas:

- Any requirement of the medical course that may reasonably inhibit completion of the course by students with a disability (including an infectious disease).
- The standards of health and character set by the medical boards that are requirements for registration as a medical practitioner.
- The implications of disability and infection for medical practice.
- Infection control procedures.

Furthermore, the AMC notes that there are also nationally-agreed on minimum standards for infection control in Australia released by the National Health and Medical Research Council and the Australian National Council on AIDS. New Zealand's Medical Council also has its own "Policy Statement on Transmissible Major Viral Infections."

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, p. 34.

Guide to the Preparation of an Accreditation Submission, Section 10.

Extract from the 1995 AMC "Report of the Working Party on the Registration of Disabled/Impaired Graduates" (currently under review).

Table of Contents and pp. 111-112 from "Infection Control in the Health Care Setting" (recommendations to training institutions concerning the education, prevention and management of exposure to infectious diseases of health care students).

6. Resources for the Educational Program

(a) Finances: The medical school must have adequate financial resources for the size and scope of its educational program.

(b) Facilities:

(i) The medical school must have, or be assured use of, physical facilities and equipment, including clinical teaching facilities, that are quantitatively and qualitatively adequate for the size and scope of the educational program, as well as the size of the student body.

(ii) The medical school should be encouraged to conduct biomedical research and must provide facilities for the humane care of animals when animals are used in teaching and research.

The AMC's Accreditation Guidelines do address the adequacy of a medical school's physical facilities. Specifically, the AMC requires the following of medical schools:

- Sufficient resources to achieve their objectives and to maintain high standards of medical education;
- Facilities adequate to allow the educational objectives of the medical school to be achieved;
- The capacity to expose medical students to a range of settings in which health care and health promotion are delivered; and
- The clinical teaching institution is also expected to provide suitable facilities for the students.

The Accreditation Guidelines also discuss the research environment of the medical school. The Guidelines state that "Undergraduate medical education is greatly enhanced by a medical school environment in which research is actively pursued. The AMC will enquire into the research activities of medical schools as part of its evaluation of their medical teaching programs because of the acknowledged benefits for both staff and students of vigorous research programs."

In addition, the on-site evaluation team conducts tours of the facilities and examines the school's commitment to research through interviews to determine their adequacy. The Guidelines do not, however, reference biomedical research, specifically, or any proviso requiring that schools must provide for the humane care of animals when animals are used in teaching and research.

Nevertheless, there is a code concerning the humane care of animals used in teaching and research that is published by Australia's National Health and Medical Research Council. The Australian Vice-Chancellors Committee officially endorses that code. This Committee represents all Australian universities. Furthermore, in New Zealand the Health Research Council, which coordinates health research, has developed its own "Guidelines on Research Involving Animals or Animal Materials."

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools –
pp. 29 and 30 – concerning teaching settings,
pp. 35 and 36 – concerning research,
pp. 36 and 37 – concerning issues relating to management of the medical school,
p. 38 – concerning funding,
pp. 39 and 40 – concerning physical resources.
Introduction to the "Australian Code of Practice for the Care and Use of Animals for Scientific Purposes" published by the National Health and Medical Research Council.

(c) Faculty:

- (i) Members of the medical school's faculty must be appropriately qualified to teach in a medical program leading to the M.D. (or equivalent) degree and effective in their teaching. The faculty must be of sufficient size, breadth, and depth to provide the scope of the educational program offered.**
- (ii) The medical school should have policies that deal with circumstances in which the private interests of its faculty or staff may conflict with their official responsibilities.**

The AMC's Accreditation Guidelines are general in nature when dealing with the issues related to the academic staff of the medical school. The Guidelines cover recruitment issues; the provision of adequate administrative support and infrastructure facilities; joint appointments between the university and hospitals; honorary clinical academic titles for hospital or community practitioners involved in teaching and research; and faculty development and appraisal.

The AMC determines the sufficiency of the size of the faculty through the accreditation submission that schools must complete during the accreditation process. The school must report the size of the faculty (both actual and full-time equivalent), information on the make up of the academic staff, and school policies on appointment and promotion.

The on-site evaluation team is responsible for verifying the faculty data reported by the medical school on the survey and conducts extensive interviews with faculty members to determine, among other things, the quality of the faculty.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, p. 39.
Guide to the Preparation of an Accreditation Submission, Section 11.

(d) Library: The medical school must have a library sufficient in size, breadth, and depth to support the educational program and adequately and professionally staffed.

The AMC expects that libraries will maintain a collection of reference materials adequate to meet the curriculum and research needs of the students and faculty staff. In addition, there should be supportive staff available to help the students. Finally, access to computer-based reference systems should also be provided.

In the AMC accreditation submission, schools are required to provide a detailed description of the medical library's collection and the institutional resources committed to the growth and maintenance of the collection. The on-site evaluation team interviews senior staff of the medical library and individuals/committees responsible for the allocation of institutional resources to the library.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, p. 40.
Guide to the Preparation of an Accreditation Submission, Section 12.3.

(e) Clinical Teaching Facilities: The medical school should have affiliation agreements with each teaching hospital or clinical facility it uses that define the responsibilities of each party.

The AMC's Accreditation Guidelines expects that there be effective communication and liaison between the university, the school of medicine and the healthcare and research institutions affiliated with the university. The desirability of having formalized arrangements is stressed.

The Accreditation Guidelines recommend that there be a formally constituted mechanism for high-level communication between the university and the affiliated institution to ensure appropriate communication on matters of mutual interest, especially those relating to teaching, research and clinical service.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, pp. 37-38.

PART III Accreditation/Approval Processes and Procedures

The entity within the foreign country that is responsible for evaluating the quality of medical education in the country and has authority to accredit/approve medical schools should have processes and procedures for granting accreditation/approval to medical schools that are comparable to the following:

1. Site Visit

The accreditation/approval process must include a thorough on-site review of the school (and all its geographically separated sites, if any) during which sufficient information is collected to determine if the school is in fact operating in compliance with the accreditation/approval standards. This review should include, among other things, an analysis of the admission process, the curriculum, the qualifications of the faculty, the achievement of students and graduates, the facilities available to medical students (including the training facilities), and the academic support resources available to students.

The AMC's Accreditation Guidelines make it clear that the medical school going through the accreditation or reaccreditation process must submit extensive documentation that is verified on-site by the AMC's evaluation team.

As the AMC's response notes, the expert team reviews all the documentation and visits the school and all its facilities and teaching locations. The length of the visit is normally a full workweek and during that time, the team reviews the medical curriculum, including the processes, resources and facilities that underpin its delivery.

During a typical visit the team meets with the heads of departments or disciplines within the faculty of medicine and other relevant faculties, teaching hospital staff, curriculum committee, interest groups or committees in medical education and research, representative staff members, both full-time and part-time, and with recent graduates and students. The team also typically consults with senior administrative and academic officers of the university.

The detailed list of activities the AMC requires during an on-site evaluation visit is contained in the document entitled "Model Schedule for an AMC Assessment Visit."

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, pp. 9 and 12.

Model Schedule for an Assessment Visit.

2. Qualified On-Site Evaluators

The accreditation/approval process must use competent and knowledgeable individuals, qualified by experience and training in the basic or clinical sciences, responsible for the on-site evaluation, policy-making, and decision-making.

Assessors on the on-site evaluation team must be approved by the AMC. The AMC maintains a database of potential assessment team members "which it generates from nominations by medical schools, specialist medical colleges, and medical registration boards." Typically, team members are chosen so that there is a balance of experience between the basic and clinical sciences, between teaching and research, between hospital and community-based teachers, and between experienced and new assessors. Nominees are required to provide information on their qualifications and experience. The response also notes that all members of the AMC Accreditation Committee must take part in at least one accreditation visit so they will have first-hand experience of the process.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, pp. 7 and 8 – concerning membership of assessment teams.

Australian Medical Council Constitution,

Clause 3 – concerning membership of the Council,

Clause 14 – concerning membership of the Accreditation Committee.

(3) Re-evaluation and Monitoring

The accreditation/approval process must provide for the regular reevaluation of accredited/approved medical schools in order to verify that they continue to comply with the approval standards. The entity must also provide for the monitoring of medical schools throughout any period of accreditation/approval granted to verify their continued compliance with the standards.

The longest period of accreditation granted by the AMC is ten years. The first time a school is accredited it can receive a maximum of six years. However, an additional four years can be confirmed subject to a satisfactory written report by the school during its fifth year of accreditation. Accreditation may also be

granted for shorter periods of time if the AMC identifies a significant level of deficiency.

At the conclusion of an accreditation period, if a school desires to continue to have accredited status with the AMC, it must undergo a complete accreditation review process, including the submission of a completed survey and the hosting of an on-site evaluation team.

Periodic reports are required to ensure that the Accreditation Committee is appraised of changes or emerging issues that may impact a school's ability to deliver the medical curriculum. Schools are asked to submit written reports two, five, and seven years after the Committee's review. The report submitted at the five-year mark is a comprehensive report that provides assurances and evidence that the school has maintained its standards of education and resources. Additional reports may be required of schools that have conditions on its accreditation. Schools granted accreditation of a major structural change and new medical schools are to submit annual reports.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools,
pp. 14 and 15 – maximum periods of accreditation available to a medical school, and pp. 21 and 22 – concerning the requirements for periodic reports.
Australian Medical Council Constitution, Clause 16.
The AMC Proforma for Periodic Reports.

4. Substantive Change

The accreditation/approval process must require medical schools to notify the appropriate authority of any substantive change to their educational program, student body, or resources and must provide for a review of the substantive change by the appropriate authority to determine if the school remains in compliance with the standards.

The AMC's Accreditation Guidelines require all medical schools to notify the AMC of any proposed changes to the accredited medical course almost two years before the change is implemented. The Guidelines contain detailed policies and procedures on the review of major structural changes to medical courses, including a definition of major structural change.

In addition, it includes the initial assessment by the AMC of the medical school's broad plans and its capacity to manage the change process about 18 months before the new course commences. Furthermore, the AMC requires a detailed review of the school's planned curriculum, including a site visit to the medical school, at least eight months before the course commences.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, pp. 16-21.

5. Controls against Conflicts of Interest and Inconsistent application of Standards

The accreditation/approval process must include effective controls against conflicts of interest and inconsistent application of the accreditation/approval standards.

The AMC's Accreditation Guidelines provide explicit policy statements regarding controls against conflicts of interest. They include declarations by members of the AMC Accreditation, the Council itself, and any proposed members of accrediting teams, of any relevant personal or professional interest that may conflict with their obligations. Decision-makers must withdraw from any formal meeting and refrain from voting on any relevant item. Furthermore, any declared interests of site visitors are disclosed to the medical school, and the school is given the opportunity to comment on the composition of the proposed assessment team.

Consistency is ensured since visiting teams include at least one member who is also a member of the AMC Accreditation Committee. The secretary, who is a senior member of the staff of the AMC Secretariat, is a member of all teams and is the Secretary of the Accreditation Committee.

Consistency is further supported by showing the draft accreditation report to all members of the team and to the medical school for comment. The draft report and any school comments are then scrutinized by the Accreditation Committee to check for balance and soundness. The report is then returned to the school for final comment. The AMC then makes the final decision on accreditation.

Documentation:

**Guidelines for the Assessment and Accreditation of Medical Schools,
pp. 8 and 12 -14.**

The AMC's Guide to Assessors for Assessment Visits.

6. Accrediting/Approval Decisions

The accreditation/approval process must ensure that all accreditation/approval decisions are based on the accreditation/approval standards. It must also ensure that the decisions are based, in part, on an evaluation of the performance of students after graduation from the medical school.

The AMC's Accreditation Guidelines include a requirement that medical schools examine the quality of their graduates. There must be feedback from the hospitals where the students work and from the graduates themselves. Community perceptions about graduates are also monitored.

There is also a further safeguard to help ensure consistency. If the university believes the decisions were not based on the standards it can appeal the decision. The AMC's Accreditation Guidelines specify the appeals mechanism.

Documentation:

Guidelines for the Assessment and Accreditation of Medical Schools, pp. 13-14.



NEWDOC

Committee Name 3	Year yyy	Meeting Summer(s)-Winter(w)
NCFMEA	2001	S W

005717
Doc Number (Bates Stamp here)

Document Class

circle one

01 Agenda

Country Materials for 3

Enter country-code number from the Master List.

21 Staff Analysis

23 Agency Response

24 Addendum

29 Secretary's Decision Letter

02 Decision Memo

04 Federal Register Notices

05 General Correspondence

06 Handouts

07 Minutes

08 Readers/Recusals

09 State Department Notice

10 Transcripts

Date

____ - ____ - ____
yyyy mm dd

30 By-Laws

62 Appointment Letters

64 Membership Lists

66 Guidelines

68 Miscellaneous

Country response to draft Staff Analysis



FAXED

PLEASE ADDRESS ALL CORRESPONDENCE TO

THE EXECUTIVE OFFICER AUSTRALIAN MEDICAL COUNCIL PO BOX 4010 KINGSTON ACT 2604 AUSTRALIA

QUOTE REFERENCE NUMBER 5/10/4

19 February 2001

BY FAX : 0015 1 202 219 7005 (20 PAGES)

Ms Carol Griffiths
Chief, Accrediting Agency Evaluation
Accreditation and State Liaison
1990 K Street NW., Room 7105
Washington, D.C. 20006-8509
United States of America

Dear Ms Griffiths,

Thank you for providing a copy of the Department of Education's review of our submission to the National Committee on Foreign Medical Education and Accreditation.

Your document provides an accurate summary of the Australian Medical Council's (AMC) processes and accreditation standards. The AMC has found the analysis very useful in highlighting some issues that are not clearly explained in our Accreditation Guidelines, and I will ask the next meeting of the AMC Accreditation Committee to review and clarify the wording of the Guidelines in these areas.

I have provided below additional information on the three areas where our documents did not explain clearly the existing policies:

1. **Admissions, Recruitment and Publications** (Page 16 of your document). While the AMC Accreditation Guidelines do not specifically address the medical school's publications concerning student recruitment, in their accreditation submission to the AMC medical schools are required to provide copies of their policy and procedures for student selection, including copies of any publications that explain the selection process to potential students and information on the process for appeals against admission decisions.

Supporting documents: *AMC Guide to the Preparation of an Accreditation Submission* Section 10.2 (already submitted)

2. **Student Services** (Page 18 of your document). While the AMC Accreditation Guidelines do not specifically require medical schools to have policies regarding education, prevention and management of exposure to infectious diseases, a separate Australian Medical Council document emphasises the importance of informing medical students about:

- Any requirement of the medical course that may reasonably inhibit completion of the course by students with a disability (including an infectious disease).
- The standards of health and character set by the medical boards that are requirements for registration as a medical practitioner.
- The implications of disability and infection for medical practice.
- Infection control procedures.

There are also national agreed minimum standards for infection control in Australia released by the National Health and Medical Research Council and the Australian National Council on AIDS. In New Zealand, the Medical Council of New Zealand has its own "Policy Statement on Transmissible Major Viral Infections".

Supporting documents:

- Extract from the 1995 AMC "Report of the Working Party on the Registration of Disabled/Impaired Graduates". This document is currently under review.
- A copy of the table of contents of "Infection Control in the Health Care Setting" and pages 111 and 112 which are recommendations to training institutions concerning the education, prevention and management of exposure to infectious diseases of health care students.

3. **Resources for the Educational Program** (Page 19 of your document). Requirements concerning the humane care of animals used in teaching and research are set by Australia's peak health research body, the National Health and Medical Research Council. The NHMRC code has been endorsed by the Australian Vice-Chancellors' Committee which is the peak organisation representing all Australian universities. In New Zealand, the Health Research Council, which is the major government-funded agency responsible for coordinating health research, has developed "Guidelines on Research Involving Animals or Animal Materials".

Supporting documents: Introduction to the National Health and Medical Research Council's "Australian code of practice for the care and use of animals for scientific purposes".

I hope this information is sufficient for the Committee's purposes. Unfortunately, the Australian Medical Council is unable to accept the NCFMEA's invitation to attend the meeting on 9 March to present material directly to the Committee as your meeting clashes with another local meeting. Please advise the AMC Secretariat if the Committee requires further information on the Australian Medical Council's standards and processes in order to make its decision.

Your document, page 2 "Summary of Findings", recognises that the Australian accreditation standards and processes are used to assess medical schools in Australia and in New Zealand. I understand that the Medical Council of New Zealand, which is the authority in New Zealand that registers medical practitioners, has lodged its own submission to the National Committee on Foreign Medical Education and Accreditation. This should provide information on laws that are specific to New Zealand, such as legislation governing student access to records and legislation governing the functions and powers of universities and medical schools.

Finally, Professor Geffen's term as Chair of the Australian Medical Council's Accreditation Committee has just ended, and I am the new Chair of the Committee. Please address any additional questions about the AMC's accreditation processes to me, through the AMC Secretariat.

We look forward to hearing the outcome of the NCFMEA's review of our accreditation standards.

Yours sincerely

A handwritten signature in black ink that reads "Ian Simpson". The signature is written in a cursive, slightly slanted style.

Professor Ian Simpson MB ChB *Otago* MD *Auck* FRACP
Chair
Accreditation Committee

AUSTRALIAN MEDICAL COUNCIL

WORKING PARTY ON THE REGISTRATION OF DISABLED/IMPAIRED GRADUATES

Recommendations

The working party on the registration of disabled/impaired graduates recommends:

- (i) that the Accreditation Committee be requested to consider amendment to the Accreditation Guidelines to include a requirement for medical schools to have policies and procedures relating to disabled and impaired students;
- (ii) that the Uniformity Committee recommend to the medical boards that they develop a formal mechanism requiring the deans of medical schools to notify, at the point of initial registration with the medical board, the names of graduating medical students who may be unfit to practise without conditions because of disability or impairment;
- (iii) that the AMC suggest to the Committee of Deans of Australian Medical Schools that all medical schools develop a comprehensive policy concerning management and counselling of students with infectious diseases;
- (iv) that the medical boards consider their responses to the eligibility for registration of medical graduates with infectious diseases;
- (v) that the medical boards consider the possibility of a uniform approach to the registration of disabled and impaired graduates and the conditions or limitations that could apply to their registration; and
- (vi) that the working party be disbanded.

BACKGROUND

1. Introduction

In March 1993, Commonwealth legislation which aims to provide uniform protection against discrimination based on physical or mental disability took effect. The *Disability Discrimination Act* (DDA) applies to a wide range of areas of life including employment, education, and the provision of goods and services.

Fundamental to the legislation is the principle of 'reasonable accommodation', which requires that reasonable modifications be made to rules, programs, structures etc to enable otherwise qualified disabled people to take part in life activities such as employment and education.

The significance of the legislation was first discussed at the Accreditation Committee in terms of the implications for a medical school's accreditation if it modified its AMC-accredited medical course to accommodate the needs of a disabled student. The August 1993 meeting of the Uniformity Committee then discussed the consequences for registration by medical boards. The Uniformity Committee established a working party to monitor developments in relation to the *Disability Discrimination Act* and other relevant regulations, and to propose national approaches to the issue of registration of disabled medical graduates.

Members of the working party have been: Professor Ross Kalucy (Chairman), Professor Laurie Geffen (to the 1993 Annual General Meeting), Professor John Horvath, Professor Bob Porter (from the 1993 Annual General Meeting), Professor John Turtle, University of Sydney (by invitation), Ms Theanne Walters (Secretary).

The Uniformity Committee identified the following as issues of particular concern to the medical boards:

- they must have assurance that medical graduates have sufficient physical and mental capacity to practise medicine; and
- they must have confidence that medical graduates have completed an appropriate and adequate course, and that there is a point beyond which those who have completed some modified course would not be eligible for general (unconditional) registration.

These issues have guided the working party. In carrying out its task, the working party has looked at organisations that play a role in providing assurance of the standards of medical graduates, the processes that are used to provide this assurance, and how these processes might be strengthened. The working party collected material on overseas approaches, information on universities' policies and procedures in relation to disabled and infected students, Commonwealth and state guidelines on management of infectious diseases, and medical board guidelines/codes of practice. (A list of the material considered by the working party is at Appendix A).

The working party has submitted reports of its meetings to the Uniformity Committee, the Accreditation Committee, and the Registrars and Secretaries Sub-Committee, and has modified its proposals on the basis of the comments of these groups.

Disability, Impairment and Infection

The *Disability Discrimination Act* defines disability to include physical, intellectual, psychiatric, sensory, neurological or learning disabilities, physical disfigurement and/or a disease-causing organism present in the body. Discrimination on the basis of past, present, future and imputed disability is covered, as well as discrimination against the associates of people with a disability.

From the beginning, the working party has maintained a deliberate distinction between a disabled/impaired student and a student with an infectious disease (for example HIV, hepatitis B or C). This distinction reflects the different issues for medical boards (those of danger to patients rather than competence to practise) that are raised by concern about infectious disease. The working party's proposals in relation to the issues raised by both groups are discussed below.

2. The Medical Schools and the Universities

The working party noted that universities have internal screening processes designed to ensure that students meet certain standards. These apply at admission, as students progress through their course (via assessment and progression rules), and at the point of certifying eligibility for graduation.

2.1 Disability/Impairment

The working party identified the following existing roles of universities and medical schools as particularly relevant to the enrolment of disabled or impaired medical students, or as points where it might be considered possible, necessary or reasonable to vary usual policy to meet the needs of a disabled student:

- (i) setting course admission and selection criteria;
- (ii) providing student counselling, support and facilities;
- (iii) modifying the academic program or the manner in which students may complete essential sections of the program;
- (iv) modifying or adjusting the study/campus environment so that the disabled students may enjoy the same privileges and benefits as other students;
- (v) monitoring progress and assessing students;
- (vi) providing mechanisms for exit to other courses;
- (vii) deciding that the student has completed a course of study that warrants the award of the medical degree.

The final point for the medical school/the university is certification that the student has met the academic requirements for the award of the degree, and this may result despite modification to the medical course (at present for example a student might fail a subject or a component of a subject but still meet the overall requirements).

A concern of the Deans of the medical schools has been that while medical schools have information on students who have satisfied their university degree requirements but may not meet the medical boards' requirements for registration, there is generally no formal mechanism which allowed the Deans to pass that information to the medical boards. Without such a mechanism, the medical schools might breach other legislation, such as privacy legislation, by passing on information.

The working party considered that this was a fundamental issue to be addressed in developing national approaches to the registration of disabled graduates: the medical schools need to be in a position to pass on concerns about such students.

2.2 Infectious Diseases

The working party looked at the range of policies and guidelines which constrain responses to students infected with HIV, or hepatitis B or C. These include the provisions of the State and Commonwealth disability discrimination legislation, university policies, and state and national guidelines/codes of practice.

The working party noted that the approach of governments, the professions etc to the issue of infection control is still evolving.

While universities'/medical schools' policies in relation to infectious diseases differ, the current view of the medical schools appears to be that students infected with one of the infectious diseases under debate (HIV, HBV, HCV) could complete an MBBS. Moreover, the working party noted that the screening of practitioners for infectious diseases is not mandatory, and it agreed that medical students should not be treated in a manner different to practitioners. The current National Health and Medical Research Council guidelines recommend that testing for HIV and hepatitis B should not be undertaken in order to exclude students from courses of study.

In general terms, national guidelines such as the NHMRC/ANCA *Joint statement on testing of health care students for HIV and Hepatitis B* and university policies on HIV and HBV stress the need for students to take responsibility for their own conduct, including knowing their own status and following infection control procedures. University policies place emphasis on:

- the education of students to inform them of the relevant guidelines and to encourage awareness of the issues so that students can make informed decisions about their future;
- the counselling of students on the implications of infection or carrier status by, for example, a specialist infectious diseases counsellor.

The working party identified two levels at which further debate of the issues should occur.

- The working party considered the policy developed by Monash University as one example of the approach by the medical schools to dealing with this issue. The policy provides for: students to receive comprehensive information at the time of enrolment on the possible effect of HIV or HBV on their ability to practise; clear policy on immunisation, testing and follow-up; personal contact with an infectious diseases physician; continuing education as part of the course; and a process for dealing with illness which develops during the course. The working party suggests that medical schools debate collectively the value of such comprehensive policies and recommends that this discussion be taken up by the Committee of Deans of Australian Medical Schools.
- The working party recommends that the medical boards debate collectively their response to the eligibility for registration of medical graduates with infectious diseases.

2.3 Education of Medical Students

In discussion of the working party's reports, a clear view has been expressed that students must be well informed about the requirements of the course before entry and of the additional requirements that will apply to practice.

The importance of such information is highlighted by the limitations that the *Disability Discrimination Act* places on requests for information about a person's disability: it is unlawful to request a person with a disability to provide information which people without that disability would not be requested to provide, where the circumstances are not materially different and where the request is for a discriminatory purpose (such as to exclude a student from entry to a course). It is therefore an important element of self-selection that students be aware of the issues so they can make informed choice about their ability to complete a medical course and to undertake later practice. (This is consistent with the approach taken by institutions in relation to HIV and HBV.)

The working party is aware that medical schools/universities already undertake this educative role. However it would emphasise the importance of informing students about:

- Any requirement of the medical course which may reasonably inhibit completion of the course by students with a disability. One approach, for example, is that of the Association of American Medical Colleges which has developed technical standards for medical school admission. These standards list five varieties of skills and abilities required of medical students: observation; communication; motor; intellectual - conceptual, integrative and quantitative; and behavioural and social attributes.
- The standards of health and character set by the medical boards which are requirements for registration.
- The implications of disability and infection for practice.
- Infection control procedures.

Endorsed April 1996 by the
National Health and Medical Research Council
and the Australian National Council on AIDS

Infection Control

in the Health Care Setting

Guidelines
for the Prevention
of Transmission of
Infectious Diseases



National Health and Medical Research Council
NHMRC

Contents

Contents	iii
List of tables	ix
Preface	xi
Working Party terms of reference and membership	xiii
Executive summary and recommendations	1
PART I CONCEPTS, PRINCIPLES AND PROCESS	9
1.1 Introduction	10
Universal Precautions	10
Standard Precautions	11
Additional Precautions	11
Principles of infection control	12
1.2 Hygiene standards for health care establishments	13
Hand washing and hand care	13
1.3 Physical environment	16
Ventilation	16
Patient accommodation	16
Hand washing basins	17
Work and treatment areas	17
Sterile operating field	18
Cleaning areas	18
Surface materials	18
Routine cleaning of facilities and surfaces	19
Spills management	19
Management of clinical and related waste	22
Handling and disposal of sharps	23
Linen and laundry services	23
Food services	24
Trolleys	24
Refrigerators	24
Transport and handling of pathology specimens	24
1.4 Sterility of instruments and equipment	27
Sterility	27
Single-use instruments and equipment	27
Single-dose vials	27
Multi-dose vials and multi-use products	28

	Cryotherapy equipment	28
	Skin disinfectants	28
1.5	Processing of re-useable instruments and equipment	30
	Immediate handling after use	30
	Cleaning of instruments and equipment	30
	Ultrasonic cleaners	31
	Sterilization of instruments and equipment	31
	Steam sterilization under pressure	32
	Dry heat sterilization	32
	Large scale irradiation systems	33
	Ethylene oxide sterilization systems	33
	Low temperature hydrogen peroxide plasma sterilization systems	33
	Automated peracetic acid systems or other chemical treatment	33
	High level disinfection of instruments	33
	Thermal disinfection (hot water disinfectors or boilers)	33
	Chemical disinfection	34
1.6	Instruments and equipment requiring special processing	36
	Flexible endoscopes	36
	ERCP and duodenoscopes	37
	Bronchoscopes	37
	Laparoscopes and arthroscopes	37
	Respiratory and anaesthetic apparatus	37
	Asthma management (spacers used with metered dose inhalers)	38
	Resuscitation manikin facepieces and accessories	38
	Diagnostic ultrasound transducers	39
	Thermometers	40
1.7	Implementing Standard and Additional Precautions	42
	Testing	42
	Special circumstances requiring Additional Precautions	42
	Exclusion from office practice	43
	Triage policy	43
	Special patient accommodation	43
	Quarantine	44
	Antibiotic resistance	44
	Occupational Health and Safety	44
	Needlestick and sharps injuries	45
1.8	Protection for health care workers	46
	Uniforms	46
	Protective clothing and equipment	46
	Gloves	46
	Protective eye wear and face shields	47
	Masks	47
	Gowns and plastic aprons	48

	Footwear	48
	Immunisation of health care workers	48
	Immunisation/health screening records	48
1.9	Protection for patients	50
	Patients' rights	50
	Standard Precautions	50
	Additional Precautions	50
	Equipment used routinely on patients	50
1.10	Quality management/quality improvement	51
	Policies and procedures	51
	Education and training	52
	Compliance and accreditation	53
1.11	Surveillance	54
	Defining what data are to be collected	54
	Role of the Infection Control Nurse and the Infection Control Committee	54
	Outbreak investigation and control	55
	PART 2 - INFECTIOUS DISEASES IN THE HEALTH CARE SETTING	57
2.1	Acute respiratory viral infections	58
2.2	CJD - Creutzfeldt-Jakob Disease	58
2.3	Cytomegalovirus	59
2.4	Diphtheria	60
2.5	Gastroenteritis and enteric pathogens	60
2.6	Hepatitis A	61
2.7	Hepatitis B	61
2.8	Hepatitis C	63
2.9	Herpes simplex virus	64
2.10	Human immunodeficiency virus (HIV/AIDS)	65
2.11	Infectious mononucleosis	67
2.12	Leprosy	67
2.13	Listeria	67
2.14	Measles and mumps	67
2.15	Meningococcal infection	67

2.16	Multi-antibiotic resistant organisms	68
2.17	Parvovirus	69
2.18	Pertussis	69
2.19	Polio	69
2.20	Rubella	70
2.21	Staphylococcal Infection	70
2.22	Streptococcal Infection	71
2.23	Tuberculosis	71
2.24	Varicella zoster virus (chickenpox and shingles)	72
2.25	Viral haemorrhagic fevers (VHF) - Lassa, Marburg, Ebola	72
PART 3 - SPECIAL ISSUES		77
No. 1	Chemical disinfection and sterilization	78
No. 2	Sterilization in office practice - principles and practice	83
No. 3a	Protocols for office practice (medical and dental)	87
No. 3b	Special requirements in dental practice	88
No. 4	Infection control in endoscopy	91
No. 5	Exposure prone procedures	94
No. 6	Surgical and operating room procedures	95
No. 7	Surveillance of hospital acquired (nosocomial) Infection	100
No. 8	Investigation of outbreaks - summary	102
No. 9	Infection control guidelines for pregnant health care workers	103
No. 10	Health care workers (and students) infected with a blood borne virus	106
No. 11	Health care workers and tuberculosis	113
No. 12	Fundamentals of TB infection control	114
No. 13	Categories of staff according to risks	116
No. 14	Overview of staff health screening	118

No. 15	Staff health issues	120
No. 16	Needlestick and blood accidents - ANCA Bulletin	122
No. 17	Infection control in midwifery and obstetric procedures	130
No. 18	Risk assessment and infection control	132
No. 19	Ethics, rights and responsibilities	133
Appendices		
A.	List of submissions received in stage one consultation	141
B.	List of submissions received in stage two consultation	143
C.	List of national organisations	147
Glossary		153
Bibliography		157

- Medical practitioners are legally required to bring to the attention of the appropriate Registration Board (medical, dental, nursing etc.) any registered professional person who is unable to practise competently and/or who poses a threat to public safety.

Confidentiality

- Confidentiality for the HCW infected with a blood borne virus not only safeguards personal rights, but is in the public interest. The right to confidentiality will encourage HCWs to seek appropriate testing, counselling and treatment and to consider disclosure of their serologic status to their employers.

Assistance for HCWs who have occupationally acquired a blood borne virus

- HCWs whose work practices have been modified because of infection with a blood borne virus should be provided, where practical, with opportunities to continue appropriate patient care activities in either their current position or in redeployed positions, or to obtain alternative career training. Health care establishments should consider whether the redeployed post should be 'equivalent' to the previous position and if so in what respects.
- Health care establishments should address the question of when (or if) treated HCWs who become PCR negative should be allowed to return to work.
- Compensation for infected HCWs should consider the actual grounds for compensation or the level of proof of occupational exposure to be applied to either new cases or to retrospective cases which are revealed by current testing.
- VMOs and agency nurses who become infected due to occupational exposure should be eligible for assistance under the same conditions as permanent employees.

'Look-Back Investigations' of patients of HCW's infected with a blood borne virus

- Selective 'look-back investigations' should be considered when there is evidence of significant violation of standard infection control practices (such as the presence of exudative dermatitis) during the time the health care worker was probably infected with the blood borne virus to ensure the treated public were not placed at risk. Evidence indicates that such investigations are of no benefit in other circumstances and should not be performed.

Compliance

- States and Territories should have systems in place to ensure compliance with these recommendations.

Recommendations for HCW students

- Training establishments should ensure that all HCW students are adequately vaccinated (in accordance with the NHMRC recommended immunisation schedule) to ensure protection against infections that are likely to be encountered in the course of their training.
- Students should not be placed in risk-exposure situations. Strategies should be developed that enable students to acquire clinical skills without risk to patients or themselves.
- Screening for hepatitis B, hepatitis C and HIV should not be undertaken in order to exclude students from courses of study.
- Training establishments should have policies or procedures in place for counselling students who may be inhibited from completing any requirement of the course because of disability or impairment, including

infection with a blood borne virus. They should inform students of these policies and implications of potential disability or impairment (risks to themselves and their patients) prior to course admission.

- Support and counselling services, including processes for dealing with illness, impairment or disability which occurs during the course, should be established.
- Current training requirements which involve performance of exposure prone procedures should be assessed and an attempt made to provide alternative programs for infected students.
- Courses of instruction which provide training in careers that involve invasive procedures should include information, counselling, opportunities for testing, and career advice. This inclusion should be a requirement for course accreditation.
- If necessary students undertaking modified programs should have suitable limitations (conditional registration) placed on their subsequent registration. This may require an undertaking that exposure prone procedures will not be performed by those persons who are proven to be infected with HIV, hepatitis B or hepatitis C.
- Urgent discussions should be instituted between the Universities, teaching hospitals and the various Registration Boards to define and implement policy in this matter.
- Health care trainees should be subject to the same infection control and professional conduct requirements as qualified staff.



Australian code of practice for
the care and use of animals
for scientific purposes

6th edition 1997

National Health and Medical Research Council

NHMRC

Other relevant legislation

Commonwealth

- (i) *Australian Wildlife Protection (Regulation of Exports and Imports) Act 1982*
- (ii) *Export Control Act 1982, including Export Control (Animals) Order 1987*
- (iii) *Quarantine Act 1908*

State-Territory

- (i) *Native Fauna Acts*
- (ii) *Occupational Health and Safety Acts*

NOTE: Copies of the above legislation and relevant regulations may be obtained from Federal, State and Territory publishing services.

Definitions of terms used in this Code

Animal: Any live non-human vertebrate, that is, fish, amphibians, reptiles, birds and mammals, and encompassing domestic animals, purpose-bred animals, livestock and wildlife¹.

Animal Ethics Committee (AEC): A committee constituted in accord with the terms of reference and membership laid down in this Code of Practice.

Approved project: A project which has been formally approved by a properly constituted AEC, on the basis of a written proposal.

Death as an end-point: When the death of an animal(s) is the deliberate measure used for evaluating biological or chemical processes, responses or effects.

Distress: An acute or chronic response of an animal caused by stimuli that produce biological stress, which manifests as observable, abnormal physiological or behavioural responses.

Euthanasia: The process of inducing a painless death.

Investigator: A person approved by an AEC to be responsible for the conduct of an approved project involving animals.

Livestock: Animals which are used in commercial agriculture, including cattle, sheep, pigs, poultry, goats and horses.

Project: A series of related studies or teaching activities that form a discrete piece of work.

¹ See definition of wildlife.

3.3 Conduct of studies	21
General considerations	21
Limiting pain and distress	21
Signs of pain or distress	22
Repeated use of animals in scientific and teaching activities	22
Duration of scientific and teaching activities	22
Handling and restraining animals	22
Completion of projects	23
Humane killing of animals	23
Autopsy	23
Additional considerations	23
Surgery	24
Post-operative care	24
Implanted devices	25
Neuromuscular paralysis	25
Electroimmobilisation	25
Animal models of disease	25
Modifying animal behaviour	25
Toxicological studies	26
Scientific and teaching activities involving hazards to humans or other animals	26
Animal welfare and animal health research	26
Experimental manipulation of the animal's genetic material	27
Experimental induction of neoplasia	27
Lesions of the central nervous system	27
Withholding food or water	28
Fetal experimentation	28
Research on pain mechanisms and the relief of pain	28
Section 4. Acquisition and care of animals in breeding and holding areas	29
4.1 Animals obtained from other States or countries	29
4.2 Transport of animals	30
4.3 Admission of new animals into holding areas	30
4.4 Care of animals in holding and production facilities	30
Outdoor holding areas	31
Indoor housing	31
Environmental factors	31
Food and water	32
Pens, cages and containers and the immediate environments of the animals	32

4.5 Management and staff	33
Person-in-charge	33
Staff	34
4.6 Routine husbandry procedures	35
4.7 Identification of animals	35
4.8 Disposal of animal carcasses and waste	35
Section 5. Wildlife studies	37
5.1 Wildlife captured from natural habitats	37
5.2 Capture of wildlife	38
General	38
Use of traps	38
Non-trap capture	39
5.3 Handling and restraint of wildlife	39
5.4 Holding and release	39
5.5 Transport	40
5.6 Identification	40
5.7 Field techniques	41
5.8 Voucher specimens	41
5.9 Wildlife interaction studies	41
5.10 Feral animal studies	42
Section 6. Care and use of livestock for scientific and teaching activities	43
6.1 General principles	43
6.2 AEC applications	44
6.3 Teaching and demonstration requirements for all livestock	44
Section 7. The use of animals in teaching	45
7.1 General principles	45
7.2 Responsibilities of teachers	45
7.3 Animals in schools	46
Appendix. Information sources	49
Bibliography	53
1. Recommended introductory reading	53
2. Periodicals	53
3. Ethics and animal welfare	54
4. Animal ethics committees	57
5. Alternatives	57
6. Animal care and use	58



PLEASE ADDRESS ALL CORRESPONDENCE TO

THE EXECUTIVE OFFICER AUSTRALIAN MEDICAL COUNCIL PO BOX 4810 KINGSTON ACT 2604 AUSTRALIA

ROUTE REFERENCE NUMBER 5/3/4/
6/10/18

31 August 2000

Dr Karen Kershenstein
Director
Accreditation and State Liaison
1990 K Street, NW, Room 7105
Washington, DC 20006-8505
UNITED STATES OF AMERICA

Dear Dr Kershenstein,

I am responding to a request for information to assist the National Committee on Foreign Medical Education and Accreditation to determine whether the standards used in Australia to evaluate medical schools are still comparable to those used in the U.S.

Attached to this letter is the Australian Medical Council's response to the questions in the NCFMEA Guidelines, together with copies of the AMC's standard accreditation documents and other documents which clarify and support statements made in our response.

If you have any questions concerning our response or would like additional information, please contact the Australian Medical Council's Deputy Executive Officer, Theanne Walters at the following address:

Ms Theanne Walters
Deputy Executive Officer
Australian Medical Council
PO Box 4810
Kingston ACT 2605
AUSTRALIA

Email: theanne@amc.org.au
Fax: 61 2 62709799

I look forward to advice concerning the outcome of the NCFMEA's review in due course.

Yours sincerely

Laurie Geffen
Chairman
AMC Accreditation Committee

**Response to
U.S. Department of Education
National Committee on Foreign Medical Education and Accreditation**

PART I: The Entity Responsible for the Accreditation/Approval of Medical Schools

What is the name of the entity responsible for evaluating the quality of medical education in your country?

By what authority does this entity accredit or approve medical schools?

The Australian Medical Council (AMC) is Australia's national standards body for basic medical education. Australia's State and Federal Health Ministers established the AMC in 1985. It reports annually to Health Ministers.

The AMC derives its authority to accredit medical schools from two sources:

1. The Constitution of the AMC provides for the AMC "to advise and make recommendations to the State and Territory Medical Boards in relation to the accreditation of Australian and New Zealand medical schools and of courses leading to basic medical qualifications conducted by those schools largely or entirely in Australia and New Zealand".

The Constitution also provides for an Accreditation Committee of the AMC, to have responsibility for developing recommendations concerning accreditation policy and procedures on the Council's behalf. The terms of reference and membership provisions of the Committee are set out in the Constitution.

2. The legislation of the individual Australian States and Territories. In Australia, all the States and Territories have adopted uniform minimum requirements for initial registration as a medical practitioner. These requirements limit entitlement to general or full registration to graduates of Australian and New Zealand medical schools accredited by the AMC and overseas trained doctors who hold the AMC examination certificate. This means that medical schools in Australia and New Zealand must be accredited by the AMC in order for their graduates to be registered to practise medicine in Australia.

Supporting Documents

- Australian Medical Council Constitution.
- Extracts from the Medical Practice Acts of two of the Australian State and Territories concerning the AMC's authority to accredit medical schools.

PART II: Accreditation/Approval Standards

What are your country's requirements related to the educational mission of medical schools? How does the mission serve the general public interest?

The AMC had adopted *Guidelines for the Assessment and Accreditation of Medical Schools* that set out the educational principles that guide the AMC's accreditation of medical schools. Concerning the general public interest, the Accreditation Guidelines indicate that medical schools must respond to the

AUSTRALIAN MEDICAL COUNCIL

Postal Address
PO BOX 4810
KINGSTON ACT 2604
AUSTRALIA

Street Address
Unit 3, 40 Macquarie Street
BARTON ACT 2600
AUSTRALIA

Telephone No: (02) 6270 9777
Facsimile No: (02) 6270 9799
Email: amc@amc.org.au
Web: http://www.amc.org.au

evolution of health needs in the communities they serve, and should have methods to communicate with recipients of health care to allow the medical school to respond appropriately to the community.

Supporting Documents

- *AMC Guidelines for the Assessment and Accreditation of Medical Schools* Page 5 re aims of the accreditation process, and Page 38 re responses by medical schools to the health care needs of the community.

What are your country's requirements related to how medical schools must prepare graduates to qualify for licensure and to provide competent medical care?

The AMC Accreditation Guidelines describe the overall goal of basic medical education as "to produce broadly educated medical graduates with an appropriate foundation for further training in any branch of medicine including family medicine (general practice), medical, surgical, investigational or other specialties, medical research, public health medicine or health service administration. Knowledge and skills should be firmly based on scientific principles, and graduates should have developed appropriate professional attitudes. Above all, graduates in medicine should be competent to practise safely and effectively under supervision as an intern."

Concerning preparation of medical students for internship, the AMC Accreditation Guidelines recommend:

- A graded increase in practical involvement in patient management during the clinical years of the course.
- Specific transition programs in the final year of the medical course.
- Medical school representation on the bodies that oversee intern training.

Medical schools are asked to comment on the way in which medical students are prepared for internship in their accreditation submission.

Supporting Documents

- *AMC Guidelines for the Assessment and Accreditation of Medical Schools* Pages 23 and 24 concerning the objectives of medical education, and Pages 40 and 41 concerning preparation for internship.
- *AMC Guide to the Preparation of an Accreditation Submission* Section 13.6.

What are your country's requirements related to authorization or licensure of medical schools in your country? Are they required to be legally authorized or licensed in order to provide a program of medical education in your country? If so, what is the name of the entity that authorizes or licenses medical schools?

The authorisation of medical schools to provide a course of medical education comes from two sources: State and Commonwealth (Federal) Government.

All of the Australian medical schools are located in publicly funded universities, which are set up under State legislation. Their legal authority to grant degrees and offer courses is specified in their enabling legislation.

The Commonwealth Government operates a national universal health scheme "Medicare" which rebates doctors for medical services. For this reason, the Commonwealth sets national controls on the number of doctors entering Australia's medical workforce. This includes the allocation of funds for medical student places and for universities who are not permitted to enrol Australian citizens and permanent residents over and above the number approved and funded by the Government as fee-paying students in medical schools.

What are your country's requirements related to the accountability of the management of a medical school to some authority external to the medical school? Is there such an external authority? If so, what is that authority?

The AMC Guidelines do not specify any requirements concerning the accountability for the management of a medical school to an external authority. This has been unnecessary, since all the Australian medical schools are located in State funded universities, and are responsible to the governing body of their university, and ultimately to State and Commonwealth Government.

Each of the public universities in Australia is governed by a Senate or Council that draws its members from government, industry, the community, and the University's academic staff, graduates and students. At both State and Commonwealth levels, there is a range of controls to ensure the proper operation of universities. These include requirements for annual external audits and annual reports to State Parliament. At Federal level, the performance of universities is reviewed annually in educational profile discussions, and against Commonwealth performance indicators.

In the information it provides in preparation for accreditation by the AMC, a medical school is asked to provide information on the University's structure, organisation and governance.

Supporting Documents

- A copy of a letter from the Commonwealth Education Minister to the Vice-Chancellor of Australia's newest medical school, at James Cook University, which demonstrates that both Commonwealth and State approval of medical schools is required.
- *AMC Guide to the Preparation of an Accreditation Submission, Section 2.*

What are your country's requirements regarding how medical schools are to be administered?

The AMC Accreditation Guidelines include requirements regarding the administration and management of medical schools that cover:

- The autonomy of the medical school
- The medical school's control of the curriculum
- Administrative support and infrastructure facility to support academic staff
- The role of medical school academic staff in teaching hospitals and affiliated institutions.

The AMC asks medical schools to provide specific information on these matters in the questionnaire that they complete in preparation for accreditation.

Supporting Documents

- *AMC Guidelines for the Assessment and Accreditation of Medical Schools* Pages 36 to 38 concerning management of the medical school and Page 39 concerning academic staff.
- *AMC Guide to the Preparation of an Accreditation Submission* Sections 3, 4 and 11.

What are the qualifications your country requires for the person who holds the position of chief academic official of a medical school?

The general requirements for the senior academic faculty are determined by the statutes and policies of the university that contains the medical school. The AMC has not specified additional requirements for the chief academic officer of a medical school. The issues of leadership and management of the medical school, however, are considered by assessment teams and discussed in accreditation reports.

In the questionnaire that medical schools complete in preparation for accreditation, the AMC asks medical schools to provide information on:

- the terms of office and responsibilities of the Senior Medical School Officers.
- the University's policy and practice concerning appointment and promotion of staff.

Supporting Documents

AMC Guide to the Preparation of an Accreditation Submission Sections 3 and 11.

What are the requirements related to the participation of the faculty members of a medical school in decisions related to admissions; the hiring, retention, promotion, and discipline of faculty; and curriculum?

The AMC imposes no uniform structure but requires medical schools and their faculty to have sufficient autonomy over admissions and curriculum to achieve their stated objectives, including direct responsibility for resources.

The statutes and policies of the university that contains the medical school determine the general requirements for the hiring, retention, promotion, and discipline of the faculty. The AMC requires information on measures taken to recruit and support high quality staff and an explicit policy for development including mentoring and specific courses in teaching, assessment, evaluation, grant writing, management and information technology.

What requirements does your country impose on a medical school that offers part or all of its program at a geographically separated site (sometimes called a branch campus or additional location) to ensure that the quality of education at that site is comparable to that at the main campus and that students are evaluated in a comparable manner at all sites?

The AMC Accreditation Guidelines includes expectations that medical schools will:

- Have processes in place that allow the overall content and balance of the curriculum and its assessment to be defined and be able to demonstrate that they are able to implement and change the curriculum according to these overall requirements.

- Have mechanisms to ensure that all clinical placements, in hospitals and in the community, are supervised and well organised, with clearly defined objectives and assessment.
- Make special effort to monitor the educational experiences of clinical attachments outside the main teaching hospitals.
- Allocate sufficient resources to its teaching sites.

It is also expected that teaching sites have appropriate support services and facilities for students.

In the submission that medical schools prepare for accreditation, the AMC ask medical schools to provide specific information on these issues, including:

- How assessment is made consistent with the curriculum goals and objectives and across teaching sites.
- How the school coordinates clinical teaching within the teaching hospitals, during rural and remote area rotations and general practice attachments.
- How the school provides educational support to students away from the main campus.
- The provision of facilities for teaching students in the health services (eg hospitals, community centres etc).

When reviewing a medical school for accreditation, the AMC accrediting team visits all the medical schools' major teaching sites. On these site visits, the team inspects the teaching facilities such as the library, and meets academic staff, clinicians who teach medical students, medical students and interns, and senior administrative staff.

Supporting Documents

- *AMC Guidelines for the Assessment and Accreditation of Medical Schools Page 31.*
- *AMC Guide to the Preparation of an Accreditation Submission Sections 12 and 13.*
- The AMC Model Schedule for an AMC Assessment Visit shows the structure of the accreditation visit program.

Educational Program

How long must a medical school's program of medical education leading to the M.D. degree (or equivalent) be in your country?

The AMC Accreditation Guidelines does not prescribe a minimum length for medical courses. The medical courses in Australia are either:

- Five or six years in length. These courses generally admit students directly from secondary school, or
- Four years in length. The four year courses admit only graduate students.

(Please see the list of accredited medical courses, which shows the length of individual courses.)

The AMC Guidelines do require "a significant period of time devoted to students' personal contact with patients", which would normally entail the equivalent of at least two years spent primarily in direct contact with patients, as well as contact with patients during other parts of the course.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Page 27.

AMC Accreditation Register, which shows the length of the Australian and New Zealand accredited medical courses.

What are your country's requirements related to the basic sciences component of a medical program leading to the M.D. (or equivalent) degree? What subjects does your country require a medical school to include in the basic sciences? What requirements does your country have for the laboratory portion of the basic sciences curriculum?

What are your country's requirements related to the clinical sciences component of a medical program leading to the M.D. (or equivalent) degree? What subjects does your country require a medical school to include in the clinical sciences?

What are your country's requirements related to the inclusion of disciplines that support the fundamental clinical subjects in a medical program leading to the M.D. (or equivalent) degree? What does your country require a medical school to include in these disciplines?

What are your country's requirements related to the inclusion of ethical, behavioural, and socio-economic subjects in a medical program leading to the M.D. or an equivalent degree?

What are your country's requirements related to the inclusion of communications skills in a medical program leading to the M.D. (or equivalent) degree?

The AMC specifies the requirements relating to the basic sciences, clinical sciences component, fundamental clinical subjects, ethical, behavioural, and socio-economic subjects and communications skills in the form of objectives relating to the knowledge and understanding, skills and attitudes expected of medical graduates. The policy of the AMC is that each medical school is responsible for developing its objectives for its medical course and putting in place a curriculum that achieves these objectives, providing the objectives of the medical school are concordant with those articulated in the AMC Accreditation Guidelines. The AMC Accreditation Guidelines define the medical curriculum in broad outline, and reference is made to emergent areas where the AMC believes particular emphasis should be given.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Pages 23 to 31.

What are your country's requirements related to the design, implementation, and evaluation of a medical school's curriculum? Does your country require each medical school to have its own system for evaluating the effectiveness of its curriculum and making changes to the curriculum as a result of its evaluation? If so, what role does your country require the faculty members of the medical school to play in that process?

The AMC Accreditation Guidelines specify that medical schools have:

- Processes that allow the overall content and balance of the curriculum and its assessment to be defined and the ability to implement and change the curriculum according to these overall requirements.
- Processes to allow gradual changes to the curriculum and its components.
- Mechanisms to recognise emergent topics and themes that should be incorporated into the organisation of the curriculum.
- Mechanisms for evaluation, review and change to the curriculum. The Guidelines specify a range of evaluation mechanisms including: student questionnaires, representation of the student body on curriculum committees, student access to course conveners, examining pass rates in individual course components, and examining the quality of the graduates.

The AMC Accreditation Guidelines impose no uniform structure on the role faculty members should play in these processes, apart from its expectations that medical schools have:

- sufficient autonomy over their curriculum to achieve their stated objectives, and
- a medical curriculum committee to develop overall curriculum design, implementation and student assessment, with membership that includes the basic and the clinical sciences.

However, in their accreditation submission, medical schools are required to provide information that will allow the accrediting team to judge the extent of participation of all faculty members in the life and decision-making processes of the medical school. In the assessment visit, the team then meets with faculty from all levels and from all the departments/units that contribute to the medical course.

Supporting Documents

- *AMC Guidelines for the Assessment and Accreditation of Medical Schools* Pages 28 and 29 concerning the design and organisation of the curriculum and Pages 32 and 33 concerning monitoring and evaluating the curriculum.
- *AMC Guide to the Preparation of an Accreditation Submission* Sections 3 to 5.
- AMC Model Schedule for an AMC Assessment Visit.

Medical Students

What are the requirements for the admission of students to medical schools? Are these requirements specified at the national level for all medical schools or is each medical school allowed to set its own standards for admission provided it meets the general requirements specified by the government or other appropriate body?

Each medical school is allowed to set its own requirements for admission. General requirements are set in the AMC Accreditation Guidelines, which indicate:

- that certain standards of literacy, numeracy, aptitude and scientific knowledge are required for successful completion of a medical course, and
- that admission requirements must be clearly defined, defensible and free of discrimination or bias.

- that medical schools are expected to have a mechanism for student appeal against admission decisions.

What access do students have to their records in your country? What laws (if any) govern student access to records and the confidentiality of student records in your country?

Each Australian State has Freedom of Information and privacy legislation that governs access to documents held by state authorities. The Australian Vice-Chancellors' Committee, which is the peak organisation representing Australian universities, has produced a generic statement, "Universities and their Students: Expectations and Responsibilities". Each university sets its own detailed rules and regulations concerning student access to and confidentiality of records, which is in accord with State legislation and the Australian Vice-Chancellors' Committee statement.

Supporting Documents

- *AMC Guidelines for the Assessment and Accreditation of Medical Schools* Page 33 re student admission.
- *AMC Guide to the Preparation of an Accreditation Submission* Section 10.
- Australian Vice-Chancellors' Committee statement "Universities and their Students: Expectations and Responsibilities", see A2 concerning admission requirements, A8 concerning student review of results, and A11 concerning confidentiality of information.

What are the requirements related to how medical schools must evaluate student achievement? Are medical schools free to establish their own methods? If so, how does your country determine if they are adequate? Alternatively, are there some national requirements such as standardized examinations that all medical school students must take?

The AMC Accreditation Guidelines on student assessment cover:

- The need for explicit assessment criteria.
- The requirement for summative (barrier) assessment and formative assessment.
- Encouragement to medical schools to develop valid and reliable assessment instruments for all specific educational objectives, including attitudinal objectives.
- Monitoring by the curriculum committee of the pass rates in individual components of the course.

Medical schools are free to establish their own methods to evaluate student achievement, but the AMC Accreditation Guidelines suggest a range of assessment methods. The Guidelines also state that clinical examinations, on real or simulated patients, should form a significant component of the overall process of assessment of the clinical disciplines and that assessment should include observation of the student performing a complete clinical evaluation.

When it is being accredited, a medical school is required to provide detailed information on its examination system and procedures, assessment techniques and examination controls. This often includes scrutiny by the accrediting team of samples of student work, computer-administered formative tests, examination papers and reports on the school's examinations by external examiners. Student assessment and examination is a major topic in each AMC accreditation report on a medical school.

There are no standardized examinations that all Australian medical school students must take.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Pages 31 and 32.

AMC Guide to the Preparation of an Accreditation Submission Section 7.

AMC Topics Covered in an AMC Accreditation Report.

What are your country's requirements for the provision of student services by medical schools?

The AMC Accreditation Guidelines specific requirements concerning:

- Physical facilities including facilities for student study and recreation, adequate lounge, locker and food service areas.
- Support services such as counselling services, student health services, student academic advisers.
- Specific support and counselling services to deal with student illness, impairment and disability.

Medical schools are required to provide specific information on their student support services and facilities in the submission they prepare for accreditation.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Page 34.

AMC Guide to the Preparation of an Accreditation Submission Section 10.

What are the requirements related to the facilities a medical school must have?

The AMC Accreditation Guidelines specify that medical schools must have:

- Sufficient resources to achieve their objectives and to maintain high standards of medical education.
- Facilities adequate to allow the educational objectives of the medical school to be achieved.
- The capacity to expose medical students to a range of settings in which health care and health promotion are delivered.

They also specify that clinical teaching institutions should provide suitable facilities for students.

Concerning the research environment of the medical school, the AMC Accreditation Guidelines state, "Undergraduate medical education is greatly enhanced by a medical school environment in which research is actively pursued. The AMC will enquire into the research activities of medical schools as part of its evaluation of their medical teaching programs because of the acknowledged benefits for both staff and students of vigorous research programs."

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Pages 29 and 30 on teaching settings; Pages 36 and 37, issues relating to management of the medical school; Page 38 funding; Pages 39 and 40 physical resources; Pages 35 and 36 Research.

AMC Guide to the Preparation of an Accreditation Submission Sections 12, 14 and 15.

What are your country's requirements related to the size of the faculty a medical school is required to have? What are its requirements related to the qualifications for appointment to the faculty?

The AMC Accreditation Guidelines contain general recommendations concerning the academic staff of a medical school. These cover:

- Recruitment issues.
- Provision of adequate administrative support and infrastructure facilities.
- Joint appointments between the university and hospitals.
- Honorary clinical academic titles for hospital or community practitioners involved in teaching and research.
- Faculty development and appraisal.

In their accreditation submission to the AMC, medical schools are required to provide detailed information on the number and make up of their academic staff, and policies on appointment, promotion, staff development and appraisal.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Page 39.

AMC Guide to the Preparation of an Accreditation Submission Section 11.

What are your country's requirements related to a medical school's library?

The libraries should maintain a collection of reference materials adequate to meet the curriculum and research needs of the students and the faculty staff. Supportive staff should be available to help the students. Access to computer-based reference systems should also be provided.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Page 40

AMC Guide to the Preparation of an Accreditation Submission Section 12.3.

What are your country's requirements related to a medical school's clinical teaching facilities?

The AMC Accreditation Guidelines recommend:

- Effective communication and liaison between the university, the school of medicine and the health care and research institutions affiliated with the university, desirably with formalised arrangements.
- A formally constituted mechanism for high level consultation between the university and the affiliated institution to ensure appropriate communication and liaison on matters of mutual interest, particularly those relating to teaching, research and clinical service.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Page 37 and 38.

AMC Guide to the Preparation of an Accreditation Submission Section 13.

PART III: Accreditation/Approval Processes and Procedures

1. Site Visit

Does the entity that is responsible for accrediting/approving medical schools in your country conduct a site visit to a medical school prior to granting it accreditation/ approval? If so, does the site visit include a review of the school's admissions process, its curriculum, its faculty, the achievement of its students and graduates, the facilities, and the academic support services available to students? Does the site visit involve both the main campus of the medical school and any other branch campus(es) or additional locations) operated by the medical school?

Yes, the AMC asks the medical school being accredited to respond to a detailed questionnaire. Using this questionnaire as a guide, the medical school supplies extensive documentation on the school, the medical curriculum and the resources that support the curriculum. The AMC then sets up an expert team that reviews this material and then conducts a site visit to the school, its facilities and teaching hospitals. This visit normally takes a week.

Yes, the site visit includes a review of the medical curriculum, and the processes, resources and facilities that underpin its delivery. It includes site visits to all the medical school's principal teaching locations.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Pages 9 and 12.

AMC Model Schedule for an AMC Assessment Visit.

2. Qualified On-Site Evaluators, Decision-Makers, and Policy-Makers

What are your country's requirements regarding the qualification and training of the individuals who participate in on-site evaluations of medical schools, the individuals who establish the accreditation/approval standards for medical schools, and the individuals who decide whether a specific medical school should be accredited/ approved?

The individuals who participate in on-site evaluations of medical schools.

The AMC maintains a database of potential assessment team members, which it generates from nominations by medical schools, specialist medical colleges, and medical registration boards.

Nominees are required to provide information on their qualifications and experience pertinent to the accreditation process, including their current undergraduate and postgraduate medical teaching, and research interests. Team members are expected to support the concept of professional accreditation, and to be willing to contribute directly to the growth and further development of the process. Persons chosen as assessment team members are expected to be aware of current issues in basic medical education, and be supportive of change and innovation.

In appointing a team, the AMC aims for members from a range of States and of medical schools in Australia and New Zealand, as well as for a balance between the basic and the clinical disciplines, between hospital and community-based teachers, and between experienced and new assessors. At least one member of the Accreditation Committee is included in the membership of a team. The Accreditation Committee always chooses an experienced AMC assessor to chair the assessment team.

The individuals who establish the accreditation/approval standards for medical schools

The AMC Accreditation Committee established the accreditation standards. The membership of the Committee is set out in the AMC Constitution. It includes members of the medical schools, the Australian Medical Council itself, the specialist medical colleges, and Medical Council of New Zealand. To increase the transparency of the process, the Council is also considering a proposal that the Committee include a member nominated by the peak health consumer group in Australia and a member nominated by the Australian Medical Students' Association.

All members of the Accreditation Committee take part in at least one accreditation visit and thus have first hand experience of the process. A list of the current members of the Committee is attached.

The individuals who decide whether a specific medical school should be accredited/ approved

The final decision on accreditation is made by the Australian Medical Council, on the recommendation of the Accreditation Committee. The membership provisions of the Council are set out in the AMC Constitution.

Of the seventeen members of the Council, sixteen are medically qualified. The Council includes members nominated by the major medical bodies in Australia: the medical schools, the specialist postgraduate medical colleges, the Australian Medical Association, the Australian Health Ministers Advisory Council, and the state and territory medical registration boards. Eight of the members are presidents of the state medical registration boards, and therefore have a direct interest in the standard of the assessment/accreditation process since graduates of accredited schools will be entitled to register as medical practitioners. At least two members of the Council are members of the Accreditation Committee.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Pages 7 and 8 on membership of assessment teams.

Australian Medical Council Constitution Clause 3 re membership of the Council and Clause 14 re membership of the Accreditation Committee.

3. Re-evaluation and Monitoring

Does your country require accredited/approved medical schools to undergo periodic re-evaluation to determine if they are still in compliance with the standards for accreditation/approval? If so, how frequently are medical schools re-evaluated?

Yes, the AMC Constitution, Clause 16 requires that "Each medical school shall be assessed at least once in each ten year period".

A medical school may obtain accreditation for a maximum period of ten years, which is available for six years in the first instance. A further four years can be confirmed subject to a satisfactory written report by the school in the fifth year of accreditation.

The AMC may also set shorter periods of accreditation where it identifies deficiencies in a medical school.

Supporting Documents

Australian Medical Council Constitution Clause 16.

AMC Guidelines for the Assessment and Accreditation of Medical Schools Pages 14 and 15 sets out the maximum periods of accreditation available to a medical school.

How does your country monitor medical schools throughout any accreditation/approval period granted to them to verify their continued compliance with the standards? Are medical schools required to submit an annual report? If so, what does it contain?

In the period between assessment visits, the AMC Accreditation Committee monitors change in the medical schools through periodic reports. Medical schools granted the full period of accreditation submit reports two, five and seven years after their assessment by the AMC, with a major report required in the fifth year of accreditation. All other medical schools, for example those with conditions on their accreditation, those introducing a major structural change to their medical course and new medical schools submit annual reports.

For each report, the AMC asks the person who chaired the AMC team that visited the school to comment on the medical school's report. The Accreditation Committee then considers the report and any comments by the team chair.

The reports contains information on changes since the last report by the school in the following areas:

- The medical school's relationships with the University and the health care services
- Issues relating to students
- Curriculum structure and evaluation
- Student assessment
- Arrangements for clinical teaching
- Staffing
- Funding
- Other matters judged by the medical school to be of relevance
- Issues identified as concerns in previous AMC accreditation reports

Supporting Documents

- *AMC Guidelines for the Assessment and Accreditation of Medical Schools* Pages 21 and 22 set out requirement for periodic reports.
- The AMC proforma for periodic reports.

4. Substantive Change

If a medical school wants to make a substantive change to its educational program or some other aspect of the medical school, what are the requirements requiring notification of the change to the appropriate entity and review by the entity?

Since the AMC is the accrediting body, medical schools are required to notify the AMC of any proposed changes to their accredited medical course. The AMC Accreditation Guidelines require a medical school to notify the AMC of a proposed change about 2 years before the change is implemented.

The AMC Accreditation Guidelines contain detailed policy and procedure on the review of major structural changes to medical courses. This policy includes:

- A definition of a major structural change.
- An initial assessment by the AMC of medical school's broad plans and its capacity to manage the change process about 18 months before the new course commences.
- A detailed review of the school's planned curriculum, including a site visit to the medical school, at least eight months before course commencement.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Pages 16 to 21.

5. Controls against Conflicts of Interest and Inconsistent Application of Standards

How does your country ensure that those involved in the accreditation/approval decision for a specific medical school do not have a conflict of interest that might prevent them from making an objective decision?

The AMC Accreditation Guidelines set out AMC policy concerning conflict of interest, which entails:

- Declaration by proposed members of accrediting teams of any relevant personal or professional interest that may conflict with their obligations.
- Declaration by members of the AMC Accreditation Committee and the Council itself of any relevant personal or professional interest that may conflict with their obligations and a requirement that such members withdraw from formal meeting and voting on the relevant item.
- Disclosure of any such declared interests to the medical school.
- Medical schools are given the opportunity to comment on the composition of the proposed assessment team.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Page 8.

AMC Guide to Assessors is the AMC's detailed guidance for new assessors.

How does your country ensure that your standards for the accreditation/approval of medical schools are applied consistently to all schools that seek that accreditation/approval?

Through:

1. The choice of members of visiting assessment teams.
 - Each visiting team includes at least one member who is also a member of the Accreditation Committee.
 - About half the members of any team will have participated in at least one previous visit.
 - The secretary, who is a senior member of the staff of the AMC Secretariat, is a member of all teams and is the Secretary of the Accreditation Committee.
2. The process of consideration of the assessment team's report within the AMC.

A draft accreditation report is seen by all members of the team and by the medical school (so that errors of fact may be corrected). The team's draft report and any comments on the report by the medical school are scrutinised by the Accreditation Committee to ensure the report is balanced and that the conclusions drawn by the team are sound.

After the Accreditation Committee has endorsed a draft report, it is returned to the university for final comment. The Australian Medical Council makes the final decision on accreditation, on the basis of the Accreditation Committee's report and any comments by the university.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Pages 12 to 14.

6. Accrediting/Approval Decisions

How does your country use information on the performance of a medical school's graduates in reaching a decision on whether or not to grant that school accreditation/approval?

The AMC Accreditation Guidelines include a requirement for medical schools to examine the quality of the graduates. Medical schools are expected to:

- Have mechanisms for obtaining feedback from the hospitals where their students work as interns and residents after graduation and from the graduates themselves.
- Monitor and, where appropriate, respond to community perceptions about deficiencies in graduates
- Identify forms of medical practice which their graduates appear reluctant to pursue, as this may reflect insufficient exposure to these areas during basic medical education and the early stages of postgraduate training.

In accrediting a medical school, an AMC team visits the medical school's range of teaching hospitals and meets with senior staff of the hospitals to obtain feedback on the quality of the graduates and on their performance as interns, it also meets with interns and seeks their views on deficiencies in their training. The visiting team also meets the body responsible for intern training and accreditation and the State medical registration board and seeks their feedback on the quality of the graduates.

Until recently, coordination of intern training in Australia has varied significantly from state to state. In 1998, the bodies in each State and Territory responsible for intern training have formed a confederation and have begun to discuss education and training issues in a national forum. The AMC hopes to collaborate with this confederation to improve its data on the evaluation of medical graduates.

What procedures does your country use to ensure that accreditation/approval decisions are based on your accreditation/approval standards?

In addition to the internal checks and balances in the accreditation process that are described above, the AMC Accreditation Guidelines also specify an appeals mechanism to allow a university to appeal independently of the AMC and its Committees against the accreditation report or accreditation decision on its medical school.

Supporting Documents

AMC Guidelines for the Assessment and Accreditation of Medical Schools Pages 13 and 14.

Does your country have any benchmarks or minimal levels of performance on licensing examinations that medical school graduates must meet in order for the medical school to be granted accreditation/approval? If so, what are they?

There are no external licensing examinations in Australia.



NEWDOC

Committee Name 3	Year yyy	Meeting Summer(s)-Winter(w)
NCFMEA	200	S (W)

000170
Doc Number (Dates Stamp here)

Document Class

circle one

01 Agenda

Country Materials for 3

Enter country-code number from the Master List.

- 21 Staff Analysis
- 23 Agency Response
- 24 Addendum
- 29 Secretary's Decision Letter

Country - Submission

- 02 Decision Memo
- 04 Federal Register Notices
- 05 General Correspondence
- 06 Handouts
- 07 Minutes
- 08 Readers/Recusals
- 09 State Department Notice
- 10 Transcripts

Date - -
 yyyy mm dd

30 By-Laws

- 62 Appointment Letters
- 64 Membership Lists
- 66 Guidelines
- 68 Miscellaneous

ASSESSMENT AND

ACCREDITATION OF

MEDICAL SCHOOLS



AUSTRALIAN MEDICAL COUNCIL

GUIDELINES FOR THE

ASSESSMENT AND

ACCREDITATION OF

MEDICAL SCHOOLS



© Australian Capital Territory, Canberra 1998

ISBN 1 875440 21 6

This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced by any process without written permission from:

Australian Medical Council Incorporated
PO Box 4810
KINGSTON ACT 2604
AUSTRALIA
Telephone: (02) 6270 9777
Facsimile: (02) 6270 9799
Email: amc@amc.org.au
Home Page: <http://www.amc.org.au>

Contents

Foreword	iv
Executive Summary	v
Part 1. Background and Aims of the Accreditation of Medical Schools	1
1 The Role of the Australian Medical Council	1
2 History of Accreditation of Australian and New Zealand Medical Schools	2
3 Accreditation as an Alternative to Licensure Examinations	4
4 Aims of AMC Accreditation	5
5 Accreditation of Professional Courses in Australia	6
Part 2. The Procedures for Assessment of Medical Schools	7
1 Assessment of an Established Medical Course	7
1.1 <i>Initial contact</i>	7
1.2 <i>Initial documentation</i>	7
1.3 <i>Assessment team</i>	7
1.4 <i>Timing of assessment visits</i>	9
1.5 <i>Review of initial documentation</i>	9
1.6 <i>Preliminary meeting of the assessment team</i>	9
1.7 <i>Preliminary visit to the school</i>	9
1.8 <i>Assessment visit</i>	9
1.9 <i>Consultation and additional feedback</i>	12
1.10 <i>Formal report</i>	12
1.11 <i>Review of the accreditation committee's report</i>	13
1.12 <i>Final decision on accreditation</i>	14
1.13 <i>Options for decisions on accreditation of established medical courses</i>	14
1.14 <i>Unsatisfactory progress procedures</i>	15
2 Assessment of a Major Structural Change in an Established Medical Course	16
2.1 <i>Definition of a major structural change</i>	17
2.2 <i>The criteria for assessment of major structural changes</i>	17
2.3 <i>Assessment of proposed changes</i>	17
2.4 <i>Procedures for the conduct of the assessment</i>	20
2.5 <i>Options for decisions on accreditation of major changes to existing courses</i>	20
2.6 <i>Unsatisfactory progress procedures</i>	21
3 Periodic Reports by Medical Schools to the AMC	21
4 Assessment of New Medical Courses	22

Contents

Part 3. Educational Guidelines for Medical Schools	23
1 Introduction	23
2 Goals and Objectives of Basic Medical Education	23
<i>Goals</i>	23
<i>Objectives relating to knowledge and understanding</i>	24
<i>Objectives relating to skills</i>	25
<i>Objectives relating to attitudes as they affect professional behaviour</i>	26
3 The Basic Medical Curriculum	26
<i>Design and implementation</i>	28
<i>Organisation and integration</i>	28
<i>Emergent topics requiring especial emphasis</i>	29
<i>Elective periods</i>	29
<i>Teaching and learning methods and settings</i>	29
4 Student Assessment	31
5 Monitoring, Evaluating and Changing the Curriculum	32
6 Issues Relating to the Students	33
<i>Methods of student selection</i>	33
<i>Student support and facilities</i>	34
<i>Students with a disability</i>	34
<i>Mechanisms for exit to alternate courses</i>	35
<i>Personal development of students</i>	35
<i>Overseas students</i>	35
7 Research	35
8 Issues Relating to Management of the Medical School	36
<i>Administration and structure within the university</i>	36
<i>Relationship of the medical school with the state health department</i>	37
<i>Relationship with affiliated institutions and the community</i>	37
9 Funding	38
10 Academic Staff	39
11 Physical Resources	39
<i>Teaching</i>	39
<i>Library resources</i>	40
<i>Facilities in hospitals and other teaching centres</i>	40
12 The Continuity of Medical Education	40
Part 4. References	42

Foreword

This guide to the Australian Medical Council's accreditation procedures for Australian and New Zealand medical schools supersedes the guidelines published in 1992. It aims to meet the obligations of the AMC to provide quality assurance of basic medical education in Australasia while safeguarding the academic interests of universities.

The first round of formal accreditations, begun in 1988, was completed in 1995. During 1996-97 a working party comprising Professor Laurie Geffen (convenor), Dr Kerry Breen, Professor Richard Henry, Professor Richard Larkins, Professor Ian Simpson and Ms Theanne Walters reviewed the administrative procedures and the educational guidelines in the light both of the AMC's experience over the last decade and of developments in medical education world-wide. The views of the various stakeholders in the process, such as medical schools, medical registration boards, postgraduate education bodies, medical colleges and state and commonwealth health authorities, were also taken into account.

The outcomes of the review that are incorporated in this edition include an examination of the value of the accreditation process (Part 1), more explicit and flexible procedures for assessing existing medical courses, major course changes and new medical schools (Part 2), and updated educational guidelines for the design and delivery of curricula (Part 3).



Laurie Geffen

Chair

Accreditation Committee

January 1998.

Executive Summary

These guidelines are used to conduct the assessment and accreditation of medical schools in Australia and New Zealand.

Part 1 deals with the background to accreditation. It:

- reviews the role of the Australian Medical Council in accrediting Australian and New Zealand medical schools and courses to enable registration of their graduates as Interns by the Australian State and Territory medical boards and by the Medical Council of New Zealand
- describes the history of accreditation in Australasia resulting from the decision of both Australia and New Zealand in the mid 1980's to relinquish reliance on the procedures of the General Medical Council of the United Kingdom
- compares the advantages of accreditation as a quality assurance mechanism to a national licensure examination
- affirms that the accreditation process aims to respect university autonomy by judging medical courses against their own goals and objectives
- encourages innovation in medical education to meet the changing needs of the profession and of society
- reviews general principles for accreditation of professional courses in Australia.

Part 2 is concerned with the process of assessment and accreditation. It:

- describes the processes for periodic assessment of an established medical course on a ten-year cycle
- outlines the processes that are invoked if an established and accredited course undergoes major structural changes
- specifies the requirements for regular periodic reports from accredited schools
- provides for mechanisms of appeal against adverse findings
- outlines the role of the AMC in assessing proposed new courses and new medical schools.

Executive Summary (contd.)

Part 3 comprises the educational principles that guide the assessment process. It addresses:

- the general goals of basic medical education to produce broadly educated graduates capable of further training in any branch of medicine and competent to practise safely under supervision as interns
- specific objectives relating to knowledge and understanding, skills, and professional attitudes and behaviour
- curricular design, implementation, organisation and integration including special topics and electives
- teaching and learning methods and settings
- matching of goals and objectives to student assessment both formative and summative
- monitoring, evaluating and changing the curriculum
- a variety of issues relating to students including selection and support facilities
- the role of research in enhancing the educational environment of the medical school
- issues relating to management of the medical course and school including relationships within the university, with affiliated institutions, the community and with health departments
- academic staff development and support in their teaching role
- funding and physical resources for the medical course
- the continuity of basic medical education with prevocational (including internship) and vocational training, and with continuing medical education.

Part 1. Background and Aims of the Accreditation of Medical Schools

1 The Role of the Australian Medical Council

The Australian Medical Council (AMC) was established by the Australian Health Ministers in 1984 as a national standards body for primary medical training. It is an association incorporated in the Australian Capital Territory and its Secretariat is based in Canberra. The functions of the AMC are:

- to advise and make recommendations to State and Territory medical boards on:
 - the accreditation of Australian and New Zealand medical schools and medical courses
 - the assessment for admission to practice of overseas trained medical practitioners
 - uniform approaches to registration
- to advise the Australian Health Ministers' Advisory Council on the registration of doctors
- to maintain a national network of medical registers.

Membership of the Council is drawn from a broad cross-section of the groups associated with the standards of medical practice in Australia, including nominees of the State and Territory medical boards, the universities, the specialist medical colleges, the Australian Medical Association, and the Commonwealth and the States.

The AMC has a series of standing committees and working parties whose membership encompasses a wide range of expertise in medical education and practice. One of these committees is the Accreditation Committee which is responsible for the management of the Council's accreditation process.

The registration of medical practitioners in Australia is a state responsibility and is regulated by separate legislation in each State and Territory. Under this legislation, the medical boards are the designated authorities to administer registration. Accreditation followed by regular reports is undertaken by the AMC to assure the Australian State and Territory medical boards and the Medical Council of New Zealand of the satisfactory standard of graduates of the Australian and New Zealand medical schools.

In 1991, the Australian Health Ministers agreed to changes to the registration of medical practitioners and agreed to streamline registration across state boundaries.

Minimum qualifications for registration without conditions have been adopted by the Australian States and Territories. These grant eligibility for registration to graduates of medical schools in Australia and New Zealand accredited by the AMC; and to graduates of other medical schools who have passed the AMC examination.

Both categories are required to complete a period of supervised training (a one-year internship in the case of graduates of Australian and New Zealand medical schools) before unconditional registration is granted.

The 1991 decision by the Health Ministers to recognise graduates of accredited New Zealand medical schools means that the recognition of primary medical qualifications obtained in New Zealand is different to that which applies to all other countries of training. This is in keeping with the special relationship between Australia and New Zealand established by the *Closer Economic Relations Agreement*.

The process of reciprocal recognition of registration between the Australian medical boards was subsequently incorporated in broader micro-economic reforms by Heads of Government and in the development of national strategies to streamline the provision of goods and services between the States. This process has become known as *mutual recognition*.

2 History of Accreditation of Australian and New Zealand Medical Schools

Before the establishment of the AMC, the General Medical Council of the United Kingdom visited individual Australian medical schools to assess whether their graduates would be eligible to register as medical practitioners in the United Kingdom without further examination. Although this assessment had no official status within Australia, the decisions were shared with the Australian medical boards to assist them in determining the standard of graduates for registration purposes.

At its first Annual General Meeting in 1985, the Australian Medical Council established an Accreditation Committee to advise the Council on accreditation matters. The AMC awarded interim accreditation to all ten Australian medical schools with effect from January 1986 as a precursor to establishing its own accreditation process. In 1988, assessment teams of the Accreditation Committee began a program of visits to medical schools. Between 1988 and 1992, the AMC used the Guidelines of the General Medical Council but thereafter assessments were conducted using criteria established by the AMC and

published in its own accreditation guidelines¹. By November 1995, all the Australian medical schools had been assessed for accreditation purposes, and the States and Territories had amended relevant legislation and regulations so that, to register as a medical practitioner, Australian and New Zealand graduates must have completed a medical course accredited by the AMC.

New Zealand also has a history of assessment of its medical schools by the General Medical Council of the United Kingdom. The Medical Practitioners Act 1968 empowered the Medical Council of New Zealand to offer advice to any New Zealand university on medical education matters, and to satisfy itself on the standard of medical courses and curricula. Under the Act, the Council's oversight of medical education was delegated to a Medical Education Committee. In the 1980s, the Medical Council of New Zealand considered mechanisms for review and accreditation of New Zealand medical schools. In 1984, it established policy on the standards expected of a medical student on graduation, and in 1987 it agreed that the medical courses in New Zealand be assessed both from an educational point of view and in terms of their appropriateness to New Zealand requirements. The medical schools were reviewed in 1988 by an ad hoc committee of the Council.

Following the Australian Health Ministers' decision to restrict the unconditional registration of medical practitioners in Australia to graduates of Australian and New Zealand medical schools and to holders of the AMC examination certificate, the AMC and the Medical Council of New Zealand agreed to extend the AMC accreditation process to include the two New Zealand medical schools. As had been done for the Australian medical schools, the AMC awarded the two New Zealand schools interim accreditation from 1 August 1992 until they could be formally assessed. By December 1995 the AMC had visited and accredited both New Zealand medical schools, and the AMC accreditation reports had been endorsed by the Medical Council of New Zealand.

The AMC Accreditation Guidelines are intended for courses preparing graduates for medical practice in Australia and New Zealand. In 1994, in response to the potential development of off-shore courses sponsored by Australian and New Zealand medical schools, the AMC clarified that its accreditation function relates only to Australian and New Zealand medical schools and to medical courses conducted by those schools largely or entirely in Australia or New Zealand.

5 Accreditation as an Alternative to Licensure Examinations

There is general acceptance that some external process of assessment or measurement of the educational programs or the quality of the graduates of the medical schools is required to ensure that the educational standards of any one medical school do not fall below acceptable standards and that the graduates are suitable for registration as interns under supervision.

In Australia and New Zealand, accreditation of medical schools based on a process of regular review by an independent external agency has been chosen as the preferred means of providing such quality assurance of the primary phase of medical education. The only viable alternative process to accreditation is a national licensing examination, such as is used in the USA and Canada *inter alia*. The Australian Medical Council and the medical schools, however, consider a national licensing examination to have considerable disadvantages at this stage of medical education. These include a tendency to induce homogeneity of curricula designed to meet national examination requirements, and a focus by both Faculty and students on the need to pass a knowledge-based examination with less emphasis on clinical skills and the development of appropriate professional attitudes.

In 1996-97, the Australian Medical Council conducted a review of the first ten years of experience of its accreditation process. This review sought input from the medical schools, medical boards, postgraduate training committees, medical students' associations, and members of the assessment teams which conducted accreditation visits in Australia and New Zealand. There was overwhelming support for the accreditation process, which was perceived to have the following advantages:

- Regular external review provides the medical school with a periodic stimulus to undertake a systematic process of self-examination and self-directed improvement.
- The accreditation process encourages diversity and acknowledges that there is no single best way to produce a good doctor.
- The accreditation process respects university autonomy by assessing medical schools against their goals and objectives.
- The accreditation process supports and fosters medical educational initiatives.

- The assessment visit, by a team composed of experienced and expert educationalists and teachers drawn from other Australian and New Zealand medical schools, allows for the mutual exchange of ideas and solutions to common problems.
- Each team learns from and builds upon previous assessments.
- The accreditation report assists medical schools by drawing attention both to factors that are affecting the school's capacity to deliver the medical curriculum and to its strengths.
- The accreditation process allows an emphasis to be placed on medical education issues not adequately addressed by national licensing examinations, such as selection of medical students, communication and other clinical skills, development of professional attitudes, and development of lifelong learning skills.

4 Aims of AMC Accreditation

The overall aim of the accreditation process is to assess the medical course in any particular school against its own goals and objectives provided these are concordant with the general principles described in Part 3 of these guidelines. The responsibility rests with individual medical schools to respond to local, national and international developments in medical education and to the evolution of health needs in the communities they serve. Accordingly, the process by which the AMC conducts its accreditation program is intended to be collegial and constructive and to respect the academic autonomy of the medical school.

Doctors must be able to care for an individual patient in illness, to assist with the health education of the community, to be judicious in the use of health resources, and to work with a wide range of health professionals and other agents. As health needs evolve and change, doctors must possess a sufficient educational base to respond to them throughout their careers. Just as the practice of medicine is continually evolving, so too must methods of medical education be reviewed and changed. The AMC supports diversity in teaching approaches, subject to the over-riding requirement for medical schools to produce graduates who are competent to practise as interns under supervision and who have an adequate basis to undertake further pre-vocational and vocational training.

5 Accreditation of Professional Courses in Australia

While the AMC was in the process of reviewing its accreditation guidelines, the Higher Education Council, which is an advisory body to the Commonwealth Minister for Education, examined the relationships between universities and professional bodies in Australia, and developed a best practice model for professional education and its links to professional bodies. The Higher Education Council's report concluded that:

Having reviewed the range of external accreditation processes in place and examined their strengths and weaknesses, the Council has identified a model of good accreditation which should be borne in mind by the universities and professional bodies in refining their processes in the future. The Council believes that a 'good practice' course review and accreditation process is one which:

- *includes all stakeholders;*
- *is open, consultative and consensus building about future course developments;*
- *is transparent to all parties;*
- *as far as possible meshes the external registration requirements and public safety aspects with internal academic priorities;*
- *monitors implementation of recommended changes after the accreditation of the course is approved;*
- *involves an ongoing cycle of review; and*
- *is focused on the achievement of objectives, maintenance of academic standards, public safety requirements, and good outputs and outcomes rather than on detailed specification of curriculum content².*

The Australian Medical Council endorses the above principles of good practice and endeavours to adhere to them in its accreditation guidelines.

Part 2. The Procedures for Assessment of Medical Schools

The Australian Medical Council has developed standard procedures for the assessment and accreditation of established medical courses, major course changes and newly developed courses. These are intended to make explicit to the medical schools and to others with an interest in the outcome of the process of accreditation the nature of the information required and the processes for assessing the medical school against the educational guidelines contained in Part 3 of this document. The decision-making procedures for accreditation and the requirements for periodic reporting during the period of accreditation are also described.

1 Assessment of an Established Medical Course

The stages of an assessment of an established medical course are described below. They are presented in summary in Table 1.

1.1 Initial contact

Approximately two years before the accreditation of a medical school is due to lapse the AMC writes to the Vice-Chancellor of the university concerned to advise of the process for re-accreditation.

1.2 Initial documentation

A questionnaire is sent for completion by the medical school. It is a guide to the information that has been found to be helpful to assessment teams, and medical schools are free to modify its structure to their circumstances. The questionnaire inquires about overall objectives and priorities of the curriculum; course content; educational methods; assessment techniques; course outcome evaluation; alternative options and opportunities for electives within the course; school and course management and governance; patterns of staffing including staff development and review; resources including laboratories, hospitals and libraries; responsibilities of hospitals, community centres and individual practitioners; the school's relations with the community; student selection procedures; student support and advice; and remedial programs. The questionnaire also seeks information on plans for future development and problem areas identified by the school, and requests that topics be nominated for specific consultation with the assessment team.

1.3 Assessment team

Before the AMC appoints assessors on the recommendation of its Accreditation Committee, the school has the opportunity to comment on the proposed membership of the team.

Each proposed team member is required to declare to the Accreditation Committee any relevant personal or professional interest which may be perceived to conflict with their ability to undertake impartially their duties as a member of an assessment team. Following receipt of any such comments, the Accreditation Committee, in consultation with the medical school, makes recommendations to the AMC on the composition of the assessment team. In doing so it will disclose all declared interests of the persons recommended, and any comments made by the school in relation to the proposed composition of the team. The AMC has full regard to such interests and comments in appointing assessors.

Similarly, members of the Accreditation Committee and the AMC will declare to the Committee and Council, as appropriate, any personal or professional interests which might, or might be perceived to, impact on their capacity to undertake impartially their roles as members of the Committee or Council. Where, after such declaration, it is decided that the member should nevertheless continue to participate, the declared interest will be disclosed to the school.

The composition of the team provides for a balance of assessors from various States, medical schools, the basic and the clinical disciplines, hospital and community-based teachers and experienced academic managers and, desirably, for gender balance. In the case of a New Zealand medical school, the assessment team will include an assessor from New Zealand, other than the Dean of the other New Zealand medical school. An assessment team normally comprises six or more assessors.

One member of the team, who will be an experienced AMC assessor, is appointed as the chairperson; another member from the AMC Secretariat will be the secretary. The chairperson is responsible for the on-site conduct of the visit and the presentation of the team's report to the Accreditation Committee. All communication with the AMC about the assessment should be through the secretary of the team.

The chairperson and secretary of the team allocate specific responsibilities to each team member according to members' expertise and interests. These responsibilities are directly linked to the program of reviews/interviews conducted by the assessor during the assessment visit and to the contents of the eventual accreditation report.

