University of Otago Review

Rural Medical Immersion Programme

16 – 19 July 2012
## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Executive Summary</td>
<td>2</td>
</tr>
<tr>
<td>2. Introduction</td>
<td>7</td>
</tr>
<tr>
<td>3. Operational Management</td>
<td>13</td>
</tr>
<tr>
<td>4. Space, IT and Resources</td>
<td>22</td>
</tr>
<tr>
<td>5. Teaching</td>
<td>26</td>
</tr>
<tr>
<td>6. Research</td>
<td>36</td>
</tr>
<tr>
<td>7. Community Connections and Service</td>
<td>40</td>
</tr>
<tr>
<td>8. Strategic Positioning</td>
<td>46</td>
</tr>
<tr>
<td>9. Final Comment</td>
<td>52</td>
</tr>
</tbody>
</table>

## APPENDICES

APPENDIX A: Review Panel Members.................................................................54
APPENDIX B: Terms of Reference .................................................................55
APPENDIX C: Methodology .................................................................59
APPENDIX D: A Description of RMIP Areas.................................................60
1. Executive Summary

Summary of Commendations

Operational Management
1. The RMIP Director and the RCs for their input as an important factor in the success of RMIP.
2. The support for and the between the RCs
3. The Finance Manager and RMIP Director for working together on the 2013 budget and completing an analysis of RMIP costs.
4. The work within the Faculty to achieve harmony between the various MOUs.

Space IT and Resources
5. The West Coast DHB student learning centre as a good practice initiative and would like to see similar dedicated learning areas within each rural centre, wherever practicable.
6. MSS for providing communication support via the ViPr system which directly enhances the communication between locations and the delivery of the RMIP.

Teaching
7. The RMIP Staff for their passion to provide an excellent learning experience for the students.
8. The strong endorsement of pedagogical learning.
9. The focus and work of the new Assistant Administrator to provide clear timeframes and detailed documentation of assessments required.
10. The RMIP initiative in that it has demonstrated that medical education can occur successfully outside the traditional tertiary hospital setting, and has “shifted thinking about community-based education”.
11. The RCs and Clinical Teachers for their support and commitment, which is essential to the success of the RMIP.
12. The RMIP Director and staff are commended for the direction they have taken to use technology to enhance teaching and learning, especially:
   - Maximising the resource materials available to students through MedMoodle
   - For ensuring appropriate physical and IT resources at each of the regional sites.
13. The RMIP Director and staff are commended on their goal to ensure that all RCs and staff teaching on the Programme receive opportunities for teacher training and that their teaching is informed by research. Teacher-training workshops are a model of good practice.

Research

14. RMIP staff for recognising the absence of research in this programme and their willingness to engage with research at some level.

Community Connections and Service

15. The links already forged between local communities and students in the RMIP.
16. Current efforts in raising awareness of the benefits of the RMIP to local communities.
17. Recognition of the best practice model established by the Rural Learning Centre on the West Coast and the benefits which have been reaped from it, including greater attraction of staff.

Strategic Positioning

18. The benefits of immersion learning as shown by the success of this programme demonstrate that high quality learning can occur in different settings.
19. The RMIP Director and staff for their commitment to growing the number of regional sites available for students to undertake their 5th year of study.

Summary of Recommendations

Operational Management

a. The Dean of the Faculty of Medicine and RMIP Director develop a communication plan between the 3 Medical Schools to ensure a sense of ownership of RMIP, whilst maintaining Faculty oversight. This may be considered with the longer term strategy for the possible establishment of a Rural Health Centre (Refer to the Strategic Positioning section of this Report).

b. The Dean of the Faculty of Medicine and RMIP Director develop a succession plan for RMIP staff with a particular focus on academic leadership, as a matter of urgency.
c. The RMIP Director reviews the process of student selection to the RMIP, with specific consideration to the ideal student specification, primary interest in Rural Health, location, and other pre-requisites.
d. The Finance Manager and RMIP Director review operational costs to consider where changes could be made to enable more students or more rural locations to extend participation in the Programme, including a review of the Living/Accommodation Allowances with a view towards phasing these out and possibly replacing them with location-based scholarships, where justified.
e. The RMIP Director annually reviews the RC Job Descriptions to reflect current University policy (e.g. Senior/Honorary Lectureship status and PBRF rules) as the Programme is further developed.

Space, IT and Resources
f. Use of available technology be expanded and that it be used to its full potential where available.
g. The RMIP Administrator update all RMIP material to ensure consistency to clearly state that the RMIP is a Faculty Programme and to ensure equitable access by all students on the programme.

Teaching
h. The BOS reviews RMIP curriculum taking into account the following points:
   - Ensure that the health needs of Maori are clearly identified and competencies in this area are met by students.
   - Ensure the teaching of biomedical ethics meets a common standard across the Faculty.
   - Receive input from the RMIP Director and the RCs and consider formalising opportunities for more inter-professional learning.
i. The BOS reviews assessment taking into account the following points:
   - The summative component to be in keeping with the RMIP process of learning across the whole year rather than specific topics at various times of the year in the conventional course.
   - The role of the Logbook in support of student learning and assessment to aim to ensure it reflects the students’ ability to use clinical reasoning and risk assessment processes.
- Adequate rural clinician input into the end of year summative assessments be recognised explicitly.
- Movement to the use of EMCQ, rather than MCQs, and the method of marking to reflect end of year assessments.

j. The Dean of the Faculty of Medicine convenes a Working Party, to rationalize and streamline material resources between the 3 Schools and the RMIP. This Working Party should consider:
- Development of common Faculty learning resources to share/utilise the best materials across the Faculty.
- How to maximise technology to optimise appropriate access to relevant learning materials.
- Equity issues for students in relation to access of knowledge and specialist/hospital.
- Base input into their learning, expediting publication of the curriculum map.
- Consider good practice initiatives such as distance tutorials supported by IT for all students across the medical course.
- Competencies when working with Maori are appropriately assessed in a community setting.

Research

k. A Research Working Group, which includes appropriate research expertise, and the RMIP Director, be established to develop a research programme and that this become an integral part of the RMIP.

l. Any RMIP – Based research endeavour should consider the following:
- Collaborative input from willing members of RMIP staff and representation from Faculty staff from DSM, UOC and UOW in keeping with the University strategic direction for research.
- RCs interested in being involved in research should be encouraged and the grade appointment (PPF to Lecturer level) should be explored at that time, potentially adding value to future appointments.
- Research into determining RMIP outcomes and any added value from community-based education should begin, with clearly recognised academic leadership.
- Whilst it is not advocated that the RMIP student experiential opportunities be diluted through an expectation of research it is recommend that once a research nucleus of staff is developed (able to offer appropriate supervision) that opportunities for students to conduct research either on rural practice or the RMIP programme should be available through current University structures, e.g. intercalated BMSc, PhDs, student summer studentships with appropriate supervision.

- Once an RMIP research profile is established, serious attention is given to attributing placement of the research outputs to Faculty, and not to any particular Department.

- The development of a strategic plan to address the imbalance between research and teaching in the RMIP programme.

- PBRF requirements are to be recognised in the strategy for research staffing.

m. A body of research needs to be established to determine the educational effectiveness of the RMIP.

Community Connections and Service

n. That the RMIP Director proactively engages with community stakeholders by establishing a formal Community Advisory Group, with broad representation.

o. The RMIP Director and RCs plan and implement further communication of the benefits of the RMIP within the RMIP communities.

p. The RMIP Director implements a mentoring programme so that students on the RMIP can link with a student who has recently completed the programme.

Strategic Positioning

q. The PVC convene a Working Party to: develop a University-wide strategy towards:

- a Centre of Rural Excellence and
- a School of Rural Health, (over the next 5 to 10 years);
- utilising an inter-professional and immersion-learning structure, modelled on the success of the RMIP and other rural health programmes (nationally and internationally). Strong academic leadership is essential for all strategies.
2. Introduction

The Rural Medical Immersion Programme (RMIP) was established in 2007 as an innovative programme involving a new paradigm of education with a clear focus on rural workforce outcomes. The original success of the RMIP has been in part due to the entrepreneurial spirit of the founder, the late Dr Patrick Farry, and his supporters.

At the University of Otago, the MB.ChB degree is 6-year course with clinical training traditionally taking place mainly within tertiary level hospitals. Admission to the course is in the 2nd-year to Early Learning in Medicine (ELM), after either a prescribed 1st-year health sciences course or entry via the Competitive graduate or the Other category. Therefore, in each year, there is a mix of undergraduate and graduate entry students.

The 2nd- and 3rd-years are a largely seminar-based introduction to the foundation medical sciences and psychosocial issues that underpin clinical medicine, and are based in Dunedin.

From 4th-year, students begin 3 years of clinical training at one of the University of Otago’s Advanced Learning in Medicine (ALM) Schools, based in Dunedin, Christchurch and Wellington as well as in satellite hospitals in Invercargill, Timaru, Ashburton, Palmerston North and Hastings. Over these clinical years, students undertake mainly tertiary, hospital-based attachments, which include all of the major specialities in medicine and surgery. Students also spend time in the community during general practice attachments.

In Dunedin, all 5th-year students undertake a rural rotational run. The Panel were unsure though whether all students completed a rural rotation if based in Wellington or Christchurch Schools. Students are assessed on their performance throughout their attachments and by examinations that are common to all students at the end of the fifth year.

The RMIP option offers a parallel curriculum for 5th-year medical students, in a rural setting, that follows an apprenticeship model. At the initial stages there was a concern from the wider medical community about whether RMIP students would be able to effectively cover the 5th-year curriculum and achieve course requirements.
The pilot RMIP took students from the 2007, 5th-year class - 3 students each from the Dunedin School of Medicine (DSM) and the University of Otago, Christchurch (UOC) volunteered to take part. The University of Otago, Wellington (UOW) decided not to participate in this pilot year of the RMIP and joined the programme at a later date.

The RMIP students were expected to complete the 5th-year curriculum from their original clinical school - either DSM or UOC, during their respective rural placements. In the DSM and UOC students complete slightly different attachments in fifth year as 4th- and 5th-year are considered a continuum at Otago with different attachments being covered at different times throughout the two years in each of the clinical schools. Both schools have 5th-year attachments that cover: Paediatrics; Obstetrics and Gynaecology; Musculoskeletal medicine; Otolaryngology; Ophthalmology; Psychological medicine and Intensive Care; with UOC’s attachments also including Neurology and Public Health; whilst DSM students have attachments in both urban general practice and rural health. Therefore, although the curriculum material for RMIP students was integrated from the start and covered each speciality throughout the year, there were some differences expected in what each student would experience. RMIP students thus faced the challenge of learning a number of hospital-based specialties in rural areas, with far fewer medical services than in the Dunedin and Christchurch base hospitals.

The RMIP commenced with 3 students in the West Coast (Greymouth) and 3 in Southland (Queenstown). Each centre had been previously used by the DSM Rural Rotational attachment, and teaching and supervision were provided by experienced local GPs; practice nurses; rural hospital generalists and specialists; nurses; midwives and visiting specialists.

The initial group of RMIP students were provided with laptops with remote wireless internet access, accommodation and a travel allowance.

Students were intensely monitored and all students passed their exams well. Subsequently the Programme was continued in these sites and was augmented with 3 more students based in Clutha (Balclutha) and Tararua (Dannevirke). In 2009, 2 further centres were introduced and, having larger hospitals, these were established with 4
students each in the Wairarapa (Masterton) and Marlborough (Blenheim) bringing total RMIP student numbers to 20.

In 2012, the numbers of students in Clutha, Greymouth and Queenstown were increased to 4 bringing the total number of RMIP students to 23 (Dannevirke continues to support three students).

The delivery of the RMIP differs in each area, because of the unique characteristics of each (refer Appendix D of this Report). Some have larger and more comprehensively equipped hospitals and advantage is taken of these opportunities, while others have a solid primary care emphasis.

**Definition of Rural**

It is recognised that the term ‘Rural’ includes a spectrum of ‘rurality’. According to the pragmatic definition for Medical matters accepted by the University and the Ministry of Health this includes:

- Independent urban communities
- Rural areas with high urban influence
- Rural areas with moderate urban influence
- Urban areas with low urban influence
- Highly rural/remote areas

**Aims of Programme**

The primary aim of the RMIP has been described as “to provide a faculty wide, innovative, patient-centred, rural community-based and educationally sound full year rural medical curriculum with teaching centres in a number of rural areas (currently in Southland, Clutha, Westland, Marlborough, Wairarapa and Tararua)”.

Additional RMIP aims of the current programme are:
To utilise real life experiential learning integrating primary, secondary and tertiary care
✓ To ensure high quality inter-professional teaching of the 5th-year curriculum, based in rural teaching centres
✓ To encourage interested students to pursue a career in rural medical practice
✓ To enhance links between rural general practice, rural hospitals and urban tertiary teaching hospitals
✓ To enhance the development of distance teaching technologies in undergraduate medical education
✓ To provide rural academic career opportunities and hence encourage both recruitment and retention of rural doctors
✓ To utilise the large range of rural community clinical learning experiences which are not available to students in tertiary teaching hospitals
✓ To undertake continuous evaluation of the course using defined criteria of success

The aims of this Review were to:

➢ Identify and commend areas where the Programme has achieved its aims
➢ Make recommendations, concerning strategic and operational issues designed to enhance the running and future of the RMIP.

Environment Scan

Globally, the health of rural communities is often characterized by poorer health status than metropolitan communities, with poorer access to health services and fewer per capita resources spent on health services than in urban communities. Over the past 2 decades, this has led to the development of a global movement in medical education centred on the principles of social accountability and community engagement.

In 1994, the World Health Organization (WHO) and the World Organization of Family Doctors (WONCA) held a conference at the University of Western Ontario in Canada, with a focus on developing medical education to meet community needs. The concept of social accountability of medical education was subsequently promoted as the obligation to direct
...education, research and service activities towards addressing the priority health concerns of the community, region and the nation...¹

By international standards (e.g. Australia), there are relatively few opportunities for University of Otago medical students to receive part of their education in a rural immersion Programme. However the RMIP model has the potential to be adapted for use in other medical programmes and to be used for collaborative opportunities in international research and exchanges.

On a New Zealand front, it is generally recognised and accepted that health status is largely determined by socio–economic, lifestyle and other factors in the community, as well as access to appropriate health services. Immersion programmes such as RMIP generate an understanding of these determinants in the students who participate. The presence of University health-teaching infrastructure and activity can also lead to improvement in access to health services and an opportunity for research and evaluation of health status.

Professor Des Gorman, Chair of Health Workforce New Zealand, has stated that innovative changes are being developed in our health workforce and that the health sector is changing rapidly. This presents an exciting opportunity to play a role in these changes. An emphasis is being placed on greater teamwork and inter-professional education including working with groups such as nurses, pharmacists, physiotherapists and practice assistants amongst many others).

Such teams can work outside the traditional hospital system, and relate more directly with rural communities. Because of changing health demographics there is some urgency considering new models of healthcare that will meet the current and future needs². This vision fits in well with the aims of the RMIP.

Planning for future medical training programmes will need to consider the many environmental factors, including political, social, health, technology and economic factors.

3 Operational Management

Structure

The RMIP was recently positioned within the DSM Department of General Practice and Rural Health (DGP&RH) to receive appropriate academic and administration support. This is a reasonable practical interim solution, although it must be emphasised that the RMIP is a Faculty of Medicine initiative and remains under the overall control of the Faculty and the Faculty Curriculum Committee (FCC).

The Panel considered an appropriate strategy for the longer term, (5–10 years), is to move toward the development of a Rural Health Centre and a School of Rural Health. These may be developed as separate entities and sited anywhere (Refer to the Strategic Positioning section of this Report). Therefore, the structure of RMIP may alter in the future.

The RMIP is essentially run by the Director with support from colleagues of the DGP&RH. Traditionally, modules are accountable to a Medical Education Group (MEG) and Heads of Departments (HODs); but it was unclear where this was achieved for RMIP. The chain of communication between the Director, the DGP&RH, the Board of Studies (BOS) and the FCC requires clearer definition, particularly relating to effecting a clear strategy for the RMIP (Refer to the Strategic Positioning section of this Report, under Governance).

The Panel found good support exists for the students through the Regional Coordinators (RCs) and the RMIP Director; and for the RCs via the RMIP Director, RMIP Assistant Director, staff support and the RMIP Administrator. The Head of the Rural Section of the DGP&RH supports the RMIP Director. There is also reasonable awareness of the broader student support offered to students by the Faculty of Medicine e.g. Associate Deans for Student Affairs (ADSAs).

Communications and Marketing
The Panel found there was confusion of reporting responsibilities within line management. The recent structural changes have yet to be “bedded in” and the Panel identified a need to clarify reporting lines as a result of positioning the Programme within the DGP&RH. The channel of communication to the FCC and BOS remains unclear to the Panel i.e. via the HOD DGP&RH or via the RMIP Director?

The Panel found that the arrangement whereby the DGP&RH provides support to the RMIP on behalf of the Faculty was not widely understood; for example in some cases course materials and other communications refer to the RMIP as a DSM programme which is incorrect. RMIP students from UOC and UOW find this disturbing because they remain students of their home Schools. A wider perception of the RMIP as a DSM programme was found to be a barrier to cooperation between the RMIP and Departments within the Medical Schools.

Students, RCs and clinical teachers reported that the RMIP Director has spent time in each rural centre, developed strong links and provided wonderful support to them. This is a valuable aspect and needs to be balanced with the RMIP Director’s other responsibilities.

RCs and RMIP students reported occasions where there were overlaps with students on rural rotations from the 3 Medical Schools, and those students invited by consultants to attend their rural clinics. This resulted in an excess of students competing for these learning opportunities. Such overlaps were most evident in the regional base hospitals and do not help the relationship between RCs and Medical Schools’ Departments, nor the University’s relationship with specialists and students i.e. misunderstandings expose the University to negative perceptions and perceived risks. Therefore, the Panel identified that better communication is required between the Medical Schools’ Departments to minimize the overlapping of students during rural rotations. The FCC and the BOS should ensure that the overlapping of students on rural placements from all courses is carefully controlled to ensure equitable access to teaching and patient resources. It also requires close supervision by the RMIP Director and the RCs, as well as visiting consultants, and good communication with the students.

There is good communication between the RMIP centres through regular, 2-weekly video conferencing and opportunities for professional development in training the teachers.
Earlier concern with regards to communication with and support by the parent schools seems to have dissipated over the years but never-the-less is still an aspect of concern.

It was the Panel’s opinion that the Faculty should ensure ongoing marketing of its programmes, such as the RMIP, to continue to attract a cross-section of the students who are recruited from a diverse range of backgrounds into medical education.

Student Selection to the Programme

The student selection process includes attending a talk on the RMIP (July); submitting a 600-word personal statement about themselves to the RMIP Director, outlining why they wish to join the RMIP, and why they think they would do well in it; selection in rank order of 3 of the sites available on the Programme where they would like to work, and whether this is an irrevocable choice on their part (end August); and then an interview (held in Wellington, Christchurch or Dunedin) early in September. A standardised mark sheet is used to rank students.

The primary purpose of selection needs further discussion and clarification. The Panel was unsure as to whether it is to:

- allow students from rural backgrounds already with a strong interest in rural health to experience RMIP; or
- allow non-rural students an opportunity to experience the benefits of rural health and lifestyle; or
- ensure that the best candidates for completion of the course, with a particular focus on commitment and appropriate learning styles.

At least 1 student reported that they had been attracted to medical training at Otago because of the opportunity to take part in the RMIP. It is yet to be determined whether students with an interest in rural practice and/or from a rural background are more likely to exhibit the characteristics of resilience and be attracted to the challenge of a largely self-directed RIMP programme.
It is the Panel’s view that an ideal RMIP student should have an interest in a rural medical career. While the Programme remains small, there does not exist the opportunity for all students to experience a significant length of time in a rural placement. Therefore the opportunity should be provided for those who demonstrate an interest in future rural practice. This does not necessarily mean they are of rural origin, although the potential for this to be the case has been argued in the granting of increased numbers of Medical Students to the Otago Medical School.

Assessment of this criterion could become complicated where the RIMP has such a good reputation for teaching excellence, that students are attracted to the Programme because they perceive it as being educationally superior, rather than because the students having an interest in rural practice per se. Therefore, assessment of this criterion needs to be rigorous and may need to involve several modalities of assessment.

As RMIP students are required to be reasonably mature, self-directed learners, with a degree of resilience, the Panel suggests a person specification, including past performance in the medical courses, could be developed as an additional selection tool. In the case of academic performance is was not clear to the Panel whether the RIMP would have student support and other resources sufficient to meet the needs of a student struggling to demonstrate competencies.

The Panel also identified that a perceived need exists to select an equal number of students from the 3 Medical Schools. This may result in suitable candidates missing out on the Programme (because the quota for their School has been filled) and the place has been allocated to a less suitable candidate from another School. This practice also decreases the likelihood of selection as the number of applications for a School increases.

In 2012, while selection equity was achieved between schools, only 3 male students were placed on the Programme compared with 20 female students. RCs do not currently have the right of veto over the way students are assigned, although this was not necessarily seen as a problem. However, it may be useful for RCs to provide comment before students are confirmed onto the programme in a particular region, to ensure best fit and maximise potential for success.
Therefore, the Panel recommends that the selection process be reviewed to ensure the most suitable candidates are chosen for RMIP.

**Staffing**

The Panel found differences in the way doctors are funded to carry out teaching duties. It was noted that the Faculty have already convened a working party to address such issues of consistency.

In tertiary hospitals, specialists involved in teaching students generally have joint University and District Health Board (DHB) appointments, so that the teaching aspect of their job is as a University employee.

Rural GPs are funded directly for their teaching services. However the rural hospital doctors usually do not have joint appointments with the University and are not funded directly, yet they also carry out a teaching role for medical students. This is done as part of their hospital employment e.g. as a DHB employee, or community-owned hospital employee.

Therefore, the RMIP depends on the goodwill of these rural, hospital-based doctors. In addition, the cost to rural hospitals becomes disproportionately greater than in tertiary hospitals. There needs to be consideration of how this can be resolved, given the financial constraints of both the University and the rural health providers. There are also wider implications for University/Divisional memoranda of understanding (MOUs) with providers in regard to the wider context of health professional students.

The Panel suggests that consideration be given to formally recognising the academic role of some RCs. It is acknowledged that whilst some have no interest in research, others indicated a strong desire to participate. Therefore, consideration of appointment at Lecturer/Senior Lecturer rather than the PPF level might be considered, where appropriate (*Refer also to the Research section of this Report*). The Panel heard that being able to participate in research at some level was a potential attraction to the RC role. Any such changes in appointment conditions needs to consider and define clearly the resulting
effects on PBRF requirements. This could present a significant element of recruitment and retention of rurally-based staff.

**Succession Planning**

The Panel also identified that attention to succession planning with a focus on academic leadership, via the RMIP Director role, is urgently required. This should ideally occur in conjunction with the recruitment of a Chair of Rural Medicine. However, as recruitment to this post has been unsuccessful over the last couple of years, consideration needs to be given to adopting measures which would make this role attractive to prospective recruits. This may include flexibility in positioning of the role within the Faculty or Divisional structure, with a commitment to lead the development of a School of Rural Health. *(Refer to the Research and Strategic Positioning sections of this Report).*

In the meantime, succession planning for the RMIP Director position may need to occur within the current structure, depending on the short-/medium-term plans of the incumbent. Academic leadership needs to be seen as an urgent priority.

The Panel also noted that 3 of the current RCs have been appointed only recently, and the Panel identified a need for a more comprehensive succession planning strategy for these core positions.

**Finance**

Inclusion of the RMIP within the structure of the GP&RH provides support from a Finance Manager who is also a Chartered Accountant. The Finance Manager and RMIP Director are working together on the 2013 budget and an analysis of costs and the Panel commends this initiative. This will hopefully provide clearer insight concerning the costs incurred by various parts of this large and complex Programme, and permit clearer rationale for the allocation of resources to future developments.

Inconsistencies within MOUs between the DHBs and health centres have been identified i.e. the Panel was advised that differing University, Faculty, School and Departmental
MOUs might exist all with the one partner. The Panel supports the initiative to achieve harmony between these comparable agreements. However, the Panel also recognises the importance of acknowledging the differing cost structures of similar organisations and that a blanket, one-size-fits-all application of e.g. teaching fees or clinical access fees may not always be appropriate.

The coordinated input of both the Finance Manager and RMIP Director is required to (re)develop the MOUs for the RMIP. This should include consideration of financial aspects, clarification of responsibilities with regard to the students, (for example, health and safety, attendance and human resource matters). Additionally, the current arrangements with other stakeholders in the community could be included in the MOU (where appropriate). While there is a desire to harmonise the MOUs, they will still need to reflect the differences between communities, and respect the current arrangements that work well.

*Operational Costs*

The Panel noted the reality of the current economic climate in the University. There is concern at all levels that cost reductions will be required in 2014 and beyond. The work being undertaken to better understand the true costs of each part of the Programme, including fixed and variable costs, along with identifying possible efficiencies is commended. This will also enable consideration of the financial impact and inform planning around any possible increase in student numbers and/or RMIP delivery locations.

The Panel identified that a review of current costs should also include re-evaluation of the RMIP student living allowance. The Panel found it was unclear whether advice was originally sought prior to deciding to pay a living allowance to RMIP students; nor could it establish what advice was received prior to deciding the mechanism of payment and whether this payment exposes the University to any taxation risk. The Panel considered that it may be more appropriate to subsidize living costs via scholarships for selected students which may not include all those opting for the RMIP. This approach then opens the door for corporate or community sponsorship and/or targeted support. While many submissions identified the allowance as helpful, none indicated that the absence of the allowance would be a barrier to participation in the RMIP.
Other costs may also be reviewed such as the supply of laptops (when many students already have a laptop) and should be in line with any potential to share Faculty resources.

Overall, the Panel supports moves to share resources internally, and externally to look at ways to partner with other stakeholders in the community to cover shared costs and benefits, particularly if any expansion of the Programme is to be considered. These needs to be considered nevertheless, in the context of general acceptance internationally that rural health education programmes, by their very nature, are more costly than programmes delivered in urban settings.

**Commendations**

The Panel commends:

1. The RMIP Director and the RCs for their input as an important factor in the success of RMIP.

2. The support for and the between the RCs

3. The Finance Manager and RMIP Director for working together on the 2013 budget and completing an analysis of RMIP costs.

4. The work within the Faculty to achieve harmony between the various MOUs.

**Recommendations**

The Panel recommends that:

a. The Dean of the Faculty of Medicine and RMIP Director develop a communication plan between the 3 Medical Schools to ensure a sense of ownership of RMIP, whilst maintaining Faculty oversight. This may be considered with the longer term
strategy for the possible establishment of a Rural Health Centre (Refer to the Strategic Positioning section of this Report).

b. The Dean of the Faculty of Medicine and RMIP Director develop a succession plan for RMIP staff with a particular focus on academic leadership, as a matter of urgency.

c. The RMIP Director reviews the process of student selection to the RMIP, with specific consideration to the ideal student specification, primary interest in Rural Health, location, and other pre-requisites.

d. The Finance Manager and RMIP Director review operational costs to consider where changes could be made to enable more students or more rural locations to extend participation in the Programme, including a review of the Living/Accommodation Allowances with a view towards phasing these out and possibly replacing them with location-based scholarships, where justified.

e. The RMIP Director annually reviews the RC Job Descriptions to reflect current University policy (e.g. Senior/Honorary Lectureship status and PBRF rules) as the Programme is further developed.
5. Space, IT and Resources

Space

While high standard facilities have been an aim of the RMIP for some time, it seems that there are significant variations between the rural centres, with some providing excellent facilities and others a bit lacking. The Panel agreed that the establishment of suitable study environments for the students within each rural centre is a priority.

The Panel is aware that a conscious effort has been made by each of the rural centres to find a suitable study space for their students. This has involved partnership arrangements with other stakeholders in the community (Refer to the Community section of this Report).

The West Coast DHB has established a Rural Learning Centre, which provides a dedicated environment for inter-disciplinary rural learning. It also provides a ‘one-stop shop’ for students to access administrative and clinical support. The Panel identified this model of support as one of best practice and would like to see similar dedicated learning areas within each RMIP and rural centre, wherever practicable.

When considering RMIP locations, a well-articulated minimum, specific criteria (such as infrastructure, educational provision, clinical provision (e.g. size of associated hospital, bed numbers) should be devised by the RMIP team and met by the centres. Continual evaluation, undertaken at least annually, should determine whether these criteria are met.

One of the restrictions imposed on the rural teaching is space. It is often difficult to locate a spare room in general practices, health centres, and/or hospital clinics to enable a student to assess and examine a patient. Furthermore, the limited number of appropriate practices has resulted in conflicts with places established by the medical schools for other students. There is also a perception that options for non-RIMP students undertaking a rural placement, as part of their rotational experience in the regular curriculum, is restricted to areas where immersion students are not located (in both a GP and secondary hospital environment). Therefore, identification of further appropriate teaching settings and better coordination of placement rosters would help solve this issue. The Panel suggests that improved communications between the three Schools, the RCs, and the Director RMIP
might be better able to identify further GP practices/rural hospitals with suitable facilities for all immersion students as well as any other students on rural attachments.

The Panel would like to see the Faculty consider the physical needs for both staff and all rural placement students as part of a Division-wide review of the adequacy of the resources provided for health professional students on placements outside of the DSM, UOC and UOW tertiary centres.

**IT**

The Director and staff are to be commended for their attempts to ensure that students have appropriate IT resources at each of the regional sites to enable RIMP students to have the same level of access to resources as other students. IT resources are a basic requirement of medical education, and reliable access (as for the distance learning students at the University) is a high priority in a rural medicine context.

Many students have indicated they are satisfied or very happy with the resources provided. The Panel queries the need for future RMIP students to be routinely issued with a laptop, given that many resources are on line and tertiary students often have their own computers.

Greater use of the ViPr system is to be encouraged with consideration of further cost efficiencies and the potential benefits of extending the use of the resource to Faculty staff and students, and potentially to others. The close collaboration and assistance of the Mobile Surgical Services has been very helpful and greatly appreciated by RMIP staff and students. Faculty learning resources could be used not only by RMIP students but equally by those on the traditional hospital runs. Potential efficiency gains were evident to the Panel.

**Resources**
The RMIP handbook, in several places, makes reference to the ‘Dunedin School of Medicine’ 5th year RMIP. This should be changed in the next edition to “Faculty” (Refer to the Operational Management section of this Report).

To date, students’ access to material from the three Medical Schools has been variable. The actual value of a particular resource may be limited where it has not been constructed for a distant audience. Communication, to e.g. consultants, of the need for this information to be applicable to a distance audience may solve the issue.

The resource materials available to students through MedMoodle are very good and the use of the medium has potential to be developed further.

RMIP staff identified the problem of communication/liaison concerning availability of teaching resources. This should be resolved at a Faculty level to try to ensure these are neither duplicated nor distributed in random fashion amongst RMIP students’ and that these students have equal access to the resources.

The Panel would like to see that RMIP students also have equitable access to pastoral care supports, e.g. counselling services, should they be required. The matter of equity is something that perhaps should be considered across all campuses for all students studying at a distance. These matters are not just relevant to medical students on the RMIP but need to be addressed across the Faculty and at a Divisional level.

Commendations

The Panel commends:

5. The West Coast DHB student learning centre as a good practice initiative and would like to see similar dedicated learning areas within each rural centre, wherever practicable.

6. MSS for providing communication support via the ViPr system which directly enhances the communication between locations and the delivery of the RMIP.
Recommendations

The Panel recommends that:

f. Use of available technology be expanded and that it be used to its full potential where available.

g. The RMIP Administrator update all RMIP material to ensure consistency to clearly state that the RMIP is a Faculty Programme and to ensure equitable access by all students on the programme.
6. Teaching

Overview

The diversity of students’ clinical experiences and learning experiences across the Programme was seen by the Panel as a positive aspect. RMIP students are exposed to a variety of clinical teachers, including rural GPs, midwives, allied health clinicians, visiting specialists and regional hospital-based specialists. This diversity provides a rich, learning environment for students, with exposure to a variety of teaching styles as well as a variety of perspectives towards health care delivery. The educational innovations introduced by the RMIP are seen as a major strength of the Programme. Many respondents commented on the fact that the RMIP has demonstrated that medical education can occur successfully outside the traditional tertiary hospital setting, and has “shifted thinking about community-based education”. These factors are in keeping with initiatives proposed by Health Workforce NZ.

The Panel found that for some students there was a perception that the lack of hospital patients and their consultant servicing was a handicap in some areas. However, this tended to diminish as the year progressed.

The Panel noted areas of benefit delivered by the RMIP such as: more 1:1 time with a senior doctor; students becoming valuable members of a multidisciplinary team; and increased patient contact time. Such benefits were identified through an internal audit reporting to the FCC in August 2011 and through a research project conducted by a summer scholarship student in December 2011 and January 2012.

The inclusion of all teachers in the teacher-training workshops is also seen as a unique and valuable aspect of the Programme.

Each of the 6 RMIP centres offers a slightly different experience and the Panel considers that this diversity of learning opportunities should be encouraged and continued. (Refer to Appendix D of this Report for descriptions of the RMIP areas).
Although the RMIP is perceived overall as providing a successful learning experience, formal research is required to determine whether the Programme is successful in its workforce aims (Refer to the Research section of this Report). Generally, the Panel found the RMIP to be a well-received by both staff and students. The pedagogical learning approach adopts a mature stance embedded within experiential, on-the-job, learning in context.

The RMIP Director and staff are to be commended for their passion to provide an excellent learning experience for the students.

Curriculum Requirements

The curriculum is detailed in the RMIP Handbook that students receive at the start of their course - ‘Rural Immersion Programme’ (Http://rmip.otago.ac.nz).

This documentation includes Section A: Introductions; Section B: Aims; and Section C: Curriculum Structure and Syllabus. There is also a 2-week period based in Dunedin at the beginning of the Programme where students are briefed regarding RMIP expectations. This residential course allows the opportunity for students to identify possible areas of deficit and to receive formal common ‘teaching’. It also forms a positive opportunity for both the RCs and students to develop appropriate support mechanisms.

Although documentation exists and is supplemented by material from each centre, there is still a sense of uncertainty amongst some staff and students regarding the level, both depth and breadth, of learning required. It is noted that this anxiety is not unique to the RMIP and can also be present in the conventional tertiary learning environment. The ‘newness’ of the course may also add to anxiety, but this has tended to dissipate over time during each academic year.

The Panel considers that, whilst the syllabus is detailed in Section C of the RMIP handbook, a clear process should also be present to ensure cohesion with the Faculty curriculum map, and that relevant sections have been negotiated and refined with input from DSM, UOC and UOW staff members. The Faculty initiative to develop its curriculum
map is considered a matter of urgency; its publication would assist with the depth and breadth of learning required for the end of year assessment. This would also help to ensure that ownership of the syllabus resides equally amongst the 3 Medical Schools and not just within the DSM. In addition, vertical integration of the curriculum could beneficially be discussed with staff of the School of Medical Sciences (SMS).

Furthermore, the RMIP has an important, self-directed ethos and therefore continual vigilance is required to ensure that the fine line between the expectation of learner-centred, self-motivation and perceived disorganisation is not breeched.

In terms of research the Panel suggests that one topic should be focussed on perceptions underlying the fact that the Programme is so well received. The key features may then be fully considered by the Faculty for potential broader adoption (Refer to the Research section of this Report).

Curriculum Provision

Consideration should be given to the pathway of rural education not just within the Faculty of Medicine but with pre-vocational and vocational training and their interface.

Rural attachments are popular with students but they need more focus, good communication and a rationalising of resources with the RMIP.

 Provision to fulfill curriculum requirements should always be possible although it is noted that deficits have been reported in some centres. The Panel heard anxiety regarding variation in teaching provision between centres and also a desire for access to parent Medical School information resources as a back-up. This was especially pertinent to the preparation for end of year examinations.

The RMIP Director oversees the provision of curriculum requirements to the students in their area and the strategy to achieve this should be negotiated with RCs. If there is any inadequacy in curriculum requirements this should involve a negotiated strategy by the students, RCs, and the Director; and this should be defined explicitly.
Whilst some RMIP areas have few competing medical students from different programmes/years, there appears to be an increasing frequency of occasions where there is an overloading of students for one clinical opportunity e.g. obstetrics, pediatrics. The Panel recommends a Faculty-wide policy and practice with communication guidelines, to reduce the overloading of students and co-ordinate student placements more carefully.

Where there is poor provision to fulfil curriculum requirements this should involve a negotiated strategy by the students and RCs, which is then stated explicitly.

On the other hand, the benefits of the “extra” learning opportunities within the RMIP should be highlighted. Students reported the amount of patient exposure, with one-to-one supervision, as a major aspect of the Programme. Often this involves clinical material not specifically included in the conventional 5th-year curriculum, but provides significant learning opportunities for the students in preparation for their Intern year and their future career generally.

Assessment

Currently the RMIP students are assessed on a quarterly basis, with a portfolio, MCQs and an OSCE station. They sit the common examination at the end of the 5th year. Members of the RMIP team sit on both the OSCE and EMCQ standard setting committees to ensure appropriate representation. Currently 1 member of RMIP sits on the SAQ committee.

Concern was raised over the clarity and detail of the documentation required for assessments. However, the Panel noted this has recently been addressed.

While the students are positive towards the format of the quarterly OSCE stations, and view it as ‘good practice’ for the end-of-year examinations, there are concerns over the summative nature of these assessments. Traditionally, the OSCEs and MCQs are designed for students who have just completed a block module on a specific topic, and the assessments are geared towards that topic. The RMIP is much more focused on year-
long learning (rather than individual modules), which means that early in the year, the RMIP students have had less exposure to specific topics and may not perform as well with such specific OSCEs or MCQs. Despite this, to gain a potential distinction the students are required to perform well in these early assessments. A more formative approach to these early assessments should be considered along with a review of the summative component of student assessment.

A major concern from RMIP students has been potential discrepancies between their learning and their examination. One concern is that the students perceive that they are being taught ‘by generalists’, while their examinations are being set ‘by specialists’. We recommend further input into the SAQ section of the exam, as well as a clearer explanation being given to the students that the RMIP is involved in setting the final examination.

In the MCQ component of the quarterly examinations there is a regular section of ‘negative marking’, where a wrong answer will subtract a mark from the total. This is not currently viewed as best practice, and its role in these assessments is unclear. Similarly, it is not a method employed in the end of year exams. Therefore, the Panel recommends a review of the negative marking component in the MCQ assessments and alignment with the EMCQs at the end of the year.

There are ongoing issues with students having access to the learning materials from their parent clinical schools. To an extent, this has been resolved with an attempt to ensure that all learning resources from each School being given to each student. However not all material is presented in a relevant way: some of the course material provided is of little benefit, as it is designed to be used in tutorial sessions that the RMIP students do not attend. A more coordinated approach e.g. an annual review of the material provided, including asking the students which materials were useful, would establish which materials were worth obtaining for future years. Placing this material on MedMoodle would save on resources, and may support equitable access to the parent schools’ resources. Therefore, the Panel recommends streamlining the resources available from the three clinical schools. Learning materials should be consolidated and the best utilised across the Faculty.
Some students expressed concern that the aims of the Programme were not clearly outlined, and there was some confusion as to the expectation of the RMIP to produce rural GPs as an outcome. Students expressed a preference for a focus on rural medicine, rather than rural general practice, within the Programme.

Some students expressed anxiety about access to specialist-level care in the programme and specialist input into their learning. There were variations in this level of anxiety between the sites, which reflects perceptions amongst students of inequitable access to secondary hospital care across the sites. The Panel noted that this anxiety tends to dissipate as the academic year progresses as is the case for most students' learning.

The Panel acknowledges that each of the RMIP sites strives for appropriate specialist-level input into the teaching programme. This could include distance tutorials supported by IT, or selective student exposure to specialist outpatient clinics, ward-rounds and other hospital-based care, such as emergency departments and operating theatres. Consideration should also be given to inclusion of video-consultation between regional specialists and patients within the student’s community as a learning tool.

The Logbook is used as a summative assessment tool. Some of the conditions and skills are impractical and unreasonable for the students to achieve. The RCs vary in their view of the Logbook as a valuable educational tool and may contribute to it being undervalued. It was also noted that this issue had been raised and published in an internal review undertaken in 2011. But the Panel had no evidence of action being taken to modify this form of assessment. Therefore, the Panel recommends a review of the summative role of the Logbook and the objectives and learning outcomes associated with it, so that it becomes a more effective resource for student learning.

**Teacher Training**

The RMIP programme employs a 0.2 FTE staff member to offer support for the development of staff inputting into the Programme.
Opportunities for teacher training are available with support from the 3 Medical Schools and are based in both urban and rural centres. These training sessions are accessed and greatly appreciated by the majority of staff.

The RMIP Director and staff are commended on continuing to ensure that staff who are new to the Programme have opportunity to develop skills required to facilitate their role as a teacher. Where possible, data is fed back to staff regarding the outcomes of the RMIP students and also their perception of the course.

A body of research needs to be established to determine the educational effectiveness of the RMIP.

Innovations in Medical Education

The RMIP has provided a mechanism for student exposure to different health settings, in particular the community setting where the vast bulk of healthcare is delivered, in many cases as a model of interdisciplinary team-based care. This has implications for other health professional education programmes other than medicine, as well as validation of the essential role of community, team-based care within the health system.

Demonstration of the educational advantages of community-based education should be highlighted as a major outcome of the RMIP. A research programme investigating this outcome should be commenced as soon as is feasible (Refer to the Research section of this Report).

It was clear to the Panel that the roles of enthusiastic RCs and clinical teachers are an essential part of the RMIP. The Programme could not continue without the local academic leadership undertaken by the RCs. The importance of this role was stressed by senior leaders involved in the Programme as well as by students under their supervision.

Teaching in specific areas: Maori Health/Public Health/Ethics
The dangers for triplication of learning material across the 3 clinical campuses and a desire for efficiencies in the development of learning material have been acknowledged. To this end, the Faculty (via the FCC) needs to ensure that strategies are adopted to ensure the commonality of outcomes and also the development of common resources that may be used equally amongst all students irrespective of parent school or locality.

It was noted that a member of the RMIP staff has completed training in ethics, and would be responsible for teaching this important topic in this Programme. There is a need to ensure that the teaching of ethics is comparable to that received by non-RMIP students.

As a matter of good practice the Panel supports a BOS review of the RMIP curriculum and assessment processes to ensure that the health needs of Maori are clearly identified and competencies in this area are met by students.

The Panel further supports moves for the RMIP Director and RCs to maximise inter-professional learning and integrate this model into the provision of healthcare in a rural setting.

Commendations

The Panel commends:

7. The RMIP Staff for their passion to provide an excellent learning experience for the students.

8. The strong endorsement of pedagogical learning.

9. The focus and work of the new Assistant Administrator to provide clear timeframes and detailed documentation of assessments required.
10. The RMIP initiative in that it has demonstrated that medical education can occur successfully outside the traditional tertiary hospital setting, and has “shifted thinking about community-based education”.

11. The RCs and Clinical Teachers for their support and commitment, which is essential to the success of the RMIP.

12. The RMIP Director and staff are commended for the direction they have taken to use technology to enhance teaching and learning, especially:
   - Maximising the resource materials available to students through MedMoodle
   - For ensuring appropriate physical and IT resources at each of the regional sites.

13. The RMIP Director and staff are commended on their goal to ensure that all RCs and staff teaching on the Programme receive opportunities for teacher training and that their teaching is informed by research. Teacher-training workshops are a model of good practice.

Recommendations

The Panel recommends that:

h. The BOS reviews RMIP curriculum taking into account the following points:
   - Ensure that the health needs of Maori are clearly identified and competencies in this area are met by students.
   - Ensure the teaching of biomedical ethics meets a common standard across the Faculty.
   - Receive input from the RMIP Director and the RCs and consider formalising opportunities for more inter-professional learning.

i. The BOS reviews assessment taking into account the following points:
- The summative component to be in keeping with the RMIP process of learning across the whole year rather than specific topics at various times of the year in the conventional course.
- The role of the Logbook in support of student learning and assessment to aim to ensure it reflects the students’ ability to use clinical reasoning and risk assessment processes.
- Adequate rural clinician input into the end of year summative assessments be recognised explicitly.
- Movement to the use of EMCQ, rather than MCQs, and the method of marking to reflect end of year assessments.

j. The Dean of the Faculty of Medicine convenes a Working Party to rationalize and streamline material resources between the 3 Schools and the RMIP. This Working Party should consider:
  - Development of common Faculty learning resources to share/utilise the best materials across the Faculty.
  - How to maximise technology to optimise appropriate access to relevant learning materials.
  - Equity issues for students in relation to access of knowledge and specialist/hospital.
  - Base input into their learning, expediting publication of the curriculum map.
  - Consider good practice initiatives such as distance tutorials supported by IT for all students across the medical course.
  - Competencies when working with Maori are appropriately assessed in a community setting.
7. Research

The Panel noted the University’s strategic imperatives in terms of research and research-informed teaching.

There appears to be minimal engagement in research within RMIP, either in the form of the evaluation of the success, or otherwise, of the Programme or clinical/epidemiological/workforce research pertinent to the rural setting. There is also few PBRF eligible academic staff engaged with the Programme, and indeed, currently, neither RMIP students nor staff have an expectation to conduct research as part of the activities of the Programme.

A demonstration of the educational advantages of community-based education has been highlighted as a major outcome of the RMIP. A research topic investigating this outcome should be commenced as soon as is feasible.

The RMIP Director and RCs are Professional Practice Fellow appointments without an academic component. The Head of the Rural Section of the DGP&RH is an Associate Professorial appointment. It is acknowledged that the embryonic nature of the Programme has resulted in energies being appropriately focussed on development issues to start up and maintain the programme. The RCs have indicated a variable interest in being involved in research.

The Panel notes that most academic departments have a responsibility in line with the University’s strategic direction to be actively involved in research. However, outputs through the PBRF exercise do not allow for allocation to Faculty designation or to PPF roles.

Whilst it is not advocated that the RMIP student experiential opportunities be diluted through an expectation of research, it is recommend that once a research nucleus of staff is developed (i.e. able to offer appropriate supervision) opportunities for students to conduct research either on rural practice or within the RMIP should be available through current University structures, e.g. intercalated BMedSc, PhDs, student summer
studentships. Appropriate supervision is essential. Opportunities already exist for students to enrol in a BMedSci degree programme between the fifth and sixth year of their course, thus extending their rural experience and enhancing their and the RMIP’s academic standing. A RMIP Research Scholarship could be established and promoted to permit undergraduate and/or postgraduate research efforts.

Enthusiasm for research varied considerably amongst RCs; those who expressed an interest in conducting research were enthusiastic about the prospect and they should be encouraged and helped to develop their research potential. Research productivity would not only enhance the academic standing of the Programme, but attract and enthuse high quality applicants to staff posts. Inter-departmental and interdisciplinary research would extend the influence and academic standing of the RMIP and the Otago Medical School. This would also enhance the University policy of having research-informed teaching, with both staff and students aware of the research contribution of the Programme. Community participation could also promote better understanding and education amongst the public.

Appropriate administrative arrangements would need to be established to ensure those staff, participating in research, were in the appropriate grading with respect to PBRF eligibility. Once a research base has been established, this should be Faculty-based and recognised, rather than primarily to any Department or School.

The type of research performed would be dictated by training and supervision of staff, facilities available, time pressures, and funding. This could extend from simple evaluation of student progress (where students could be part of the research) to projects of educational and medical interest (where students may not have the time to participate fully, but where staff could lead a productive study).

Research in the RMIP needs careful direction and supervision. The RMIP Director needs to have a close link with the research, although, depending on the person in that role, need not be the person doing the research him/herself. The Panel recommends that a Research Working Group, which includes appropriate research expertise and which draws expertise and strong academic leadership from a wide range of interested staff, be established to develop a research programme within the RMIP. This research programme should be developed with specific aims regarding knowledge transfer, up to and including
input into government policy in the area of rural health service delivery and rurally-based, health science education. Research themes, methods and funding would be developed by this Working Group.

There could be the employment, immediately, of a research coordinator to work with the RMIP Director to ensure that a programme of research evaluating aspects of RMIP is instigated. This research programme should include input from willing members of RMIP staff and representation from PBRF-eligible Faculty staff, from across DSM, UOC and UOW. Another option is to employ in the medium-term a high-profile academic at the Head of the Rural section of the DGP&RH and/or the RMIP Director post. (*Refer also to the Strategic Positioning section of this Report*).

Development and usage of appropriate IT facilities and access would greatly enhance both the research productivity and the teaching and administrative aspects of the RMIP.

The Panel identified potential for a strategic plan is developed to address the imbalance between research and teaching in the RMIP programme. While the standard workload division for University academic staff of 40/40/20 (i.e. 40% Teaching, 40% Research, and 20% Community Service) is well recognised, it may not apply to clinical staff in the rural sector. A pragmatic working formula needs to be established for staff in this Programme.

**Commendations**

The Panel commends:

14. RMIP staff for recognising the absence of research in this programme and their willingness to engage with research at some level.

**Recommendations**
The Panel recommends that:

k. A Research Working Group, which includes appropriate research expertise, and the RMIP Director, be established to develop a research programme and that this become an integral part of the RMIP.

l. Any RMIP – Based research endeavour should consider the following:
   - Collaborative input from willing members of RMIP staff and representation from Faculty staff from DSM, UOC and UOW in keeping with the University strategic direction for research.
   - RCs interested in being involved in research should be encouraged and the grade appointment (PPF to Lecturer level) should be explored at that time, potentially adding value to future appointments.
   - Research into determining RMIP outcomes and any added value from community-based education should begin, with clearly recognised academic leadership.
   - Whilst it is not advocated that the RMIP student experiential opportunities be diluted through an expectation of research it is recommend that once a research nucleus of staff is developed (able to offer appropriate supervision) that opportunities for students to conduct research either on rural practice or the RMIP programme should be available through current University structures, e.g. intercalated BMSc, PhDs, student summer studentships with appropriate supervision.
   - Once an RMIP research profile is established, serious attention is given to attributing placement of the research outputs to Faculty, and not to any particular Department.
   - The development of a strategic plan to address the imbalance between research and teaching in the RMIP programme.
   - PBRF requirements are to be recognised in the strategy for research staffing.

m. A body of research needs to be established to determine the educational effectiveness of the RMIP.
7. Community Connections and Service

The success of the RMIP is hugely dependant on the involvement and contribution of a large number of stakeholders in the community, and this needs to continue to be cherished and nurtured. These stakeholders include rural health providers, DHBs, community owned organisations, GP practices, other health professionals and those in the community who provide sporting opportunities, other learning opportunities e.g. SARs, accommodation etc. This is not an exhaustive list of those currently participating, and there probably will be the potential to tap into other community resources to enhance the programme and experiences for the students.

Student Perspectives

Students and RCs report that the Programme provides an environment where students are warmly welcomed and encouraged to be immersed in the community where they are placed. Students were enthusiastic about their experience of living and working in rural communities. There were many examples given of their participation in sports and other local activities. As well, they feel known and valued by the medical staff and other health care professionals, and thought that patients and staff had a positive view of their programme. Students have also commented on the benefits of opportunity to work in environments with a more multidisciplinary approach.

Student feedback is very positive and they are aware of the processes in place for communicating matters of concern. They also have noted the benefit of the relative lack of stress that is associated with working in large tertiary centres. However, there is anxiety for some students regarding the variation in experiences and fulfilling curriculum requirements. Therefore the Panel recommends the RMIP Director implement a mentoring programme so that current RMIP students can link with a past RMIP students for advice and support.
The Rural Communities Perspective

It is acknowledged that it is too early to evaluate the impact of RMIP on encouraging students to return to rural communities as medical practitioners. However early indications look very promising. Research to evaluate the RMIP impact on this is being recommended. This research is required to establish whether the aim, “To encourage interested students to pursue a career in rural medical practice” is being achieved. The relative costs to the community where there are difficulties in recruiting medical staff are significant. These include the risks of having inadequate health services, as well as financial costs for rural providers – recruitment company costs, relocation and other costs of bringing in overseas doctors; often for only short-term and locum cover is very expensive. (See section on Research in this Report.)

RCs and others involved in delivering the Programme report that it is already having an impact on recruitment, retention and the practice of current practitioners in rural areas. Some RCs say that RMIP attracted them to their current post and also that ongoing involvement with RMIP students is professionally stimulating and motivates them to keep up to date and to keep sharp their clinical skills. They also feel that the Programme has already played a role in removing negative myths about rural practice and lifting the status of rural medicine. This demonstrates that the aim, “To provide rural academic career opportunities and hence encourage both recruitment and retention of rural doctors” is already being partly met.

RCs and teachers have commented that the presence of the Programme has provided a mechanism to improve links and communication between other health professionals in their area, as well as better links between primary and secondary health care services. This shows that the aim, “To enhance the links between general practice and rural hospitals” is being met.

One of the limitations for increasing rural health education in the future may be limited facilities, professional input and other resources in the rural areas. Not only RMIP, but other students require training opportunities in rural areas (eg. 5th-year medical student rotation, medical post graduate and other health professional students). However, there is the potential for business partnerships, sponsorships and other joint arrangements to
be developed with stakeholders in rural areas to address these potential constraints. These stakeholders could include health care providers, rural businesses, providers of other education services, community groups etc. A fine example of where this has already occurred is the development of a Rural Learning Centre at Greymouth by the DHB. This facility provides a base for RMIP and other students, shared administration support; access shared learning resources and technology, links to other learning health professionals and research coordination.

A difficulty that can occur for rural health professionals is ensuring that the rural location meets the needs of their other family members e.g. employment opportunities partners and education for children. Generally communities are very aware of this and are willing to assist wherever possible. Extension of the RMIP, and in particular any multi-disciplinary developments, would increase the employment potential of medical and other staff. Finding suitable employment for partners of RMIP staff would possibly increase the pool of potential applicants to rural positions.

It is acknowledged and appreciated that communities contribute to the Programme in many ways, e.g. teaching provided by both medical and other health professionals, home-stay accommodation provided for students in outlying areas, and patients are willing to participate in student learning. However, in some areas the awareness of RMIP and its potential benefits could be increased. A Community Focus Group will help ensure that these very important relationships are valued and enhanced.

The Panel found some community links were better developed in some centres than in others. Consistency is favoured. Therefore the Panel recommends that a Community Advisory Group be formed.

The Community Advisory Group

Community involvement will be of paramount importance to meet strategic objectives in the future. While positive informal community relationships currently exist, more formal relationships and the development of partnerships would potentially ensure that rural
communities can participate in the process of ensuring that they have health professionals in the future.

The Panel recommends the formation of a Community Advisory Group to ensure strong formal community links with initiation of this development to commence as soon as possible. This includes representatives from Maori (and other ethnic groups where appropriate), local government, health providers etc. Its Terms of Reference might also define the responsibilities for engagement with community stakeholders so that these are clearly articulated and understood.

There is merit in both local groups and a combined group. Local groups would be more practical and flexible enough to deal with local variations and demands. The supervision has potential to raise problems, as it is crucial that the RMIP Director is closely involved to ensure appropriate and directed efforts from these groups. That could be linked via the RCs, although their jobs are rather full and adding more might well detract their focus, besides possibly being perceived as a burden. They would report to the RMIP Director.

A single group makes sense from the economic point of view, especially related to time and focus. It would have to be linked via ViPr or telelink, as moving members of the group around the country would be a financial drain. The RCs would need to be involved; but how much responsibility and time they would be required to give would have to be negotiated.

Therefore, the Panel recommends the RMIP Director develop a Community Advisory Group in consultation with RCs and community leaders.

This Group would need to have representation for all rural centres participating in RMIP and would consider the following matters:

15. Community communications about the Programme, including information on teaching and research;
16. Who is involved and what their responsibilities are to be;
17. Welcoming and involving new students throughout their stay in their communities;
18. Liaising with other health service and health education providers to explore opportunities to share resources;
19. Develop potential partnerships with other community stakeholders e.g. for Student facilities, accommodation, support of students, sponsorships, etc.

While an aim of the RMIP is to encourage students to consider a career in a rural environment, the Programme also helps the recruitment and retention of medical staff within the regions that participate. RCs and GPs indicated that involvement in the programme was a factor in their decision to both consider rural positions and stay in those positions. The presence of the RMIP increased the strength of networks between GPs and other health professionals and decreased their sense of professional isolation. Therefore, the Panel considers that communication of the benefits of the RMIP within each community is to be actively promoted e.g. pamphlets to patients, memos in GP newsletters and through the Community Advisory Group.

**Maori**

The Panel noted that some of the rural sites have higher populations of Maori than in most cities and thus students are able to gain experience in managing the particular health needs of the Maori.

**Commendations**

The Panel commends:

15. The links already forged between local communities and students in the RMIP.

16. Current efforts in raising awareness of the benefits of the RMIP to local communities.

17. Recognition of the best practice model established by the Rural Learning Centre on the West Coast and the benefits which have been reaped from it, including greater attraction of staff.
Recommendations

The Panel recommends that:

n. That the RMIP Director proactively engages with community stakeholders by establishing a formal Community Advisory Group, with broad representation.

o. The RMIP Director and RCs plan and implement further communication of the benefits of the RMIP within the RMIP communities.

p. The RMIP Director implements a mentoring programme so that students on the RMIP can link with a student who has recently completed the programme.
8. Strategic Positioning

Governance

The history of the RMIP as an innovative Faculty-wide initiative has been noted by the Panel.

The FCC plays a pivotal role to ensure the curricular requirements of the Programme are met, and also carries a responsibility to ensure placements arranged for students meet all guidelines and expectations of the University, including student well-being.

The RMIP BOS makes recommendations and reports directly to the Board of the Faculty of Medicine and to the FCC. It has responsibility for oversight of the RMIP curriculum. It may also make recommendations concerning any aspect of the Programme, including criteria for selection and admission of candidates. The BOS is also charged with oversight of student assessment and carries broad representation including Dean of the Faculty of Medicine, Chair of the Rural Health Sub-Committee of the FCC, Associate Dean Undergraduate Medical Education DSM, a representative of academic staff of the UOW and UOC, a student nominated by the Medical Students’ Association, and a student representing the RMIP.

The FCC and the RMIP staff need to consider carefully the long-term positioning of the programme. The Panel views positioning the Programme within the DSM as a temporary arrangement because it is important that the Programme continues as a Faculty initiative i.e. the Programme does not belong solely to the DSM or DGP&RH. It is to remain a Faculty-funded Programme and involves all three Medical Schools.

The RMIP is currently perceived in some quarters by some staff and students as a DSM-based Programme funded via a “top-slice”. Its Faculty base needs clearer and explicit recognition. The Faculty and the Schools need to have confidence that RMIP funding is being applied appropriately and that the Programme is not bearing an unacceptable level of DSM, Department of GP&RH overhead. Financial matters have been further discussed in the Operational Management section of this Report.
While the FCC provides integration with the wider medical curriculum, it is an internal University committee and does not provide a connection with the community stakeholders (for example, DHBs, community health organisations, specialists, GPs and midwives) that is so critical for the continued success of the RMIP. Careful consideration should be given to widen the governance structure of the RMIP, for example, with the establishment of a Centre of Rural Excellence broad community representation would be required to effectively run such a Centre.

The Panel found that the benefits of immersion learning, as shown by the success of this Programme, demonstrate that high quality learning can occur in different settings. This has implications for future education beyond training rural doctors and it fits in well with aims expressed by Health Workforce NZ for the future structure of medical practice in NZ. Therefore it is important that all 3 Medical Schools stay involved in this Faculty-led Programme.

The Panel identified that urgent attention is required to improve communication between the three Schools, with direct participation from the UOC and UOW to ensure a sense of shared ownership of RMIP. This includes their participation in strategic planning, student selection, programme curriculum and development and assessment, and other activities. As well, there needs to be good communication regarding operational activities, for example ensuring plenty of warning when the Schools are required to accommodate some aspect of the programme, and when other students are placed in rural sites already accommodating RMIP students, and also sharing of student resources fromm all three schools. Furthermore, the School of Medical Sciences also needs recognition to promote and coordinate vertical integration of the basic sciences throughout the medical course. This relates to the Panel’s concerns that the RMIP is perceived as a DSM Programme.

There are potential opportunities for programme expansion by including the development of health education models similar to the RMIP, but instead of being focused rurally the focus could be on other targeted communities. e.g. Maori/Pacific Island communities. The Panel noted that some rural sites have high populations of Maori and thus students are able to gain experience in managing the particular health needs of Maori.

RMIP Development and Community Positioning
The Director RMIP and staff are to be commended for their commitment to growing the number of regional sites available for students to undertake their 5th-year of study.

The diverse range of regional sites throughout the South Island and lower part of the North Island enriches the experiences that can be gained by the students and thus opportunities for sharing of these experiences. The number of sites and potential development of further sites meets the Faculty and University’s strategic imperative 5 of strengthening (through the Faculty) external engagement with District Health Boards (DHBs) Health Centres and other providers.

The Panel identified that there is potential to extend the programme to have more locations and/or more students, as resources become available to do so. This will involve exploring opportunities for community partnerships, and investigating opportunities to integrate with other health and/or other professional training schemes to enable sharing of resources. Although the Panel felt that these would be desirable, it realises current resource constraints and operational practicalities would make this impractical, at least in the short term. Such developments need strategic oversight and seeking opportunities. As well, with improved financial information about the operational costs of RMIP it may be possible to consider reallocation of resources to allow more students to benefit from RMIP. (This is further discussed in the Operational Management and Community Connections sections of this Report).

Expanding the RMIP also fits with strategic imperative 6 building and sustaining capability by engaging with other providers and providing a model of medical education that is likely to achieve the outcome of increasing the number of doctors who chose to work in rural health. This in turn will contribute to the national good (strategic imperative 4) in reducing the current imbalance in New Zealand and internationally between doctors working in rural and urban settings.

3 The Faculty and its Schools:
will provide educational programmes which will prepare graduates to meet the diverse health needs of New Zealand people.
The staff and students of the Faculty of Medicine will contribute to knowledge and understanding in the health sciences and will promote health through high quality basic and applied research.

School of Rural Health

The Panel considers that a University-wide strategy towards the development of a School of Rural Health within the Division over the next 5-10 years would be beneficial to the University overall. Such a School would have a inter-professional education focus to build on the success of the RMIP and other rural health programmes. The transformational educational innovation, community benefits and potential workforce outcomes demonstrated by the RMIP provide the foundations for other rural health education programmes to be incorporated into a School of Rural Health, along with the RMIP.

A School of Rural Health would be based on the principles of social accountability and community engagement that have driven many of the international innovations in medical and health education in recent times, and would also have a strong focus on Maori health.

The Panel felt that such a development would of necessity be ambitious and require significant support from government and rural communities, as well as support from rural cohorts of the health professions.

Such a proposal would require high-level endorsement and support within the University, as well as support from the 3 Medical Schools and other health Faculties and Schools within the Division. It would provide a good new opening for attracting strong academic leadership (Chair) to the Programme, this having failed with the RMIP in its current position in the DGP&RH.

The Panel therefore recommends that a Working Party be established within the near future to consider the feasibility of a School of Rural Health and to develop a strategy for implementation of the proposal.

Centre for Rural Excellence

The Panel also recommends consideration be given to the development of a Centre for Rural Excellence. Planning should occur, with consideration of those models of best
practice e.g. West Coast DHB Rural Learning Centre, in alignment and in conjunction with the planning for future development of a School of Rural Health. Such a Centre may be established immediately or be developed as part of this new School. If it is being planned for development prior to the establishment of the new School of Rural Health, then the best fit within the current structure needs to be considered e.g. owned and funded within the Faculty, DSM or Division of Health Sciences.

The strategic group should also include consideration of the way in which the UoW and UoC would be involved in the planning, development and decision making. Leadership of the Centre must also be clearly established so that responsibilities are transparent. Other options for consideration are to develop the Centre as a base or develop it as a central hub with a number of satellite centres.

A Centre for Rural Excellence could be developed at any time, but might best be initiated sooner rather than later. It would be associated with the RMIP wherever it may be at the time. This would allow the RMIP to aim for excellence, direct research towards developing the aims and purposes of the programme, and work towards the Rural Health Centre. It should also help recruitment and retention, especially of strong academic leadership essential for the future strategic success of the RMIP.

The Panel’s view is that a Centre for Rural Excellence could be established in the near future in an appropriate rural location, and as a pilot site for the eventual establishment of a multi-centre School of Rural Health.

The Panel felt also that planning for these initiatives would be one way to meet the need for greater communication and linkage between activities of a rural nature across the Faculty.

Commendations

The Panel commends:
18. The benefits of immersion learning as shown by the success of this programme demonstrate that high quality learning can occur in different settings.

19. The RMIP Director and staff for their commitment to growing the number of regional sites available for students to undertake their 5th year of study

Recommendations

The Panel recommends that:

q. The PVC convene a Working Party to: develop a University-wide strategy towards:
   - a Centre of Rural Excellence and
   - a School of Rural Health, (over the next 5 to 10 years);
   - utilising an inter-professional and immersion-learning structure, modelled on the success of the RMIP and other rural health programmes (nationally and internationally). Strong academic leadership is essential for all strategies.
9. Final Comment

Overall the Programme has largely achieved its primary aim of being: innovative, patient-centred, rural, community-based, and educationally sound. Number of students, and rural centres, have increased, and there may be sound reason to further expand the Programme, even within current financial constraints. The students benefit greatly, not only from the educational experience, but also from closer contact with patients, teachers, rural communities, GPs and other health professionals. Student academic successes were excellent, comparing favourably with those on the conventional course.

Whilst there is much to commend, the Panel has made a number of key recommendations to not only strengthen the RMIP, but the Medical Schools of the University.

Within these recommendations the Panel has identified 3 main priority areas, the first being Research, the second Strategies for the future and the third improved coordination of resources between the 3 Medical Schools for staff and students alike.

Research is currently lacking and requires a concerted effort for the RMIP to develop and reach its academic potential. The Panel feels strongly that, Research topics should include educational aspects concerning the success of the Programme in rural communities, as well as medical and sociological topics. Essentially, strong academic leadership and good supervision is required, incorporating selected staff who are research motivated. Removal of barriers to staff participation in research is also essential e.g. with regard to PBRF.

Strategically, in order to secure the long-term future of the RMIP, movement towards a School of Rural Health is suggested, with a 5–10 year time scale. In the interim, a Centre of Rural Excellence could be established at any time, to emphasise the Faculty-wide academic base of the Programme. This could be very useful in overcoming the recent inability to recruit a Chair in Rural Health.

Significant fine-tuning is required to ensure the differences between the RMIP and the conventional courses are accommodated to facilitate successful student learning (e.g.
resource sharing, assessment consistency, time-tabling of students and consultant staff rotating through rural centres, etc).

The Panel sees the considered participation of all 3 Medical Schools in the Faculty as a key factor to the success of its recommendations.
APPENDIX A: Review Panel Members

Convenor: Emeritus Professor Gil Barbezat

Overseas Representative 1: Associate Professor David Campbell, Monash University

External NZ 1: Mrs Kitty Caldwell, Dunedin

Internal Otago 1: Dr Margot Skinner, School of Physiotherapy

Internal Otago 2: Joy Rudland, Faculty of Medicine, Administration

Internal Otago 3: Paul Pedofski, Health Sciences Division, Administration

Graduate representative: Dr Tom Clendon, Nelson

Review Secretary: Chriss Hamilton, Quality Advancement Unit
APPENDIX B: Terms of Reference


Framework

This review is an opportunity for an external panel of independent persons to critically analyse the vision, goals, objectives and principles of the Rural Medical Immersion Programme and to receive affirmation that our plans will have long term benefits to our staff and students of the University of Otago Faculty of Medicine from the Wellington, Christchurch and Dunedin Schools of Medicine.

This will be achieved by assessing the current situation of the Programme:

- What is the current situation of the programme?
- Where does the Programme want to be in 5 years’ time?
- What does the Programme need to do to get there?
- What support does the Programme need to achieve this goal?
- What does the Programme do well?

The purpose is to review and evaluate the Programme with reference to:

- its core activities:
  - (a) Teaching
  - (b) Research
  - (c) Service and/or Professional/Clinical practice
  - (d) Others.
- the Programme’s administration, operational processes, equity, support structures for staff and students, including adequate space, facilities and resources both within the contributing Department(s) and through other central areas of the University, such as the Library and Regional Teaching Centres
- the Programme’s internal, regional, national and international contexts – including alignment to Divisional and University plans;
- the University’s commitment to the Treaty of Waitangi as expressed in the University’s Māori Strategic Framework;
- the Programme’s future direction, strategic planning and goals, and challenges in achieving those.
Accountability
The Review of the Rural Medical Immersion Programme is conducted under the principles for the conduct of reviews at the University of Otago as approved by the Senate in May 1995 and the University Council in June 1995 (University of Otago Programme Review Guidelines 2011)

Terms of Reference
In relation to Teaching, to review and evaluate:
- the programme content including the range and scope of; effectiveness of processes for determining core curriculum, relevance to students, employers, Programme objectives, national and international trends; effectiveness of processes for curriculum review and for the development of new content, including resourcing issues; effectiveness of processes for the revision and rationalisation of existing content; distance teaching, inter-disciplinary teaching;
- pedagogy – quality and excellence in teaching, including innovative teaching, use of new technologies; effectiveness of programme delivery;
- course advising – ensuring appropriate learning pathways that are clearly articulated to students;
- learning – developing learning outcomes for students as reflected in the programme’s attributes;
- assessment – range and effectiveness of assessment methods; monitoring of student progress; nature of feedback;
- Academic support and administrative support for teachers in the regions.
- Effective utilisation of all available learning resources in each region.
- Access for students to teaching opportunities.
- Support for self-directed learning.
- Curriculum content and organisation of teaching in the residentials.
- Communication between teaching centres.
- student support

In relation to Research, to review and evaluate:
- research-teaching nexus – recognising, promoting and reinforcing the interdependent nature of research and teaching;
- staff research – including productivity and quality; PBRF; supporting academic freedom and integrity5;
- resourcing – including planning for purchase and replacement of research equipment
- Current and future research opportunities and support.

In relation to Service, to review and evaluate:
- staff participation in and contribution to community service; professional societies and associations locally, regionally, nationally and internationally
- Programme’s relationship with professional associations, major employer groups, and the public sector

5 Academic Integrity refers to the recognition that research and how it is carried out reflects certain standards of behaviour as articulated in the University’s policies on ethical practices in research, research consultation with Maori, intellectual property rights for both staff and students, and responsible practice in research.
Review of the Rural Medical Immersion Programme

• links with alumni groups
• the impact on regions of having an RMIP teaching centre.

In relation to Professional/Clinical Practice (as appropriate), to review and evaluate:
• the recognition of the importance of professional/clinical experience for staff in these areas;

In relation to administration and operational processes, to review and evaluate the standard (quality, appropriateness, effectiveness and efficiency) in the Programme of:
• structure and management – including institutional oversight, committee structure, the processes and procedures for ensuring effective programme co-ordination and monitoring across contributing departments; leadership in regard to developing and maintaining the professional standing and reputation of the Programme; the relevance and appropriateness of programme regulations; Programme objectives, coherence of underlying philosophy and flexibility; liaison with the Library, ITS and other central services;
• planning – including identifying, considering and responding to problems and challenges; alignment to Divisional and University strategic plans; are the vision, objectives and principles of Rural Medical Immersion Programme consistent with the vision, objectives and principles of the University of Otago Faculty of Medicine.
• monitoring and evaluation – including consultation and liaison with staff, students and other members of the university and wider community, incorporating feedback into planning, core activities and operations, identifying and making improvements to the core activities;
• physical and IT resources;
• Health and Safety

In relation to financial performance, to review and evaluate
• Sources of income
• the size of the budget
• policies, procedures, accounting and reporting of the financial management of the RIMP
• appropriate accountability
• equity of funding for regions and central office,
• value for money, outcomes vs costs
• sustainability/future funding track
• fair share of departmental overheads
Outcomes
Report and make recommendations on the function, teaching, research and service provided by the programme and any actions required to improve those aspects of the RMIP.

Responsibility
To produce a report to the Deputy Vice-Chancellor (academic and International) on the review of the Rural Medical Immersion Programme. Copies to be provided to the Dean of the Faculty of Medicine, The Head of Department of General Practice and Rural Health and the Director of Rural Medical Immersion Programme.

Membership
Chairperson: ..........Gil Barbezat ..........(Gastroenterologist, Emeritus Professor of Medicine, Rtd)
Panellist: (1) ....Margot Skinner .............................. (Deputy Dean, School of Physiotherapy)
           (2) ...David Campbell ...... .... (Director, East Gippsland Regional Clinical School)
           (3) ... Joy Rudland ............................................................... (Faculty Education Unit)
           (4) ... Paul Pedofsky ........................................ (Financial Analyst, Health Sciences Division)
           (5) ... Tom Clendon............................... (House Surgeon Nelson Marlborough DHB)
           (6) ... Kitty Caldwell.................... (Director Clutha Community Health Company Limited)

Term of the Review Panel:
16 -19th July 2012

Report:
The review will be completed by end July 2012. Further follow up of recommendations will follow at 6 months and 2 years from then.

Conflicts of Interest
Where there is a potential for conflict of interest in an agenda item, this is to be declared by members.

Quorum
The quorum of members of a committee is:
(a) if the total number of members of the committee is an even number, half that number; but
(b) if the total number of members of the committee is an odd number, a majority of the members.

Management Support
Administration and secretarial services are provided by the Quality Advancement Unit.

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Appendix C: Methodology

The Convenor and Review Secretary met with the RMIP Director and Administrator prior to the review. The purpose of this contact was to navigate the logistical aspects with a view towards full participation from relevant all parties and to encourage the provision of accurate, relevant and timely information for the Panel.

The Panel received a comprehensive self-review document together with associated Appendices from the Director, well in advance of the review.

The review was widely advertised in the Otago Bulletin and by way of emails to all Departments within the University.

Twenty-nine written submissions were received.

On 17, 17 and 18 July 2012 the Review Panel engaged in a series of interviews that included RMIP Staff, University staff, RMIP students and those who requested to meet with the Panel.

The Review Panel summarised its findings during the 19 July 2012 based on the information supplied and via the written submissions and interviews.

An initial oral report was provided to the Director and relevant staff on the afternoon of 25 July 2012.

The Panel prepared its completed review report after two further face to face meetings and additional email correspondence.
APPENDIX D: Description of RMIP Areas.

The West Coast is a rugged remote region with a population of 31,326, which is serviced by Grey Base Hospital - a 100-bed, secondary regional base hospital located in Greymouth. Students allocated to the West Coast were based in Greymouth at Grey Base Hospital and surrounding primary care practices. As such a wide range of experiential learning opportunities are available to RMIP students within primary- and secondary-level care.

Queenstown is a major tourist centre and has a permanent population of just 22,956 and at that time had a small twenty two bed hospital, Lakes District Hospital, offering limited emergency and acute care and maternity services. Regional base secondary hospital services are 1.5 hours away in Invercargill. Students in Queenstown are based at the Lakes District Hospital, at the main primary care practice in town and those in the surrounding areas. The experience of the students in Queenstown was expected to be more primary-care orientated with little time spent in the regional base hospital. Therefore this placement offers a different spread of potential experiential learning opportunities compared to RMIP counterparts based in Greymouth.

The Clutha programme is Balclutha based. This is a rural, service town in South Otago of 4062. It has a hospital, Clutha Health First, which is a community-owned integrated Hospital and Health Centre based in Balclutha; 60 minutes south of Dunedin in the South Island of New Zealand. The Clutha District, with a population of 17,000, is served by Clutha Health First, the only acute hospital in Balclutha. The Health Centre incorporates the Hospital as well as a large General Practice Group. It is located in the middle of town and a large Rest Home is located next door. Within the facility there are 15 in-patient beds which provide a wide variety of acute medical, stabilisation, resuscitation and rehabilitation services, together with a specialised palliative care/family room, as well as a wide range of Community Services, an Outpatient Department and a primary Maternity Centre with delivery and two post natal beds. Emergency cases are handled via the General Practitioners with support of the hospital-based Medical Officers. Specialists from Dunedin Hospital visit regularly minimising the need for patients to travel to Dunedin for some services. In the outlying areas Lawrence, Milton, Owaka and Tapanui resident
doctors and medical centres service their communities. With approximately 100 staff at the facility, Clutha Health First offers a wide variety of experiential learning.

Dannevirke is a small rural centre of 6000 residents in the Tararua District in southern Hawkes Bay. It has a modern, community hospital and provides 8 GP beds; is a maternity facility (3 beds); has an x-ray service and provides ultrasound service 2 days per week. The local GP’s provide care to their patients and are on a roster system to care for in-patients’ after-hours. The Tararua Health Group was established in April 2009. The range of services provided by the group encompasses GP primary-healthcare, practice nursing, community nursing, hospital, maternity and radiology services. The organisation employs up to one hundred staff, including GP’s, registered nurses, radiographers, midwives and a sonographer. There are a range of support staff providing business and quality systems to the overall organisation.

Blenheim is a rural town in the north of the South Island, in Marlborough. It has a population of 26,000. It is currently redeveloping its hospital and this is almost complete. All services expected in a hospital of this size are available, including mental health services, midwifery, internal medicine, surgery (orthopaedic, general, ENT and ophthalmology), and paediatrics. The programme is primary-care based with very adequate hospital attachments. In 2006 a new purpose built $30 million hospital was completed. This is a new facility with new equipment and new ways of working.

Wairarapa Hospital provides a full range of secondary medical, surgical and obstetric and gynaecological services. It is a busy, rural hospital with up to 92 beds, covering all aspects of secondary-health care. The ambulance service is an integral part of the operation. Wairarapa Hospital provides 24-hour emergency services.