

# Renewal of the Joint Medical Program

Discussion document for the process of review and renewal of the Bachelor of Medicine

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June 2011

## Executive summary

The University of Newcastle (UoN) established an international reputation for innovation in medical education by the introduction to Australia of Problem-Based Learning (PBL), community orientation, early clinical experience and integration between clinical and basic science. It also led change in the way students were selected for medical school. In 2008 the Joint Medical Program (JMP) of UoN and the University of New England (UNE) became the first Australian medical program to be run by two universities setting a precedent of expansion of medical education by partnership with an established medical program rather than incurring the cost and complexity of starting a new one.

One of the strengths of the partnership with UNE was the efficiency gained by using the tried and tested medical program from UoN as the basis of the new program. However the disadvantage is that there were no major changes to the curriculum at a time of great change in medical education in Australia and internationally. Following recent discussion within the School of Medicine and Public Health and the School of Rural Medicine, it is clear that there is strong support for a comprehensive review and renewal of the JMP.

A phased approach is proposed based on that used by the Universities of Sydney, Toronto and Dundee in their recent reviews of curriculum. This will be coordinated by a steering group with membership drawn from both universities. Apart from the value gained from review and renewal of the JMP, it is anticipated that the approach planned will encourage greater re-engagement with the medical program from all involved, especially conjoint academics.

The first meeting of the steering group took place on the 27 May 2011 to discuss core components of a renewed JMP including: graduate profile; educational philosophy and principles; and the duration and framework of the program.

The steering group agreed on a framework for significant change in the JMP with recommendations that included:

- Retaining undergraduate entry
- An intercalated Bachelors level degree after 3 years with advanced masters level (DM) qualification after 6 years
- Increasing the length of clinical experience to 3 years
- Changing from semester to year-long courses with greater opportunities for remediation
- Longer clinical placements with greater opportunities for student selected studies
- Greater emphasis on research and medical sciences throughout the program
- Competency based outcomes with more emphasis on being 'work ready' by graduation
- Greater use of simulation and eLearning
- Integrated digital curriculum and assessment
- Introduction of longitudinal themes of teamwork, leadership and Global Health

The steering committee is now seeking feedback on the proposed changes from key stakeholders in the medical program.

# 1. Background - What is the rationale for change?

The Joint Medical Program (JMP) of the University of Newcastle (UoN) and the University of New England (UNE), in partnership with two Local Health Networks (Hunter New England and Central Coast) is built on the successful UoN Bachelor of Medicine (BMed) program which commenced in 1978. More than 1800 doctors have graduated from the program including nearly 50% of the indigenous doctors trained in Australia.

Newcastle established an international reputation for innovation in medical education by the introduction to Australia of Problem-Based Learning (PBL), community orientation, early clinical experience and integration between clinical and basic science. It also led change in the way students were selected for medical school. These developments have been adopted widely by other medical schools. More recently the JMP became the first Australian medical program to be run by two universities setting the precedent of expansion of medical education by partnership with an established medical program rather than incurring the cost and complexity of starting a new one. The AMC granted accreditation for the JMP in 2009.

While the partnership to date has capitalised on the strengths of the existing program and has enabled more regionally focused graduates, there is a pressing need for a comprehensive review of the philosophical and operational underpinnings of the JMP. There are a number of drivers for this review:

- o Students facing increasing competition for post graduate places and internships – the best graduates are getting the best jobs and this means the reputation of the JMP is critical
- o Other Australian medical programs have ‘caught up’ with the JMP, in terms of recruitment methods and delivery of high quality learning opportunities - how can the JMP differentiate itself in this crowded marketplace?
- o The push from our external stakeholders to create ‘work ready’ graduates who are experienced in making informed decisions regarding complex situations and communicating these in a professional manner

Although there have been changes over time in the BMed these have often been driven by external events such as increases in student numbers and the need to comply with university policies such as semesterisation. Change has tended to be pragmatic and somewhat piecemeal with the loss of some of the educational coherence and philosophy of the original program. In addition there has not been a systematic critical review of the curriculum content by discipline in recent years. As a result, whereas one might consider that significant change to a medical curriculum would occur perhaps every 10 - 15 years, systemic review and renewal of the BMed has not occurred.

There is much that is still relevant and even revolutionary in the principles laid out by Maddison, Engels and others and much has been achieved in the last 4 years. However, there are always aspects any program that can be improved and we need to be aware of the need to plan for the future. If done well such a review could build on existing strengths, enhance the shared ownership of the program by both University partners of the JMP, serve as a focus to re-engage conjoint and basic science teachers, make better use of the available resources and result in a program that better meets student expectations.

The aim of this paper is to provide the context to begin such a process and outline a possible strategy for carrying it out. There will also need to be a clear process for change management to ensure quality in the existing program and ongoing engagement faculty and students with the program as they bridge the 'old' and 'new'.

This rest of this paper outlines the key issues for discussion at this point in the process. Where relevant the current structure of the medical program and the arguments underpinning the proposed changes are outlined. The steering group is seeking views of key groups on these issues through a series of reference groups, open forums and submissions through the JMP website. Having an agreed consensus on these areas will form the essential foundation on which the new curriculum will be built. **The draft nature of these proposals should be stressed. They should not be taken as indicating that we consider particular aspects of the current program are unsatisfactory.** The intention is to provide a framework for a debate about 'Where are we now? Where do we wish to go? How do we get there?'

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## 2.1 What are the attributes we want our graduates to have?

For accreditation purposes the AMC requires that medical school outcomes are consistent with the AMC's goal for medical education, to develop junior doctors who possess attributes that will ensure that they are competent to practice safely and effectively under supervision as interns in Australia or New Zealand, and that they have an appropriate foundation for lifelong learning and for further training in any branch of medicine. By implication this means that our graduates must possess the necessary attributes to be able to undertake further training in any area of medicine in any area of Australia and New Zealand.

### Current situation

Currently the graduate profile is described as 'The BMed graduates will:

1. Practice medicine based on an integrated body of knowledge and guided by evidence
2. Respect the primacy of patient interests
3. Demonstrate ethical and socially responsible practice
4. Be committed to life-long continuous educational development'

The current BMed program objectives reflect the AMC graduate attributes of knowledge and understanding, skill, and attitudes as they affect professional behavior. The objectives particularly emphasise the prevention and treatment of illness, the practice of medicine in the community or population context, the importance of productive professional relationships and a commitment to and capacity for lifelong learning. These objectives were originally grouped into domains which ran longitudinally through the 5 years of the program. With semesterisation in 2004 these domains largely ceased to exist and the objectives became packaged as the *course* objectives.

### Proposed changes

While a fully developed statement regarding graduate attributes has yet to be developed, the following core components were identified:

- JMP graduates should be able to demonstrate that they:
  - Put the patient at the centre of all they do
  - have integrated and applied knowledge and high level clinical skills
  - be committed to lifelong learning
  - have the capacity to conduct research and critically analyze published research findings
  - have a national and international focus on health care delivery
  - can, and will, advocate for change in health care system/s
  - demonstrate leadership in complex and uncertain situations
  - work effectively as part of a team
  - demonstrate ethical and socially responsible practice

In order to demonstrate that these components exist as part of a whole and that the patient is primary to all that a graduate does, the following pictorial presentation (a waratah) is suggested:

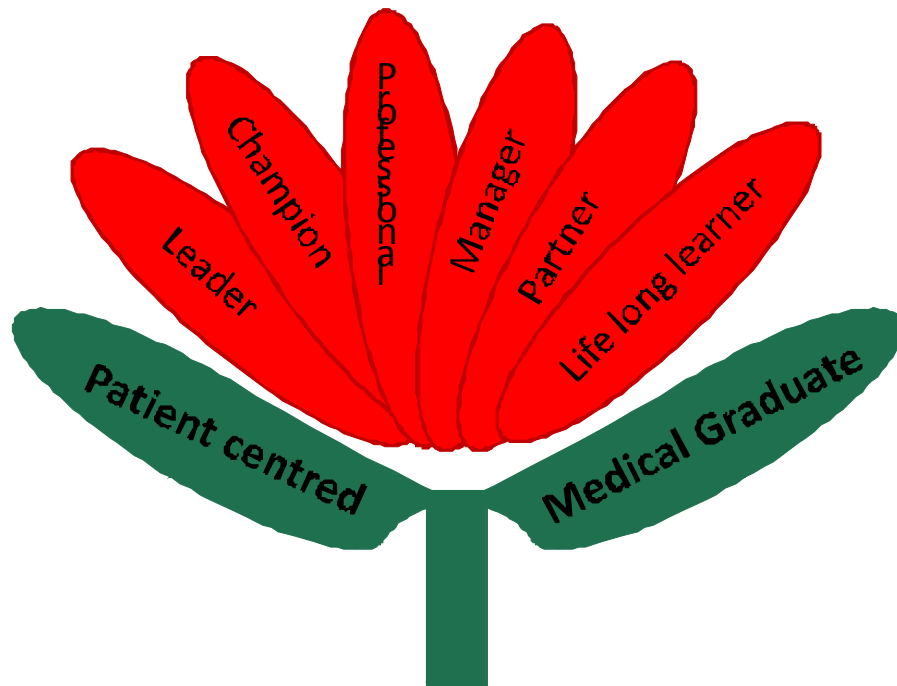


Fig 1. JMP graduate attributes

**Areas for Discussion**

What sort of graduate do we want to produce ten years from now?

If competition for intern places increases and a ranking system is introduced how do we make our graduates competitive?

Where should be the balance between concentrating on generic graduate attributes and allowing for greater 'differentiation'?

## 2.2 What should be the structure, composition and duration of The Medical Curriculum?

### Current situation

The JMP consists of four 10 unit<sup>1</sup>, twelve 20 unit and three 40 unit semester courses. The first two years of the program involve problem-based small group learning with students spending most of their time at the main Callaghan or Armidale campuses, depending on the university of enrolment. Year 3 is a transition year between problem-based learning in a university context and problem-based learning in a clinical context. Year 4 consists of two courses based around clinical attachments in the major disciplines of medicine, surgery, paediatrics and obstetrics and gynaecology together with other activities such as Psychiatry and Ethics. The overall aim of Year 5 is to provide final year students with a 'pre-intern year' by developing the necessary clinical skills.

Newcastle's success in integrated curriculum delivery is widely acknowledged. Throughout all five years of the medical program, integration remains a fundamental component of problem-based learning methodology. We should not lose sight of the unique strengths of the BMed in Indigenous and rural education. We have worked hard to build our reputation amongst Indigenous communities as the preferred school for ATSI students to study Medicine and this is starting to bear fruit. In 2011, for example, the JMP *doubled* its Indigenous student intake. We are, and should remain, the leading medical program in Australia for Indigenous medical education by ensuring that this is an integral part of any new curriculum

### Proposed changes

A six year medical degree is proposed. Students will graduate with two degrees; B Medical Science and Doctor of Medicine (DM or MD). We retain the option of undergraduate entry but by dividing the program into a 3 year BHealth/Med Sci program and a 3 year MD program with the first a prerequisite for the latter we can make a strong case for this to be treated as an 'extended Masters' degree option (provided there is a significant research component) which in the case of medicine entitles the students to graduate as 'Doctor of Medicine'.

The addition of a year to the current 5 year program will provide additional time for attaining the clinical skills and knowledge to make graduates 'work ready' and also allow students to pursue advanced learning in chosen topics and undertake research training and a research project. The program would consist of yearlong 80 unit (48 credit point courses). The additional clinical year would include longer clinical placement in general practice and hospital disciplines selected from a range of options by the student alongside a global health elective (replacing the current HES). It would also provide an opportunity for the development of a parallel rural curriculum for students to spend a year 'imbedded' in a rural setting. The fifth year would be structured to resemble the intern year with a series of terms with a strong emphasis on the practical clinical skills needed to function as a JMO.

Underpinning all 6 years would be a series of longitudinal themes. Clinical skills would be 'tracked' throughout the program so that all students would need to reach the minimum level of competence in these before graduation. Teaching and assessment of key medical sciences such as anatomy would continue throughout the 6 years. Existing themes in interprofessional learning and indigenous health would be strengthened and added to be new themes on leadership, health advocacy, global health and research skills.

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<sup>1</sup> Note: Newcastle 10 units = New England 6 credit points; Newcastle 20 units = New England 12 credit points;

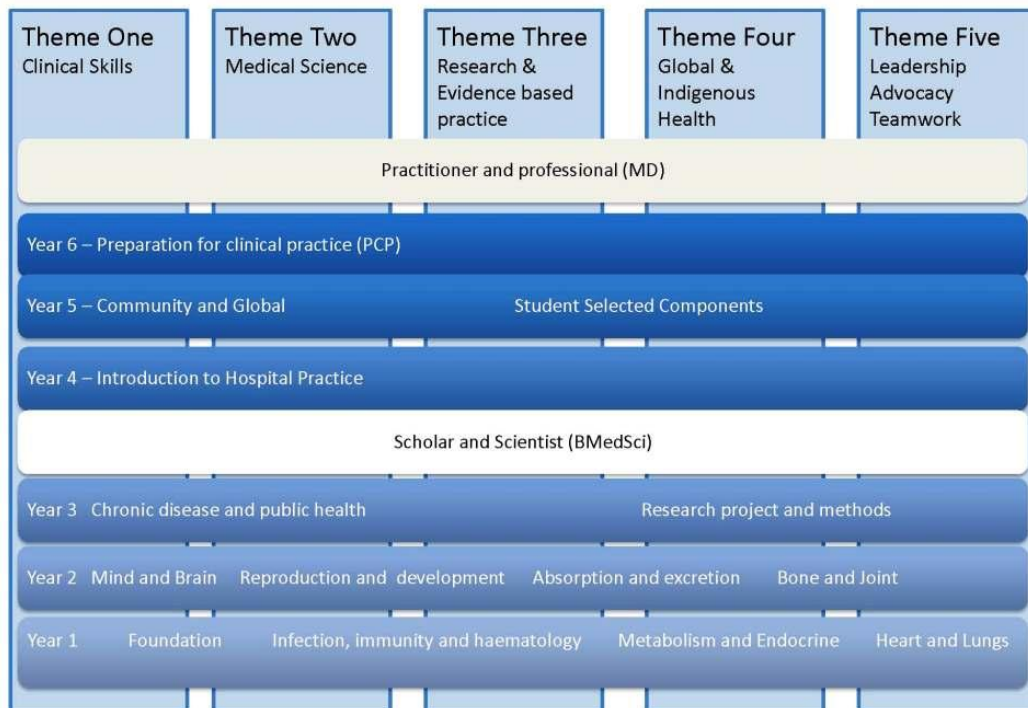


Fig 2. Proposed program structure

## Discussion

Over how many years should the program extend? What type of degree should be offered? Should we move to an MD program? UWA and Melbourne have or are planning to introduce a MD medical degree albeit in the context of a graduate entry program. If we could retain an undergraduate pathway (even through a two stage degree) resulting in an MD this would be unique and a potential advantage for our graduates competing for jobs overseas.

It would also allow students an exit option if they found that they did not suit clinical practice. The drawbacks would include the lengthening of the program by a year (we are one of the few remaining schools where students can qualify within 5 years of leaving school) and the concomitant cost to students. This would be in part offset by rendering students eligible to access Youth allowance or AusStudy (depending on age) in the MD part of the training. Currently graduate students are not entitled to Centrelink payments beyond the first 2.5 to 3.5 years of study in the JMP.

Consideration should also be given to the impact of an additional 'clinical' year on the demand for clinical placements. On the face of it this would mean a 50% increase in student numbers although this could be offset by moving the HES and GP clinical experience into the 'MD' course and by a reduction in the student numbers in each year from their present levels.

A consistent request from students is to have greater confidence in procedural skills. By extending the length of clinical training we can more confidently use the final year to develop clinical competencies to ensure that our graduates are 'work ready' when they start internship. We want our graduates to have the reputation amongst their future employers as the ones to place at the top of the list for the

best of what are likely to be increasingly competitive JMO places. This will further encourage high quality applicants to enrol in the JMP and make us more attractive to overseas students. The advantage of this would be to make our graduates more competitive with a MD degree but also to allow more time for research training in the pre-clinical degree and more time for clinical training in the MD degree, with the final year a true 'pre-internship' year making our graduates fit for purpose as JMOs.

Which areas of the curriculum need to be given greater emphasis (time) and if this is to occur what can be reduced?

Should we further expand the principle of core/student selected components to all courses so that all students who make satisfactory academic progress in the core aspects of study have an option to carry on to study an area in greater depth?

## 2.4 What should be the educational philosophy of the Medical Curriculum?

### Current situation

### Teaching and learning

In response to ongoing renewal and review activities, the Newcastle BMed curriculum was restructured during 2004/5. Whole-of-year courses were replaced by fully semesterised courses, objectives for each were defined and curriculum content was revised to meet those objectives. However, no fundamental changes to objectives, overall content or teaching and learning methods were introduced.

Key principles, first stated in the University of Newcastle's *Faculty of Medicine Working Paper No. IX (1976,)*, continue to guide the development of learning experiences which contribute to the achievement of the JMP program objectives. These include:

- an emphasis on individual and small-group learning
- progressive development of independence in learning
- problem based learning as the major educational experience
- problems chosen that reflect contemporary medicine
- the early acquisition of clinical skills
- assessment of student performance that is both formative and summative
- the inclusion of two major medical elective periods in the program
- provision of an intercalated BMed Sc (Hons) degree
- ongoing evaluation of the program by both staff and students

Important additions to these principles have been a commitment to evidence-based educational best practice and a focus on multi-disciplinary approaches to health education.

*Problem-based Learning* has been the focus for BMed learning in the first two years, when students study in working problem tutorial groups of 8-10 throughout the year. This approach encourages students to take responsibility for their learning both individually and in small groups and underpins the learning experience across the curriculum. They are supported by fixed resource sessions, small group tutorials and laboratory sessions.

*Fixed Resource Sessions (FRS)* originally intended as interactive large group sessions aimed at providing an overview or clarification of difficult concepts that may be

inadequately dealt with in textbooks are now largely in the form of traditional lectures. These occur throughout the program but are more concentrated in the early years. In Years 1 and 2 all FRs arise out of the working problems.

*Clinical Attachments* form the basis of learning in the later years, with a range of eight-week clinical attachments constituting the majority of the academic program in Years 4 and 5. Newcastle was amongst the first medical schools to include clinical placements in regional and rural Australia. Much of the rationale for the development of the JMP was to further enhance recruitment from rural communities and encourage students to return to these areas to practice after qualifying. The JMP has more than 30% of students in its intake from these areas, one of the highest of any medical school in Australia.

*Self-directed Learning* forms an integral component of problem-based learning, although there are other specific opportunities in the program for students to acquire these skills.

### **Assessment**

Summative assessment items take place either during or at the end of terms or during the Universities' examination weeks at the end of semesters.

Assessment items are graded as S (Satisfactory - Pass), NS (Non-satisfactory - Fail) or (I) Incomplete at the end of each semester. The criteria for determining passing standard are determined by the Course Coordinator and year committee. In some courses the original NS/S system is used in which all assessment items are regarded as criterion items for passing but in practice some latitude is allowed for being NS in some areas. In other courses assessment items are weighted and a single score determines the final grade. Students who are deemed NS for any course have to repeat that course and all its assessment items and are unable to progress to the following year without doing so.

### **Proposed changes**

The renewed JMP should incorporate;

#### **Horizontal and Vertical Integration of Learning:**

A 'spiraled' approach to knowledge and skill acquisition is advocated where learning takes place incrementally and in an integrated way. This will provide students with an opportunity to develop their skills over time and in a variety of settings rather than within a discrete time period and narrowly defined settings. The pattern of horizontal and vertical integration of learning will be made clear to the students at the beginning of the degree. Horizontal integration of learning will be enhanced by developing full year courses (80 units at UoN).

#### **Competency Based Learning (CBL):**

Course objectives will be expressed as core competencies that students must demonstrate to progress in their degree. There will be sufficient flexibility in the program for students to undertake remediation and/or extend their knowledge in key competencies throughout their degree.

Students will be competent professionals at the time of graduation and be "work ready". Complexity will be embedded within the competency to ensure that it can be displayed by the student in multiple and diverse settings over time.

Increased spiral of competency so that students have the opportunity to extend their learning and grow their capability over time.

There will be a clear link between the competencies being acquired and teaching/assessment.

#### **Patient Centered Learning (PCL):**

Whilst retaining the principles of small group learning with progressive development of independence in learning, the JMP will adopt a holistic approach in which we move away from 'problems' and Problem Based Learning to Patient Centred Learning which places the patient's holistic requirements at the centre of what we do.

PCL will take place in small groups and demand new cases (reflective of today's patient) and high quality tutors. Cases used will require relevant and integrated 'tasks' - all the elements of good patient care should be infused into PCL (ability to promote a positive work environment, advocacy etc.)

PCL will be integrated with other learning

PCL will facilitate an awareness of the multi-disciplinary approach to health care delivery – high quality patient-centred care is dependent on excellent team work. This should be assessed both at a theoretical and practical level.

#### **Flexible delivery:**

The JMP needs greater capacity for flexible delivery, which includes e-learning capability. Students now want to learn 'on-demand' and therefore creating flexible learning mechanisms (including technology that are more than just portals to electronic letterboxes) is critical. We need to develop a viable, future proofed, two way learning system that facilitates deep learning. We need to be smarter about delivery as we have access to numerous platforms and resources but are not necessarily using them to their full capacity.

Greater student choice in how they learn and gain competencies

Mixed mode delivery

Digital curriculum integrating assessment and delivery of content.

Opportunities for student to demonstrate competencies through building digital portfolios.

## **Discussion**

The Newcastle BMed placed great emphasis on horizontal learning with integration of basic and clinical sciences, public health and professional behaviour around a series of key clinical problems. Is this now the best way for students to 'learn'? An alternative model might be to consider periods of 'intensive immersion' in different topics, perhaps set in the context of a smaller number of clinical 'triggers' at the start of each semester. These periods of intense study could be developed as learning modules, each overseen by an academic with formative (and possibly summative) assessment at the end. Between these modules students (and staff) would have some time to pursue a range of 'selective' or non-core learning

opportunities or remedial study as necessary. These periods of immersion might be as short as a week but would usually not be longer than 6 weeks. They would tend to concentrate on a single area of study. For example, students might spend the entire module in the anatomy lab or on clinical placement. This approach has been tried elsewhere and despite initial reservations about the loss of a 'holistic' approach has proven popular with staff and students and been associated with improved student results in summative assessment.

What should be the role of large group teaching such as lectures? There is support for the idea of replacing most of the current 'FRS' with high quality digital 'lectures' that students could access when and where they choose and revisit throughout the program. This would free up resources to concentrate on FRS as they were originally envisaged i.e. interactive sessions with subject experts on hand to help students with difficult concepts.

What role should greater use of simulated learning play in delivery of the curriculum? It is clear there is a general trend for both practical and pedagogical reasons for greater use of simulated learning. To date this has been added in an ad hoc way to the program, has tended to concentrate on isolated procedural skills and has not been clearly connected to clinical experience. With a new curriculum we have an opportunity to embed simulated learning in the program from the outset and to make greater use of high fidelity simulation to teach not just procedures but also teamwork, leadership and the 'metacognition' needed to achieve competency. We should consider ideas such as integrated competency pathways that link demonstration, practice of skills in the simulation laboratory and certification of different levels of competence before moving onto 'practice' on patients. Students could then 'return' to the simulation lab to take part in more complex immersion scenarios to practice coping with complex management scenarios in a safe environment. Consideration should be given to building in rostered time each week throughout the program in the simulation lab.

How should we embed opportunities for interprofessional learning in the program? The issues of leadership and teamwork as well as those discussed for skills learning speak both of a need and an opportunity to do this, but the logistical difficulties are immense unless we also redesign a range of other health professional courses at the same time. Options might include common modules or courses in the early part of the program, multidisciplinary PBL or a common foundation course as all or part of the first year of the program. IPL has been the underlying philosophy of some programs but is it central enough and issue to 'design' the rest of the program around it?

We would like to provide more feedback to students on progress and more formative assessment opportunities. How could we manage the additional workload this would entail and avoid 'over assessment' of students whilst still retaining a range of assessment instruments?

Should we provide more information on performance in summative assessment? The current approach has been only to tell students if they have passed or failed a course.

Where should the barriers to progression be set? Is it appropriate that a student who fails a course in Years 1 - 2 has to wait 12 months before being able to re-sit?

Although there appears no imminent prospect of an Australian National registration examination like the USMLE we need to future proof our curriculum for this possibility. Extending the program by a year may give us more time to do this and we should remain at the forefront of any initiatives that emerge in this area such as

the AMSAC. In the meantime consideration should be given to having our students take the USMLE and providing the appropriate support for them to do so. This would be consistent with our strategy to have a global reach, open options for our students to work in North America and could be a strong 'selling point' for the program.

## 2.5 What should be the role of research and research training in the new curriculum?

### Current Situation

Students have the opportunity to undertake an honours degree by research (BMed Sci) after completing Year 3 of the medical program. Uptake of this has been in decline with only 4 students this year and none in 2010. There are a variety of reasons for this but the lack of any perceived long term career advantage and the additional cost are critical.

The Introduction to Public Health course has a strong emphasis on understanding the basis of clinical epidemiology and the techniques of critical appraisal. Students have to perform a number of assessment tasks involving application of these techniques as part of the course.

Understanding the use of primary sources of information from research forms an integral part of the PBL ethos.

Throughout the program students undertake assessment items that involve search for evidence and critical appraisal skills. E.g. HES report.

### Proposed changes

All students would undertake a short research project in the 3<sup>rd</sup> year of the program. This teaching on research methods would occur alongside this opportunity to 'learn by doing' A second more 'self directed' research or audit project would be completed in the final three years of the course.

### Discussion

What should be the role of research in the program? Should we include integrated research project for all/some students and if so how would we find enough projects? This could be modelled as taking place continuously over a number of years or as a block of 3-6 months towards the end of the clinical sciences part of the program.

It seems a paradox that a course that equips students so well for enquiry and discovery learning has limited scope for students to learn about the scientific process by 'doing'.

Although the logistics of organising 200 projects across the program would appear daunting initial discussions indicate that many research groups would welcome the additional students (provided that sufficient time was available to justify the time needed to train them in appropriate research methods). In this case having two universities with strong biomedical science faculties would be a great strength for the JMP. The deeper understanding of the research process would inform students critical appraisal of the evidence they would base the rest of their professional

practice on. The research would no longer seem a disadvantage because it would not delay the time to graduation. The possibility of having their work published or presented would strengthen the competitiveness of our students in the global market. Such publications and specialist knowledge might also be recognised by postgraduate training providers, at least in making them more attractive applicants for their training programs. Finally, it is likely that a higher proportion would become interested in undertaking further research, helping to build a recruitment base for RHD students and future academic staff.

## 2.6 What role should information and communication technology play in the new curriculum?

### Current situation

No additional IT facilities were put in place prior to the introduction of the JMP at UNE in 2008 although there has since been refurbishment of one large LT at UoN for videoconference teaching. The current UNE IT infrastructure used to support distance-learning students includes a large network of Access Centres located in 10 locations including Coonabarabran, Narrabri, Inverell, Tenterfield, Glen Innes, Gunnedah and Quirindi. The Centres are equipped with video conferencing facilities and computer laboratories. PBL cases are still paper based, video conferencing limited in access and lacking staff training in delivery, and multiple manual systems for recording assessment across courses

### Proposed changes

Greater use of e-Learning resources - multimedia digital PBL cases, e-portfolios/ learning logs, on line tutorials, on line support for self directed learning, greater use of UNEs existing expertise in distance learning and assessment. From the outset the new curriculum will be IT based. A platform that allows the curriculum to be accessible for students, assessment and staff is essential if we are to be seen as a state of the art medical program. Recent attempts to 'retrofit' the existing curriculum into an electronic form clearly demonstrate that failure to invest adequately in ITD at this stage will be costly to put right later.

### Discussion

Writing a new curriculum presents an opportunity to have this on a suitable LMS from the start allowing more streamlined communication and integration with longitudinal assessment and record of competency but will need significant investment.

Should we develop our own eLearning educational resources or buy these in? Having educational designers who can work in this field alongside academics may be as important for the future as year managers are now.

### 3. Next steps

#### Consultation

In order to initiate the review process a Medicine Steering Group has been formed. Members of this group, which comprises Ian Symonds, Brian Kelly, Graeme Horton, Joerg Mattes, Phillip Bolton/Trevor Day, Kichu Nair, Martin Veysey, Rafat Hussain, Maree Puxty, Robyn Smyth, Michelle Guppy, Peter McKeown (upon commencement), Judith Scott and Nick Talley, met initially on the 27 May 2011 to discuss core components of a renewed JMP including: graduate profile; educational philosophy and principles; and the duration and framework of the program.

In order to encourage an informed and grounded approach to renewing the JMP it is vital that key internal and external stakeholders are actively involved in the process. Members of the Steering Group will meet with stakeholders to seek feedback on the current proposal for a renewed curriculum.

Questions to be asked include:

- Do stakeholders agree with the proposed Graduate profile?
- Do stakeholders agree with the Education principles and philosophy?
- Do stakeholders agree with the program structure

These discussions will take place in school forums and through a series of Reference or focus Groups commencing in July 2011. The Reference groups will be asked to provide comments on the proposed changes.

These groups will include:

- Clinical discipline leads
- Medical scientists
- Potential future employers of the JMP graduates and bodies involved in their ongoing training
- Community members
- Students and recent alumni of the BMed
- Conjoint/adjunct staff of the two universities
- Education and IT
- General staff

At the end of this phase the steering group will prepare a draft report containing findings and recommendations for curriculum change to implement the 'preferred' model. This will be presented at a **JMP retreat** to be held later this year following which a number of Working Parties will be established to undertake the detailed process of curriculum development

Since the first cohort of the JMP students will complete the current JMP curriculum in 2012, it is anticipated that the start of a renewed JMP would start with the first year intake in 2013. This would allow a 12 month period for development of curriculum content, assessment items, the universities' curriculum approval processes and accreditation by the Australian Medical Council. Primary responsibility for implementation of change would rest with the JMP committee supported by a Project Officer.

#### Your feedback

This document will be uploaded onto the JMP website <http://www.newcastle.edu.au/joint-medical-program/> so that broader access and discussion can be facilitated. It is anticipated that a feedback mechanism will also

be available on the website by early July 2011. In the interim if you have any comments please e-mail [jmp@newcastle.edu.au](mailto:jmp@newcastle.edu.au)

-ENDS -

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