Australian Medical Council Limited

AMC Guidance Matrix

Version as of 1 December 2023

User guide *read this first*

This AMC Guidance Matrix accompanies the *2023 Standards for Assessment and Accreditation of Primary Medical Program (medical school standards)*.

The aim of the Guidance Matrix is to share AMC accreditation expectations and current practice related to the standards with medical schools, AMC assessment teams and reviewers, and other key stakeholders.

The Guidance Matrix includes '**Explanation**' of standards to provide further, plain language context on the standards. This includes explaining language in the standards and providing high-level frameworks for what the AMC expects when accrediting schools against the standards. Note that not all standards have a corresponding Explanation, only the (parts of) standards that the AMC has determined may require further clarity.

The Guidance Matrix further includes an indicative list of '**Evidence**' that the AMC would generally seek to demonstrate a school's achievement of or progress against a standard. Evidence supports descriptive text contained in a submission. There are two types of evidence listed:

- **Documentary evidence** – These are existing documents or descriptions of practice written for the submission, to be included in the body of a submission or in an appendix. Not all types of evidence listed will be required or even relevant to all schools, and there will usually be other types of evidence that schools provide during an accreditation activity that are not included in the list. *Documentary evidence should always be contextualised*, both in that the narrative text in the submission should describe the relevance of the evidence and in that the evidence should contain key details, for example date and authorship where relevant. More evidence is required for initial accreditation, reaccreditation or extension of accreditation submissions than for monitoring submissions.
- **Interview and observational evidence** – These are types of discussions with stakeholders and observations of facilities or activities that an AMC accreditation team would conduct during an accreditation or follow-up visit. These lists are more indicative than the list of documentary evidence, as the topics discussed, and stakeholders invited for discussion, will vary more widely depending on the challenges and strengths of the school being accredited. More comprehensive discussions and observations to cover all standards are required for an accreditation visit. For visits conducted for a material change submission or for an accreditation follow-up, discussions and observations will typically be focused on a specific set of standards.

The Guidance Matrix also contains '**Example(s)**' of practice that meets or is on the way to meeting standards. These examples have been provided by medical schools. The AMC recognises that schools will have different and innovative ways of achieving the standards appropriate to their local context and strengths. Examples are included as a platform for collaboration and innovation, particularly where schools have shared challenges.

Finally, the Guidance Matrix includes '**Resources**' that provide expert academic or policy views relevant to the standards. Except where these are AMC documents, the AMC does not necessarily endorse views contained in the resources.

Two further important notes:

1. Words or phrases that have an **asterisk*** after them are defined in the glossary. Stakeholders should refer to the glossary definition for further explanation.
2. The Guidance Matrix is a living document that will be continuously updated to reflect contemporary practice and contributions from stakeholders. Stakeholders are encouraged to provide feedback to the AMC and suggest additional examples and resources by contacting standardsreview@amc.org.au.

Contents

Standard 1: Purpose, context and accountability of the medical program

1.1 Purpose

1.1.1 The medical education provider has defined its purpose, which includes learning, teaching, research, social and community responsibilities.

1.1.2 The medical education provider contributes to meeting healthcare needs, including the place-based needs of the communities it serves, and advancing health equity through its teaching and research activities.

1.1.3 The medical education provider commits to developing doctors who are competent to practice safely and effectively under supervision as interns in Australia or Aotearoa New Zealand, and who have the foundations for lifelong learning and further training in any branch of medicine.

1.1.4 The medical education provider commits to furthering Aboriginal and/or Torres Strait Islander and Māori people's health equity and participation in the program as staff, leaders and students.

Explanation	Evidence	Example(s)	Resources
Providers should ensure that their graduates can practice safely and effectively in contexts appropriate to internship* in Australia and Aotearoa New Zealand, through the achievement of the common AMC Graduate Outcomes Statements. Providers should, at the same time, contextualise their medical program outcomes* and learning, teaching and assessment* so that providers and their graduates can contribute to the place-based needs of their communities (1.1.2 and 1.1.3). Providers should explain under Standard 1.1: Purpose, how their commitment to producing graduates who are competent for internship and meeting place-based needs relates to their purpose and the design of their	Documentary evidence could include: - The purpose statement of the medical education provider and/or program. - The process of consultation on, development of and implementation of the purpose statement. - Reports that demonstrate the providers' interpretation, based on community engagement, of place-based needs, including how this was reached and operationalised. - Descriptions of how the commitment to furthering Aboriginal and/or Torres Strait Islander and Māori people's	An example from **CSU/WSU Joint Program in Medicine:** The Joint Program in Medicine (JPM), a partnership between the School of Medicine (Western Sydney University) and the School for Rural Medicine (Charles Sturt University), endeavours to meet the health needs of under-served communities locally and wherever graduates may work. The partnership is founded on a shared commitment to working with community, guided by a cyclical three-pronged approach: listen to the community; co-design strategic and immediate actions; and co-deliver, co-assess and co-evaluate the actions. The listening is actioned through community	LIME Network: LIME Reference Group Orientation and Peer Support Vision Statement (2021) Link LIME Network: Indigenous Health Project – Critical Reflection Tool (2007) Link Jones, R., Crowshoe L., et al (2019). "Educating for Indigenous Health Equity: An International Consensus Statement." Academic Medicine 94(4): 512-519 Link

program. Specific details of how the program curriculum is designed, mapped and implemented should be explained under Standard 2: Curriculum. 'Place-based needs' refers to the needs and characteristics in the health care context of different communities, including but not limited to Aboriginal and/or Torres Strait Islander and Māori* communities, defined by their identification to location and through connection to Country. Providers should ensure they track and understand the outcomes and impact on health care needs of their program (1.1.2). Providers should demonstrate their commitment to furthering Aboriginal and/or Torres Strait Islander and Māori peoples' health equity and participation in their program by explaining how this commitment is reflected in their purpose and strategic vision (1.1.4). Specific initiatives should be explained under other standards related to cultural safety* and Aboriginal and/or Torres Strait Islander and Māori* health. For example, initiatives related to professional development and support for Aboriginal and/or Torres Strait Islander and Māori staff should be reported under Standard 5.3: Staff appointment, promotion and development.	health equity and participation in the program is reflected in the purpose statement and strategic vision. Interview and observational evidence could include: - Discussions with community stakeholders, including community controlled health settings and local Aboriginal and/or Torres Strait Islander and Māori community leaders, on their engagement with the provider. - Discussions with senior staff on how place-based health needs and commitment to health equity are embodied in the program and their responsibilities in this context. - Discussions with Aboriginal and/or Torres Strait Islander and Māori people participating in the program on the program's commitment to them.	representatives on key JPM Committees (for example the Joint Curriculum Committee, Joint Quality and Evaluation Committee). In the School of Medicine there is a dedicated Community Engaged Teaching, Learning and Research Panel. Community Forums are held at each of the metropolitan and rural Clinical Schools with a board audience of community members and service providers. As well as regular JPM community partner events, community members interview medical school applicants and there is an extensive network of community placement supervisors and community volunteers delivering the flagship Medicine in Context Year 1-3 community placements program. Co-delivery, co-assessment and co-evaluation of initiatives is tailored to each context and community need, for example by training students to identify and discuss community needs during their community placements through weekly small group sessions and clinical placements in community settings. For example, a community organisation raised the need to support integration of refugee doctors into the medical workforce. Hearing of this need, the Medicine in Context academic lead initiated a co-designed needs assessment of refugee doctors in Fairfield as a community placement activity at the organisation. The students' work was guided and assessed	Mazel, O., Anderson I. (2011) "Advancing Indigenous health through medical education." FoHPE 13(1):1-12 Link The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute: National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health. "Action 1.2: Addressing health needs of Aboriginal and Torres Strait Islander people" (2017) Link

		by the organisation's placement supervisor alongside the academic team. Following this initial placement, another student placement activity was co-designed to identify stakeholder perspectives of the needs assessment's findings. The collaboration was reported to the School of Medicine Executive, resulting in other groups from the School's networks being identified to further develop the initiative. The students were kept informed, so they could see how their contributions had made a wider impact. This experience is now embedded into Medicine in Context teaching to exemplify how students as future doctors can advocate for their local communities. The model of community-engaged pedagogy permeates across all JPM sites, focusing on listening to community needs and co-design of community placement opportunities.	

1.2 Partnerships with communities and engagement with stakeholders

1.2.1 The medical education provider engages with stakeholders, including community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori people and organisations, to:

- define the purpose and medical program outcomes
- design and implement the curriculum and assessment system
- evaluate the medical program and outcomes of the medical program.

1.2.2 The medical education provider has effective partnerships to support the education and training of medical students. These partnerships are supported by formal agreements and are entered into with:

- community organisations
- health service providers
- local prevocational training providers
- health and related human service organisations and sectors of government.

1.2.3 The medical education provider has mutually beneficial partnerships with relevant Aboriginal and/or Torres Strait Islander and Māori people and organisations. These partnerships:

- define the expectations of partners
- promote community sustainability of health services.

Explanation	Evidence	Example(s)	Resources
Different stakeholders* will require different types of engagement on the different issues. People and groups internal to the provider, including staff and students, should be extensively engaged through formal participation in decision-making structures and processes. External partners* should be consulted on decisions, have insight into	Documentary evidence could include: - Correspondence, schedules, reports and outcomes related to community engagement events such as focus groups or town hall meetings. - Terms of reference, agendas and minutes from stakeholder	An example from the **University of Western Australia Medical School**: The integration between RCS WA and WA Country Health Service (WACHS) is longstanding and encompasses supervision and education for both medical students and junior medical officers (JMO).	AHRA Women's Health Research, Translation & Impact Network: Webinar – Consumer and Community Involvement (CCI) Tap into local councils to connect with underserved populations (2023) Link

decision-making processes, and have knowledge of major decisions on the medical program made by the provider. External people and groups with an interest in the process and outcomes of medical training and education, including community groups who experience health inequities* and Aboriginal and/or Torres Strait Islander and Māori* people and organisations, should be consulted on the decisions that impact on them and should have clear information on how they can engage with the provider. While the level of detail and depth of engagement will depend, members of all three types of stakeholders should be engaged in all of three ways named in standard 1.2.1 (1.2.1). Providers should explain under Standard 1.2: Partnerships with communities and engagement with stakeholders, the strategic approach and mechanisms for engaging stakeholders at a high level. Specific details of engagement should be explained under other standards. For example, student representation should be explained under Standard 1.3: Governance, and direct involvement of community members in teaching and learning activities should be explained under Standard 5.2: Staff resources. Providers should demonstrate how they collaborate with communities, including Aboriginal and/or Torres Strait Islander	representation bodies/reference groups. - Descriptions of key partnerships that support the education and training of medical students. - Organisational charts that detail the input of stakeholders into the governance of the program, including stakeholder membership on relevant boards and committees. - Charts/tables of the provider's representation on relevant stakeholder boards and committees. - Memoranda of Understanding, placement agreements, and other formal agreement documents between the provider and partner organisations; particularly relating to consultations, joint appointments and standing committee membership. - Descriptions of the mutual benefits providers and Aboriginal and/or Torres Strait Islander and Māori people and organisations provide to each other. - Samples of written feedback from student and communities collected through provider feedback mechanisms. Interview and observational evidence could include: - Discussions with community members who experience health	This partnership has facilitated the creation of internship positions in RCS WA sites that accept final year medical students (e.g., Albany, Bunbury, and Geraldton). Clinical placements are closely matched with supervisor capacity, student numbers, JMO numbers and training opportunities. The scale of the initiative has been determined by capacity for clinical training and supervision in rural sites. Working closely with the rural workforce agency (Rural Health West, RHW) has led to several projects, including a multi-organisational collaboration to develop Health Professional Networks in each region of rural WA, for educational and networking opportunities, support for rural medical students at medical conferences, and provision of scholarships for rural electives. The creation of academic positions through UWA and RCS WA has enabled the growth of health and medical research initiatives that have engaged with community groups and been informed by rural and indigenous peoples' health priorities. The collaborative outlook from RCS WA has facilitated partnerships between the UWA Medical School and the Medical Schools of the University of Notre Dame, Fremantle, and Curtin University. RCS WA now manages the selection, supervision, and clinical placements to rural sites of medical	ACSQHC: NSQHS Standards – Partnering with Consumer Standard. "Partnering with consumers in organisational design and governance" (2021) Link The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute: National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health. "Action 2.13: Working in partnership" (2017) Link

and Māori communities, to understand the strengths and challenges of these communities in support of their health care. Providers should show how they contribute towards meeting their communities' identified needs, including through collaboration with those communities (1.2.1). Not all partnerships with the categories of organisations named in standard 1.2.2 will be supported by formal agreements. In determining whether a partnership should be supported by a formal agreement, providers should consider the operational, legal, financial and reputational risk of having a partnership without an agreement. Providers should generally secure formal agreements with services that provide structured clinical placements* for their students (1.2.2). To ensure that partnerships with relevant Aboriginal and/or Torres Strait Islander and Māori people and organisations are 'mutually beneficial', providers should demonstrate how those partnerships enhance the social accountability and acceptability of the program in line with the expectations of the community. Aboriginal and/or Torres Strait Islander and Māori people and organisations should be engaged through consultation, co-design and inclusion in governance structures, as appropriate (1.2.3).	inequities on the provider's engagement of them. - Discussions with other stakeholders on the efficacy of their partnerships with the provider. - Discussions with students and staff on their involvement in community engagement activities. - Discussions with Aboriginal and/or Torres Strait Islander and Māori people and organisations' on the nature of their partnerships with the provider.	students from all three WA Medical Schools.	

To 'promote community sustainability*', providers should not take more resources from Aboriginal and/or Torres Strait Islander and Māori people and organisations than they provide. Providers may achieve this by, for example, paying community controlled health settings to at least cover expenses incurred for placement spaces, funding or contributing to capital works, and/or providing professional development or training opportunities (1.2.3).			

1.3 Governance

1.3.1 The medical education provider has a documented governance structure that supports the participation of organisational units, staff and people delivering the medical program in its engagement and decision-making processes.

1.3.2 The medical education provider's governance structure provides the authority and capacity to plan, implement, review and improve the program, so as to achieve the medical program outcomes and the purpose of the medical education provider.

1.3.3 The medical education provider's governance structure achieves effective academic oversight of the medical program.

1.3.4 Students are supported to participate in the governance and decision making of their program through documented processes that require their representation.

1.3.5 Aboriginal and/or Torres Strait Islander and Māori academic staff and clinical supervisors participate at all levels in the medical education provider's governance structure and in medical program decision-making processes.

1.3.6 The medical education provider applies defined policies and processes to identify and manage interests of staff and others participating in decision-making processes that may conflict with their responsibilities to the medical program.

Explanation	Evidence	Example(s)	Resources
In documenting the governance structure, the provider should clearly define and document for each committee or group: • The composition/membership. • The terms of reference. • Scope of responsibilities and decision-making authority • Reporting relationships (1.3.1). 'Authority and capacity to… improve the program' refers to governance arrangements that are responsive when opportunities, needs and deficits are identified. This includes a timely process for identifying and responding to program requirements (1.3.2). 'Effective academic oversight' refers to the academic governance of the medical program being independent and able to make and implement decisions autonomously, such that the provider can consistently ensure integrity and quality of the core	Documentary evidence could include: - Detailed organisational charts, including reporting lines, outlining the relationships, responsibilities and decision-making powers for bodies (e.g. committees, panels, boards, working groups etc.) involved in medical program governance. - Current terms of reference, membership lists, and recent agendas and minutes for governance bodies. - Descriptions of primary organisational units for teaching and research that contribute to the program, including the organisational units such as clinical schools responsible for organising clinical teaching. - The job titles of, names of, and brief role descriptions for the key role holders for primary organisational units. - Descriptions of decision-making and delegation procedures of key governance bodies, including flow charts of reporting relationships.	*No examples at this time.*	TEQSA: Guidance note – Academic governance (2023) Link

activities of learning, teaching, research and scholarship; and can manage challenges to those activities (1.3.3). Students being 'supported to participate' includes: • An environment that is genuinely welcoming to student perspectives. • Representation that is inclusive of all groups in the student cohort • Representation is responded to appropriately, with action taken based on student engagement (1.3.4). Aboriginal and/or Torres Strait Islander and Māori* staff and clinical supervisors* should always be genuinely included in governance processes that relate to Aboriginal and/or Torres Strait Islander and Māori people, including decision-making processes related to learning, teaching, assessment*, evaluation*, resourcing, cultural safety* and wellbeing. The participation of Aboriginal and/or Torres Strait Islander and Māori staff and clinical supervisors in program governance should be facilitated in a manner that acknowledges cultural loading, such as by allowing flexible participation options and appropriately remunerating staff based on their level of participation in governance, and allows meaningful input into all key decisions. A well-supported Aboriginal and/or Torres Strait Islander and Māori governance committee and/or an Aboriginal and/or Torres Strait Islander and Māori education unit, with appropriate resources, sufficient independence and relevant authority, is usually required to ensure meaningful participation in governance and decision-making processes (1.3.5).	- Policies and plans for renewal of key governance bodies. - Descriptions of change management/ implementation and conflict resolution processes for key governance bodies. - Case studies of governance processes in practice, for example as used for a recent significant program, curriculum or policy change decision, or to identify and meet a resourcing need. - Descriptions of how student representation is achieved, the range of bodies on which students are represented. Include the procedure for selecting student representatives from across the cohort and program sites, and examples of how the program addresses systemic concerns raised by student representatives. - Case studies of responses or actions taken as a result of engagement of students in governance and decision-making in the medical program. - List of the medical student groups and societies, and the names of student leaders. - Descriptions and case studies of how Aboriginal and/or Torres Strait Islander and Māori staff and clinical supervisors participate in governance, such as through an Aboriginal and/or Torres Strait Islander and Māori governance committee and/or Aboriginal and/or Torres Strait Islander and Māori education unit. - Numbers and role of students who are members of governance bodies. - Numbers, level of appointment and FTE of Aboriginal and/or Torres Strait Islander and Māori staff and clinical supervisors who are members of governance bodies. - Conflict of interest policies and case studies of how these are managed in practice. Interview and observational evidence could include: - Discussions with staff on how governance structures work, are communicated about, and are participated in.		

	- Discussions with students on the efficacy of student representation in the program. - Discussions with Aboriginal and/or Torres Strait Islander and Māori academic staff and clinical supervisors' on their participation in governance and decision-making.		

1.4 Medical program leadership and management

1.4.1 The medical education provider has the financial resources to sustain its medical program and these resources are directed to achieve the provider's purpose and the medical program's requirements.

1.4.2 There is a dedicated and clearly defined academic head of the medical program who has the authority and responsibility for managing the medical program.

1.4.3 The head of the medical program is supported by a leadership team with dedicated and defined roles who have appropriate authority, resources and expertise.

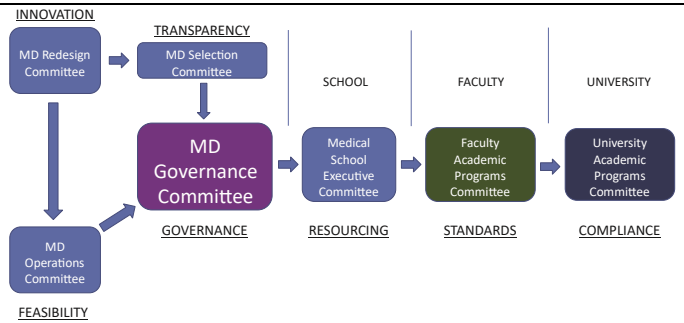
1.4.4 The medical program leadership team includes senior leadership role/s covering responsibility for Aboriginal and/or Torres Strait Islander and Māori health with defined responsibilities, and appropriate authority, resources and expertise.

1.4.5 The medical education provider assesses the level of qualification offered against any national standards.

1.4.6 The medical education provider ensures that accurate, relevant information about the medical program, its policies and its requirements is available and accessible to the public, applicants, students, staff and clinical supervisors. This includes information necessary to support delivery of the program.

Explanation	Evidence	Example(s)	Resources
'Dedicated' roles refer generally to the role holder being able to focus on that role through minimising additional roles and external responsibilities (1.4.2 and 1.4.3). For both the leadership of the medical program and the leadership of the Aboriginal and/or Torres Strait Islander and Māori health aspects of the program, 'appropriate authority and resources' refers to the leadership being integrated into the program rather than isolated, having financial and staff resources to fulfil its obligations, and being appropriately placed in the governance structure to be able to steer and influence decision-making (1.4.3 and 1.4.4).	Documentary evidence could include: - Descriptions of the budgetary relationship between the program and the broader (university) institution, and how this has changed. - Summary budget documents that describe major sources of revenue and cost centres and how these have changed over time. - Budget projections for the next several years. - Impact analyses of changes to the budget.	An example from the **University of Melbourne, Melbourne Medical School:** Academic and financial autonomy of the MD program is supported by the Department of Medical Education governance structure introduced in 2019. Through an expressions-of-interest process in 2018, staff from within the Medical School applied for and were appointed as directors of specific areas related to the Melbourne MD with responsibility for their portfolios. Most have an active program of scholarly research in their directorate which supports innovation, builds capacity and contributes to the rigor of the innovations they champion. The key committee is the MD Governance Committee, which is chaired by the Head of Melbourne Medical School, includes two elected student representatives, and two stakeholders from outside the Department of Medical Education (currently a professor of Anatomy and Cell Biology from the School of	*No resources at this time.*

Along with (a) senior leadership role(s) covering responsibility for Aboriginal and/or Torres Strait Islander and Māori health, the medical program leadership team should include medical educationalists, clinicians and professional staff. The size and nature of the team will depend on the size of the student body, the structure of the program and the range of community and health service relationships to be built and maintained (1.4.3). 'Information about the medical program, its policies and its requirements' including 'information necessary to support delivery of the program' that should be available to stakeholders* includes documentation relating to (note this list is outlining information which should be accessible, to a greater or lesser extent, to the public, applicants, students, staff and clinical supervisors*. Not all this information needs to be provided to the AMC as evidence under this standard, instead providers need some description or evidence of its availability to these stakeholders): • Selection processes, including appeals. • Assessment* philosophy or strategy, principles practices and rules. • Assessment and progression requirements. • Assessment marking methods. • The design and structure of the curriculum and learning objectives/outcomes. • Alignment of learning objectives/outcomes with learning, teaching and assessment activities.	- Descriptions of how research funding and equipment, and capital funds, are distributed. - Policy or statement that defines the responsibilities of the academic head of the program. - Current position descriptions for key leadership roles and brief biographies of the people who fill those roles. - Current position descriptions for senior leadership role(s) covering responsibility for Aboriginal and/or Torres Strait Islander and Māori health and brief biographies of the people who fill those roles. - Budget overview for operationalising Aboriginal and/or Torres Strait Islander programs (e.g. cultural safety training, scholarships, workshops, guest speakers, etc.). - The schedule of delegations, including financial delegations. - Descriptions of internal quality assurance mechanisms to assess the level of qualification against national standards.	Biomedical Sciences and a professor of anaesthetics. Directors of the DME MD portfolios attend meetings to provide information to the committee. The committee receives proposals for course improvements from the subcommittees reporting to it (particularly MD Redesign Committee and MD Operations Committee), as well as evaluation reports from the Evaluation and Quality Directorate. By the time proposals for change come to the MD Governance Committee for approval, they have been developed by the directors with most expertise in the area, well considered for educational appropriateness (through the MD Redesign Committee) and feasibility (through the MD Operations Committee), as well as demonstrated the need for the change through previous evaluations. This means that there are rarely conflicts about a change being suitable for implementation, although proposals for significant or particularly innovative changes are often tied to a deliberate evaluation framework. One recent example is the conversion of the MD program from standard grading to pass fail grading. The Director of Assessment produced several documents outlining the innovation and the rationale behind it - a MD Redesign Assessment Strategy, Proposal for Pass Fail Grading, and a Pass/Fail Grading FAQ. Each of these documents drew on the existing literature, research within the MD, and our own evaluation data to provide the rationale for change. The work was interrogated and refined through our own governance pathways and finally presented to the relevant Faculty and University committees for review and ultimate approval. The reporting relationships of the MD committees at the time of that change can be summarised as:	

• The outcomes of evaluation* and continuous improvement activities. • Bullying, harassment, racism and discrimination policies. • Student wellbeing strategy or strategies. • Inclusion strategy or strategies. • Reasonable adjustments/accommodations policies. • Professionalism and fitness to practice policies and procedures. • Standards for student conduct and procedures for disciplinary action. • Conflict of interest policies (1.4.6). Different audiences will require different types and levels of access to information. Providers should consider whether the information is relevant to the audience. For example, detail on the broad features of selection processes would be particularly relevant to applicants, while staff involved in selection processes should have detailed information on what is expected of them. While documentation that includes personally identifiable information and commercially sensitive details should be treated with care and consistent with legal and ethical obligations, providers should aim for transparency when determining if information should be made available and accessible. When information is available to the public through the provider's website, it should also be easy to navigate to and find the information (1.4.6).	- Correspondence with or reports from TEQSA or NZQA and any other relevant external accreditation documentation that indicates the status of the program level of qualification as externally accredited or self-accredited. - Links to publicly available information about the medical program, key policies and requirements. - Descriptions of how information about the medical program, key policies and requirements are provided to applicants, students, staff and clinical stakeholders. Interview and observational evidence could include: - Discussions with medical program leadership team on the authority they are able to exercise and resources they are able to direct. - Discussions with Aboriginal and/or Torres Strait Islander and Māori health leader(s) on their responsibilities in the program, the authority they are able to exercise		

	and resources they are able to direct. - Discussions with staff on the integration of the medical program leadership team, including the Aboriginal and/or Torres Strait Islander and Māori health leader(s), in the governance structure and staff views of program leadership team independence, influence and authority. - Discussions with program and provider business managers on the function of delegations and accountability procedures. - Discussions with internal and external stakeholders on the accessibility and awareness of key information.		

Standard 2: Curriculum

2.1 Medical program outcomes and structure

2.1.1 The medical program outcomes for graduates are consistent with:

- the Australian Medical Council (AMC) graduate outcome statements
- a safe transition to supervised practice in internship in Australia and Aotearoa New Zealand
- the needs of the communities that the medical education provider serves, including community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori communities.

2.1.2 Students achieve assessment outcomes, supported by equitable access to learning and supervisory experiences of comparable quality, regardless of learning context. These outcomes are supported by appropriate resources in each learning environment.

Explanation	Evidence	Example(s)	Resources
To ensure that medical program outcomes* are 'consistent with' the areas outlined, providers should demonstrate: • How each AMC graduate outcome statement maps to medical program outcomes. (The provider's detailed curriculum mapping and assessment* blueprinting documents should be explained under Standard 3.1: Assessment design). • How the general requirements of internship* in Australia and Aotearoa New Zealand, as well as the specific requirements of local prevocational training providers* map to medical program outcomes. • How the health needs of communities served relate to the medical program outcomes (2.1.1). 'Assessment outcomes' relate to student performance on assessments and performance related to progression points (2.1.2). Details of the system of assessment should be explained under Standard 3: Assessment.	Documentary evidence could include: - The medical program outcomes. - Mapping documents of AMC graduate outcome statements to medical program outcomes. - Mapping documents of program outcomes to learning objectives/outcomes for themes and/or stages of the program. - Formal agreements, correspondence or other documentation related to prevocational training provider engagement and collaboration. - Correspondence or other documentation related to community engagement and collaboration such as written consultation, community meetings, focus groups or town halls. - Descriptions of how prevocational training provider requirements and community needs are considered when developing medical program outcomes, such as consultation documents. -	*No examples at this time.*	*No resources at this time.*

Providers should ensure that no student is disadvantaged or materially affected by lack of access to learning resources and supervision by the site of education (2.1.2).	- Descriptions of learning resources and supervisory quality at each site, including any innovation or unique opportunities at sites. - Descriptions of measures taken to ensure equitable access to learning and supervisory experiences and appropriate resources in each learning environment. - Outcomes of analyses of assessment performance for students placed in different program sites. Interview and observational evidence could include: - Discussions with community stakeholders on their involvement in determining medical program outcomes. - Discussions with prevocational training providers on their collaboration and engagement with the provider on medical program outcomes. - Discussions with staff and students at different education sites about the quality of and access to learning resources and supervision. - Discussions with staff and clinical supervisors about orientation, training and professional development opportunities across different sites.		

2.2 Curriculum design

2.2.1 There is purposeful curriculum design based on a coherent set of educational principles and the nature of clinical practice.

2.2.2 Aboriginal and/or Torres Strait Islander and Māori health content is integrated throughout the curriculum, including clinical aspects related to Aboriginal and/or Torres Strait Islander and Māori health across all disciplines of medicine.

2.2.3 The Aboriginal and/or Torres Strait Islander and Māori health curriculum has an evidence-based design in a strengths-based framework and is led and authored by Aboriginal and/or Torres Strait Islander and Māori health experts.

2.2.4 The medical education provider is active in research and scholarship, including in medical education and Aboriginal and/or Torres Strait Islander and Māori health learning and teaching, and this research and scholarship informs learning, teaching and assessment.

2.2.5 There is alignment between the medical program outcomes, learning and teaching methods and assessments.

2.2.6 The curriculum enables students to apply and integrate knowledge, skills and professional behaviours to ensure a safe transition to subsequent stages of training.

2.2.7 The curriculum enables students to evaluate and take responsibility for their own learning, and prepares them for lifelong learning.

2.2.8 The curriculum design and duration enable graduates to demonstrate achievement of all medical program outcomes and AMC graduate outcome statements.

2.2.9 The curriculum outlines the specific learning outcomes expected of students at each stage of the medical program, and these are effectively communicated to staff and students.

2.2.10 There are opportunities for students to pursue studies of choice that promote breadth and variety of experience.

Explanation	Evidence	Examples	Resources
Some important 'educational principles' that providers should consider in their programs could include: • Horizontal and vertical integration. • Constructive alignment. • Articulation with subsequent stages of medical training. Concepts such as: • Flexible learning.	Documentary evidence could include: - Curriculum planning and/or policy documents that describe the guiding educational principles and how these are applied. - Detailed descriptions of the curriculum structure, including curriculum diagrams, mappings and scheduling (e.g. of clinical placements*). - Outline of program structure including the identification of individual components within each year, and how the medical program is organised by	*No examples at this time.*	Australian Indigenous HealthInfoNet (2023) Link LIME Network: Good Practice Case Studies (2012-2019) Link Lowitja Institute: Deficit Discourse and Strengths-Based Approaches –

• Reflective learning. • Culturally safe learning. • Self-regulation. • Technology-enhanced learning. • Role modelling. Also connect with these educational principles (2.2.1). Aboriginal and/or Torres Strait Islander and Māori health content should be horizontally and vertically integrated throughout the curriculum, based on a framework set out in the Aboriginal and/or Torres Strait Islander and Māori health curriculum (2.2.2 and 2.2.3). The Aboriginal and/or Torres Strait Islander and Māori health curriculum should include all aspects of Aboriginal and/or Torres Strait Islander and Māori health and cultural safety* in the Graduate Outcome Statements, including: • Aboriginal and/or Torres Strait Islander and Māori approaches to health and wellbeing, including social and emotional determinants of health. • Impacts of colonisation, racism and bias on health outcomes, and the role of anti-racism in addressing these impacts. • The history, culture and health of Aboriginal and/or Torres Strait Islander and Māori peoples • Interacting with Aboriginal and/or Torres Strait Islander and Māori patients in a culturally safe manner (2.2.3). A variety of clinicians and academics will be involved in implementing the Aboriginal and/or Torres Strait Islander and Māori health	year/terms/semesters/phases; including relevant schematics and an annual program calendar. - The Aboriginal and/or Torres Strait Islander and Māori health curriculum document. - Descriptions of how the Aboriginal and/or Torres Strait Islander and Māori health curriculum is developed and reviewed, including the key expert(s) involved. - Descriptions of how Aboriginal and/or Torres Strait Islander and Māori health content is integrated throughout the overall curriculum, including how different disciplines of health integrate clinical aspects related to Aboriginal and/or Torres Strait Islander and Māori health. - Summary of the provider's research plan and major research directions. - List of relevant research organisations affiliated with the provider. - Descriptions of opportunities for medical students and staff to engage in research in the program. - Case studies of how research informs learning, teaching and assessment in the program. - Descriptions of how the Graduate Outcome Statements are achieved by graduation, through mapping of learning outcomes/objectives for each year/phase of the program. - Descriptions of how the program design ensures students evaluate and take responsibility for their own learning, and are prepared for lifelong learning. - Descriptions of processes to ensure alignment of planning, governance, and review mechanisms. - Descriptions of how professionalism is learnt and developed in the curriculum, and linked with learning, teaching and assessment activities. - Systems for teaching or other educational awards for staff. - Documents describing the program provided to students and staff		Changing the Narrative of Aboriginal and Torres Strait Islander Health and Wellbeing (2018) Link The University of Western Australia: Good Spirit Good Life (2020) Link Australian Commonwealth Department of Health and Aged Care: Aboriginal and Torres Strait Islander Health Curriculum Framework (2012) Link CDAMS/MDANZ: Indigenous Health Curriculum Framework (2004) Link MDANZ and AIDA: National Medical Education Review – A review of the implementation of the Indigenous Health Curriculum Framework and the Health Futures report within Australian medical schools (2012) Link MDANZ: Research in the Medical Curriculum Volume 1 – A Window on Innovation and Good Practice (2022) Link

curriculum, however the curriculum should be designed under the guidance of, and led by Aboriginal and/or Torres Strait Islander and Māori health experts. The Aboriginal and/or Torres Strait Islander and Māori leadership role holder(s) (see standard 1.4.4) should be involved in the curriculum design and leadership process (2.2.3). For the curriculum to 'enable and integrate… professional behaviours to ensure a safe transition to subsequent stages of training' and 'enable graduates to demonstrate achievement of all medical program outcomes* and AMC outcome statements', providers should include learning about professionalism in the curriculum (2.2.6 and 2.2.8). The AMC does not prescribe a minimum duration for medical programs. In Australia, bachelor's and master's degrees are typically 3-4 years, separately or in combination, as outlined in the Australia Qualifications Framework. The New Zealand Qualifications Framework sets out the expectation that bachelor's degrees will be at least 360 credits (60 credits per semester with two semesters per year, typically over three years), and the minimum entry requirement for a master's degree is a bachelor's degree (2.2.8). To be 'effectively communicated', students and staff should be able to easily access and should understand learning outcomes relevant to their learning and teaching activities, in a format that is straightforward to navigate, locate and apply. For AMC accreditation purposes, the program should report on learning outcomes.	- Descriptions of how overall medical program outcomes* and other relevant learning outcomes/objectives are communicated to students, staff and clinical supervisors. - Descriptions of avenues for students to pursue studies of choice within the program. Interview and observational evidence could include: - Discussions with staff responsible for curriculum development and review on the overall curriculum philosophy. - Discussions with staff in curriculum area or year/phase leadership roles on the implementation of the curriculum. - Discussions with the Aboriginal and/or Torres Strait Islander and Māori leadership role holder(s) and other staff responsible for development and review of the Aboriginal and/or Torres Strait Islander and Māori curriculum on development and review processes, and integration with the overall curriculum. - Discussions with students and teaching staff on their understanding of the formal curriculum documentation and learning outcomes. - Discussions with research staff on the provider's research and scholarship activities and how this informs learning, teaching, research and scholarship within the program. - Discussions with clinical supervisors on medical students' achievement at different stages of the program.		MDANZ: Professionalism and professional identity of our future doctors (2021) Link

Many programs also have learning objectives as a more granular component of learning outcomes. Programs do not necessarily need to report on learning objectives but should explain how these fit within the broader curriculum framework (2.2.9).			

2.3 Learning and teaching

2.3.1 The medical education provider employs a range of fit-for-purpose learning and teaching methods.

2.3.2 Learning and teaching methods promote safe, quality care in partnership with patients.

2.3.3 Students work with and learn from and about other health professionals, including through experience of interprofessional learning to foster collaborative practice.

2.3.4 Students develop and practise skills before applying them in a clinical setting.

2.3.5 Students have sufficient supervised involvement with patients to develop their clinical skills to the required level, and have an increasing level of participation in clinical care as they proceed through the medical program.

2.3.6 Students are provided with opportunities to learn about the differing needs of community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori communities. Students have opportunities to learn how to address systemic disadvantage, power differentials and historical injustices in their practice so as to increase the inclusivity of health services for these groups.

2.3.7 The medical education provider ensures that learning and teaching is culturally safe and informed by Aboriginal and/or Torres Strait Islander and Māori knowledge systems and medicines.

2.3.8 Students undertake an extensive range of face-to-face experiential learning experiences through the course of the medical program. Experiential learning is:

- undertaken in a variety of clinical disciplines
- relevant to care across the life cycle
- situated in a range of settings that include health promotion, prevention and treatment, including community health settings
- situated across metropolitan, regional, rural and, where possible, remote health settings.

2.3.9 Students undertake a pre-internship program.

Explanation	Evidence	Example(s)	Resources
'Fit-for-purpose' learning and teaching methods means that the selections of methods are aligned with the intended learning outcomes, methods of assessment*, and the intended purpose of learning and teaching (2.3.1).	Documentary evidence could include: - Descriptions of how of learning and teaching methods are selected and used during the program to ensure they are	*No examples at this time.*	Curtis, E., R. Jones, D. Tipene-Leach, C. Walker, B. Loring, S.-J. Paine and P. Reid (2019). "Why cultural safety rather than cultural competency is required to achieve health equity: a literature review

For providers to ensure that learning and teaching methods create opportunities for students for partnership with patients*, providers themselves should establish partnerships* with patient communities (2.3.2). Details of these partnerships should be explained under Standard 1.2: Partnerships with communities and engagement with stakeholders*. 'Experience of interprofessional learning*' which 'foster[s] collaborative practice*' involves a coherent program of planning learning activities, undertaken with students from other relevant health professions, where capabilities required for collaborative practice are deliberately developed. The 'required level' of clinical skill development is the level that allows graduates to safely achieve the medical program outcomes* (2.3.5). Students' 'opportunities to learn about the different needs of community groups who experience health inequities* and Aboriginal and/or Torres Strait Islander and Māori* communities' should involve members of those communities in learning, teaching, assessment and/or co-design. The 'different needs' of these communities includes consideration of intersectionality (2.3.6). Learning and teaching that 'is culturally safe' is informed by Aboriginal and/or Torres Strait Islander and Māori knowledge systems and is spiritually, socially, emotionally and physically safe for learners and teachers. Providers should consider the differing needs of Aboriginal and/or Torres Strait Islander and Māori learners engaging with content, Aboriginal and/or Torres Strait	aligned to learning outcomes and assessment. - Agendas and minutes from curriculum/education committees/working groups that demonstrate how learning, teaching and assessment methods are designed and implemented to be fit-for-purpose. - Curriculum map which describes the nexus of learning, teaching and assessment methods. - Examples of how student time is allocated to different learning and teaching formats, such as lectures, simulation sessions, tutorials, laboratory learning, and clinical immersion sessions, during different stages of the program. - Descriptions of the learning and teaching methods employed to develop students' clinical reasoning judgement during different stages of the program. - Descriptions of interprofessional learning activities and initiatives. - Documentation of supervision arrangements and/or scope of practice agreements for students at different phases of the medical program. - Descriptions of opportunities to learn about the differing needs of community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori communities. - Correspondence or other documentation related to community member involvement in learning, teaching, assessment and/or co-design. - Descriptions of the how learning and teaching is informed by Aboriginal and/or		and recommended definition." International Journal for Equity in Health 18(1): 174. Link Harris, R., D. Cormack, J. Stanley, E. Curtis, R. Jones and C. Lacey (2018). "Ethnic bias and clinical decision-making among New Zealand medical students: an observational study." BMC Medical Education 18(1): 18. Link

Islander and Māori staff teaching, and Aboriginal and/or Torres Strait Islander and Māori communities interacting with the program. All identities are valued, and there is mutual respect and sharing of meanings and knowledges (2.3.7). 'Aboriginal and/or Torres Strait Islander and Māori knowledge systems' that providers should consider in their program include: • Social and emotional wellbeing. • Strengths-based discourse. • Decolonisation. While the AMC does not specify minimum contact hours or weeks that medical students must spend in learning environments – clinical, campus, community, laboratories etc. – an 'extensive range of face-to-face experiential learning experiences' means that a meaningful proportion of the medical program should be delivered in-person, particularly clinical learning (2.3.8). All students should be able to undertake a range of 'experiential learning experiences'. Providers should specify which students undertake which learning experiences. All students should have opportunities to undertake experiential learning in both inpatient and outpatient settings. It is noted that not all students will have the opportunity to undertake all experiences offered by the program (2.3.8). Dedicated end-to-end rural pathways will meet this standard if students within these pathways have sufficient opportunities related to healthcare in a variety of clinical disciplines, relevant across the life span, and situated in a range of settings	Torres Strait Islander and Māori knowledge systems and medicines. - Evaluation report of the cultural safety of learning and teaching and acceptance of teaching around Aboriginal and/or Torres Strait Islander and Māori knowledge systems and medicines. - Descriptions of the criteria for selection and review of clinical placements including how the placements allow students to experience a range of types of care that support student achievement of the AMC Graduate Outcome Statements. - Descriptions of how students are assigned to clinical placements. - The full list of placement providers demonstrating the inclusion of a range of placement settings. - Information in tabular form, for each clinical site, of the numbers of students placed and in what department/speciality, broken down by each cohort of the program. - Descriptions of the strategies the provider follows to ensure an extensive range of face-to-face experiential learning opportunities across clinical disciplines, the life span, and in a range of types of care and geographically diverse settings. - A diagrammatic or other representation of the student journey demonstrating the range of placements that a student will have during their program. - Descriptions of the design and implementation of the pre-internship program. Interview and observational evidence could include:		

including health promotion, prevention and treatment (2.3.8). That learnings experiences are 'undertaken in a variety of clinical disciplines' refers to clinical placements* being planned and structured to enable students to demonstrate achievement of learning outcomes across clinical disciplines in both general and speciality medicine and surgery, as well as women's health, child and adolescent health, mental health and primary care. Placements may be integrated (particularly in rural settings) and do not need to be specific to a clinical discipline, but providers should be able to demonstrate how students will gain experience in these clinical disciplines throughout their clinical learning placement (2.3.8). In pre-internship programs*, the learning needs of students are explicit and central, and the role of the student, as well as their scope of practice within the clinical team, is clearly defined and articulated. The AMC does not specify the content of or minimum contact hours or weeks for pre-internship programs. The provider should be able to justify the content and length of the pre-internship program as sufficient to facilitate a safe transition to internship through consolidation of clinical knowledge and provision of strategies and skills relevant to internship. Providers and training sites should be partners* in ensuring the quality of student learning, assessment and support. Prevocational training providers* are key stakeholders to engage while designing pre-internship programs (2.3.9).	- Discussions with students on the quality of their clinical learning opportunities. - Discussions with community stakeholders on their involvement in learning, teaching, assessment and/or co-design in the program, and the cultural safety of these activities. - Discussions with Aboriginal and/or Torres Strait Islander and Māori students and staff on the cultural safety of learning and teaching. - Discussions with Aboriginal and/or Torres Strait Islander and Māori students and mainstream students on the content of Aboriginal and/or Torres Strait Islander and Māori knowledge systems and medicine that is taught. - Discussions with clinical supervisors on supervision and scope of practice arrangements for students. - Discussions with clinicians or tutors from other health professions on their involvement in the medical program. - Observation of key learning and teaching activities.		

Standard 3: Assessment

3.1 Assessment design

3.1.1 Students are assessed throughout the medical program through a documented system of assessment that is:

- consistent with the principles of fairness, flexibility, equity, validity and reliability
- supported by research and evaluation information evidence.

3.1.2 The system of assessment enables students to demonstrate progress towards achieving the medical program outcomes, including described professional behaviours, over the length of the program.

3.1.3 The system of assessment is blueprinted across the medical program to learning and teaching activities and to the medical program outcomes. Detailed curriculum mapping and assessment blueprinting is undertaken for each stage of the medical program.

3.1.4 The system of assessment includes a variety of assessment methods and formats which are fit for purpose.

3.1.5 The medical education provider uses validated methods of standard setting.

3.1.6 Assessment in Aboriginal and/or Torres Strait Islander and Māori health and culturally safe practice is integrated across the program and informed by Aboriginal and/or Torres Strait Islander and Māori health experts.

Explanation	Evidence	Example(s)	Resources
A 'system of assessment*' refers to how the medical program explicitly blends separate assessments to achieve the different purposes, for a variety of stakeholders*. A system of assessment should assess knowledge, skills and behaviours students are expected to learn in the medical program and use resources to address the needs of students, educators, healthcare system, patients and other stakeholders. The system should promote learning and appropriate standards. Separate	Documentary evidence could include: - Assessment planning documents across the program, such as an assessment strategy and key assessment policies, regulations and rules, and assessment requirements. - The high-level assessment schedule across the program. This could include the weight of individual assessments, the approach to the extent to which performance in some assessment activities can compensate for	An example from **Bond University, Faculty of Health Science and Medicine:** Phase 2 (YR4-5) of the Medical Program underwent a major change in structure in 2023, where MD students will now progress at the end of each Subject/Semester, rather than at the end of each year. This 'Semesterisation' allows greater flexibility in use of student placement in the 2-year MD journey, gives students the opportunity to personalise their MD learning journey and	Norcini J., Anderson M.B. et al. (2018) Consensus framework for good assessment. Med Teach. 2018 Nov;40(11):1102-1109. Link

assessments within the system should be supported by quality assurance processes (see Standard 3.3: Assessment quality). The system, and the separate assessments within the system, should be consistent with assessment principles and evidence-informed criteria (such as purposes-driven, acceptability, transparency, coherence, etc.) (3.1.1, 3.1.2, 3.1.3 and 3.1.4). 'Professional behaviours' that students should be able to demonstrate progress towards achieving through assessment include culturally safe behaviours (3.1.2). The named principles of assessment (fairness, flexibility, equity, reliability, validity) are often interconnected and are complex concepts. Providers may choose to adopt additional principles to guide the design and implementation of their system of assessment. A few simple examples of how principles of assessment interact could include: • Accessibility of assessment such as approaches to reasonable adjustments/accommodations or transparency of rules/regulations/policies (fairness, equity). • Factors affecting reliability/precision/consistency of assessment and how that is considered during the assessment process (validity, reliability). • Consideration of student circumstances that may require flexibility in administration (flexibility).	underperformance in others, and requirements for progression (e.g. barrier/hurdle requirements). - Descriptions of how the governance of the program supports the system of assessment. - Descriptions of how assessment is resourced across the program. - Supporting research and evaluation evidence that demonstrate that the system and single assessments are working as intended. - Blueprints at system level that demonstrate how the system and single assessments align with the medical program outcomes*. - Blueprints at single assessment level which demonstrate alignment of curriculum to the assessment, and to learning and teaching activities in each stage of the medical program. - Descriptions of how the blueprints at single assessment level are made coherent with the blueprints at system level. - Descriptions of the validated standard-setting methods. - Planning and implementation documents related to Aboriginal and/or Torres Strait Islander and Māori health assessment demonstrating how assessment methodologies are informed by Aboriginal and/or Torres Strait Islander and Māori health experts and pedagogies.	accommodates two cohorts of students into the MD at different points in the calendar year. It also allows students who fail a Subject to repeat the component that caused them to fail, rather than repeat a whole year of content. *How does this fit in the broader system of assessment?* The MD Program Blueprint (Outcome 3.1.3) details the assessment journey of a medical student as they progress through the 5 year program. It details the transition from Phase 1 block-based teaching and assessment with a focus on assignments and exams for score and grades through to an Ungraded pass/fail competency model as students enter Phase 2. This two-year clinical apprenticeship has a focus on evaluation of multiple Workplace based assessments, clinical performance in OSCE and multiple, longitudinal lower stakes tests of intern-level knowledge known as Progress Tests (Outcome 3.1.4). Students repeating one semester for failure of a domain of competency rather than the whole year is determined to be more consistent with the principles of fairness (Outcome 3.1.1) and students are given a carefully curated, mentored and monitored repeat clinical experience, designed to meet their identified individual learning needs to support them to achieve their academic potential. Evaluation of Repeat subject pass/fail rates will be monitored to ensure this strategy is sound.	

• Influence of cultural safety* considerations on assessment design (equity, validity). • Equity of access to technology used in the assessment process (fairness, equity). • Defensibility of assessment decision making (validity). 'Fit-for-purpose' assessment methods refers to the selection of methods being appropriate to the intended learning outcomes, the learning and teaching activities, and the intended purpose of assessment (3.1.4). That assessment in Aboriginal and/or Torres Strait Islander and Māori health and culturally safe practice is 'integrated across the program' refers to this assessment being embedded across curriculum areas and different medical disciplines and occurring regularly throughout the program, rather than only being assessed within stand-alone Aboriginal and/or Torres Strait Islander and Māori health components of the program and/or isolated to a few points in time (3.1.6).	Interview and observational evidence could include: - Discussions with staff responsible for assessment on the program's approach to assessment. - Discussions with staff implementing the curriculum on how the assessment links to learning and teaching in the program. - Discussions with students on their experience of assessment, particularly aspects related to transparency, equity and fairness. - Discussions with Aboriginal and/or Torres Strait Islander and Māori staff and experts on the integration and involvement of experts in Aboriginal and/or Torres Strait Islander and Māori health assessment development and implementation. - Observation of key assessment activities.	*What led to this change?* To meet the growing needs of the Australian Health System for interns, Bond Medical Program has had two intakes of students since 2020, entering in the May and September semesters. The 2023 change to Rules of Assessment and Progression from year-long Subjects to progression at the end of each semester, aims to provide both cohorts with an equitable clinical learning experience but to take advantage of the two entry points to Phase 2, allowing students to do an Honours Subject or take a leave of absence for managing life experiences such as giving birth, managing illness or carers leave without significant time penalty. The Medical Program has simultaneously expanded the placements offering allowing students increased ability to personalise and enrich their medical journey with choice of placements, domestically and internationally. Equity of student experience in Phase 2 (Outcome 3.1.1) whilst providing this flexibility is supported by regular communication to clinical sites and Leads via Joint Placements meetings and the sharing of best practice via Clinical Advisory Board meetings. The student experience is monitored via Clinician Advisory Board meetings, TEVALs and Clinical Placement evaluation surveys (Evaluation outcome). Contact – A/Prof Carmel Tepper Academic Assessment Lead ctepper@bond.edu.au	

3.2 Assessment feedback

3.2.1 Opportunities for students to seek, discuss and be provided with feedback on their performance are regular, timely, clearly outlined and serve to guide student learning.

3.2.2 Students who are not performing to the expected level are identified and provided with support and performance improvement programs in a timely manner.

3.2.3 The medical education provider gives feedback to academic staff and clinical supervisors on student cohort performance.

Explanation	Evidence	Example(s)	Resources
Feedback that is 'clearly outlined' and 'serve[s] to guide student learning' should be transparent and related to specific learning outcomes and their component objectives. 'Performance improvement programs' refer to a formal process to assist students who are experiencing difficulties to improve their performance, with a focus on early identification, provision of feedback and support. Providers should recognise in the design of performance improvement programs that multiple factors can impact on performance, including individual skills, wellbeing and the work environment. All these factors should be considered and addressed in a performance improvement program (3.2.2). Providers should provide regular and actionable feedback to academic staff and clinical supervisors* on student cohort performance (3.2.3). The process and outcomes of providing this feedback should be explained under Standard 3.2: Assessment feedback. The communication of more formal evaluation* and continuous improvement to stakeholders*, including internal stakeholders like academic staff and clinical supervisors, should be explained under Standard 6.3: Feedback and reporting.	Documentary evidence could include: - Descriptions of processes that determine how feedback is sought by, discussed with and provided to students, including any policies that support feedback processes. - Case studies of feedback to students that show how feedback is regular, timely and clearly outlined, students are able to take action of that feedback and, therefore the feedback serves to guide student learning. - Sample feedback forms and feedback rubrics, accompanied with descriptions of how these are used in practice. - Description of student input/engagement on developing feedback reports. - Agendas and minutes from meetings of education-related committees and/or assessment committees that demonstrate how feedback issues are addressed. - Descriptions of how students who are not performing to the expected level are identified and provided with support and performance improvement or learning programs, and the strategies/policies that support these performance improvement programs. - Example of individualised performance improvement programs.	*No examples at this time.*	*No resources at this time.*

	- Descriptions of the mechanisms to provide feedback to supervisors and students on student cohort performance. Interview and observational evidence could include: - Discussions with students on how they seek and are provided with feedback; and how performance improvement programs function. - Discussions with academic staff and clinical supervisors on how they approach feedback and performance improvement programs; and the feedback they receive from the provider on student cohort performance.		

3.3 Assessment quality

3.3.1 The medical education provider regularly reviews its system of assessment, including assessment policies and practices such as blueprinting and standard setting, to evaluate the fairness, flexibility, equity, validity, reliability and fitness for purpose of the system. To do this, the provider employs a range of review methods using both quantitative and qualitative data.

3.3.2 Assessment practices and processes that may differ across teaching sites but address the same learning outcomes, are based on consistent expectations and result in comparable student assessment burdens.

Explanation	Evidence	Examples	Resources
The AMC does not specify how regularly providers should review their systems of assessment*, but the frequency of review should be supported by evidence and maintain the continued fitness for purpose underpinned by the key principles outlined in Standard 3.1: Assessment design. The 'range of review methods' providers employ may, depending on the mix of assessments used, include psychometric analyses, benchmarking or calibration analyses, analyses of passing and attrition rates across the program, feedback from staff, and feedback from students (e.g. via surveys or other mechanisms) (3.3.1). That assessment 'may differ' across teaching sites refers to the provider having the discretion to implement a mix of common and site-specific assessments that would be appropriate for the program, with attention to the implications of doing so (3.3.2).	Documentary evidence could include: - Descriptions of the review process applied to the system of assessment, including how the provider evaluates fairness, flexibility, equity, validity, reliability and fitness for purpose, and the regularity of the review. - Reports on the design/ review of the system of assessment. - Agendas and minutes from meetings of governance committees that relate to assessment. - Student surveys/questionnaires on student experience of assessment and analysis of feedback related to assessment. - Case studies of how changes to the system of assessment have emerged from review processes. - Analyses of assessment outcomes across education sites. - Assessment rubrics. - Assessor training session materials. - Blueprints of separate assessments. - Curriculum-assessment blueprints demonstrating alignment of learning	An example from **University of Melbourne, Melbourne Medical School**: Our approach to maximising reliability and validity of our assessments includes selection of appropriate and authentic assessment tasks, constructive alignment with teaching and learning activities, (including blueprinting to reflect teaching emphasis), standardisation of assessments, and use of sampling where standardisation is not appropriate. Our approach involves expert item writers and team-based assessment development processes, involvement in benchmarking activities, ongoing staff development opportunities, rigorous standard setting procedures, detailed post-test psychometric analysis and extensive evaluation processes. Our Clinical Assessment Review Panel (CARP) meets fortnightly throughout the academic year to develop and review the OSCE and SCBD stations used throughout the program. Membership of this group includes members of the assessment team, subject coordinators, discipline leads and teaching staff from clinical school sites. Our Written Assessment Review Panel (WARP) meets weekly throughout the year to produce, critique and review our new written assessment items. Membership	*No resources at this time.*

To ensure assessment practices and processes are 'based on consistent expectations', the provider should, depending on the assessment method, provide marking rubrics, engage in activities that support examiner and assessor consistency in assessment methods that incorporate standardised elements, adopt appropriate standard setting, and incorporate benchmarking/calibration activities across sites (3.3.2). 'Student assessment burdens' refers to the amount of time spent preparing for, traveling to and undertaking assessments. Providers should consider how to manage these burdens in cases where groups of students may have a higher burden, such as for students who travel to undertake an assessment (3.3.2).	outcomes, learning objectives and sampling strategies Interview and observational evidence could include: - Discussions with academic staff responsible for assessment about review processes for assessment, training sessions etc. - Discussions with students in different sites about their relative assessment experiences and assessment burdens.	includes assessment team members, subject coordinators, discipline leads and staff closely involved in clinical teaching delivery at multiple sites. Likewise, we have Situational Judgment Test review panel – who develop and refine our SJT items in collaboration with our professional practice team and year level and subject coordinators. The medical course continues to benchmark its students' performances nationally across all years of the MD through engagement with AMSAC, MDANZ and AMC benchmarking projects. Staff development opportunities include short courses, workshops in assessment item development, online assessor training modules, and formal study in assessment through the Excellence in Clinical Teaching Program (EXCITE). We regularly offer item writing workshops to promote skill development without our Department and invite attendance from members of Faculty who contribute to our teaching and assessment program. We have an online assessor training modules (for OSCE, CEX and SCBD assessments) to assist with the training and calibration of examiners of clinical assessments. These modules include simulated videos of typical student performance at borderline and clear pass levels for all clinical examination formats. Examiners are required to view and score the performances prior to the formal examination in addition to the just-in-time assessor training on the morning of each assessment delivery. The Evaluation Team (in consultation with the assessment team) prepares assessment reports for the Board of Examiners meetings at the completion of each subject. These reports provide reliability coefficients and compare variability within items/stations and across years and then submitted to the MD Operations Committee. Following committee review, the reports are circulated broadly to support ongoing staff development and quality improvement.	

Standard 4: Students

4.1 Student cohorts and selection policies

4.1.1 The size of the student intake is defined in relation to the medical education provider's capacity to resource all stages of the medical program.

4.1.2 The medical education provider has defined the nature of the student cohort, including targets and strategies for recruiting Aboriginal and/or Torres Strait Islander and Māori students, students with rural backgrounds and students from equity groups to support increased participation of these students in medical programs.

4.1.3 The medical education provider complements targets and strategies for recruiting Aboriginal and/or Torres Strait Islander and Māori students, students with rural backgrounds and students from equity groups with infrastructure and supports for student retention and graduation.

4.1.4 The medical education provider supports inclusion of students with disabilities.

4.1.5 The selection policy and admission processes are transparent and fair, and prevent racism, discrimination and bias, other than explicit affirmative action, and support the achievement of student selection targets.

Explanation	Evidence	Example(s)	Resources
If the provider intends to increase the size of the student intake, the provider should have plans and associated resources in place to ensure the current student experience and outcomes of the medical program* are not negatively impacted (4.1.1). In medicine and medical education, there is significant underrepresentation of Aboriginal and/or Torres Strait Islander and Māori people, people from rural backgrounds and people from equity groups*. The aim of targets and strategies for recruitment and retention of these groups should be to reduce and ultimately eliminate the underrepresentation of these groups in medicine and medical education.	Documentary evidence could include: - Numbers of students, including by cohort and by demographic category and other characteristics and qualities relevant to program and provider context and communities that it serves, for at least the prior five years. These numbers should also be broken down by entry pathway and type of student (e.g. in Australia, Commonwealth Supported Places, Bonded Medical Places, full fee-paying domestic and international students). - Details of student attrition rates, including the reasons for attrition, by cohort and by	*No examples at this time.*	LIME Network: Pathways Into Medicine (no date) Link AIDA: Healthy Futures – Defining best practice in the recruitment and retention of Indigenous medical students (2005) Link MDANZ and AIDA: National Medical Education Review – A review of the implementation of the Indigenous Health Curriculum Framework and

These strategies and supports should be clearly defined, appropriate to the differing needs of these communities, and aligned with community expectations (4.1.2 and 4.1.3). Providers should define the 'equity groups' that are targeted and supported to participate in the medical program, in partnership* with stakeholders* and local communities and with reference to relevant evidence (4.1.2 and 4.1.3). See the glossary definition of equity groups. 'Defin[ing] the nature of the student cohort' also includes setting the numbers of international students and domestic students, including numbers through different funding pathways, that the provider targets to form student cohorts (4.1.2). 'Infrastructure… for student retention and graduation' refers to the physical infrastructure and technology which support student success for Aboriginal and/or Torres Strait Islander and Māori students, students with rural backgrounds and students from equity groups. 'Supports' for these purposes refers to the accessible services named in standard 4.2.2 and additional health and learning support mentioned in standard 4.2.3, but also community networks, dedicated staffing, professional development opportunities (such as resourcing to attend key conferences and networking events) and others that are connected to strategies for recruiting these students (4.1.3). Providers should explain under Standard 4.1: Student cohorts and selection policies, how the available infrastructure and support is strategically linked to the strategies for recruiting Aboriginal and/or Torres Strait Islander and Māori students, students with rural backgrounds and students from equity groups.	demographic category that the provider tracks, for at least the prior three years. - The selection policy or policies, including information on governance and appeals. - Documentation around the admission process. - Summary table of selection steps, instruments, weightings and timelines; including how any standardised admission tests such as the GAMSAT and MCAT are used as part of the selection process. - Descriptions of how resources such as teaching staff, physical facilities including teaching spaces, and available numbers of placements are sufficient for the size of the student intake. If there are plans to increase the size of the student intake, descriptions of how these resources are or will be sufficient for the planned intake size. - The strategy for recruiting Aboriginal and/or Torres Strait Islander and Māori people, people with rural backgrounds and people from equity groups, including details on targets. - A description of the infrastructure and support provided to applicants and students who are Aboriginal and/or Torres Strait Islander and Māori, from rural backgrounds and from equity groups. - A description of policies, resources, staff and physical infrastructure that support applicants and students with disabilities. - Descriptions of initiatives that increase the participation of Aboriginal and/or Torres Strait Islander and Māori people, people with rural backgrounds and people from equity groups in the medical program; particularly initiatives based on an analysis of cohorts of students. Interview and observational evidence could include:		the Health Futures report within Australian medical schools (2012) Link Curtis, E., Townsend S. and Airini (2012). "Improving Indigenous and ethnic minority student success in foundation health study." Teaching in Higher Education 17(5): 589-602. Link

The specific details of support services should be explained under Standard 4.2: Student wellbeing. Specific details of physical facilities and ICT infrastructure should be explained under Standard 5.1: Facilities. A provider that 'supports inclusion' of students with disabilities: • Ensures that policies, procedures and support mechanisms are based on the principles of equity, inclusion and diversity. • Works to provide accessible physical, educational and social environments within program sites. • Provides appropriate staff resources and expertise such as a disability liaison officer. • Considers how to reduce barriers to entry for the medical program, for example by developing a disability entry pathway into the program (4.1.4).	- Discussions with staff responsible for admissions on the admissions strategy, including the (part of the) strategy specific to Aboriginal and/or Torres Strait Islander and Māori people, people with rural backgrounds and people from equity groups. - Discussions with community stakeholders, including Aboriginal and/or Torres Strait Islander and Māori communities, on how they are involved in developing and implementing the admissions strategy. - Discussions with Aboriginal and/or Torres Strait Islander and Māori students and support staff on the efficacy of support that enables the recruitment and retention of Aboriginal and/or Torres Strait Islander and Māori people, people with rural backgrounds and people from equity groups.		

4.2 Student wellbeing

4.2.1 The medical education provider implements a strategy across the medical program to support student wellbeing and inclusion.

4.2.2 The medical education provider offers accessible services, which include counselling, health and learning support to address students' financial, social, cultural, spiritual, personal, physical and mental health needs.

4.2.3 Students who require additional health and learning support, or reasonable adjustments/accommodations, are identified and receive these in a timely manner.

4.2.4 The medical education provider:

- implements a safe and confidential process for voluntary medical student self-disclosure of information required to facilitate additional support and make reasonable adjustments/accommodations within the medical program
- works with health services to facilitate medical student self-disclosure of this information through safe and confidential processes before and during the transition to internship. These processes are voluntary for medical students to participate in, unless required or authorised by law.

4.2.5 The medical education provider implements flexible study policies relevant to the students' individualised needs to support student success.

4.2.6 The provision of student support is separated from decision-making processes about academic progression.

4.2.7 There are clear policies to effectively identify, address and prevent bullying, harassment, racism and discrimination. The policies include safe, confidential and accessible reporting mechanisms for all learning environments, and processes for timely follow-up and support. The policies, reporting mechanisms and processes support the cultural safety of learning environments.

Explanation	Evidence	Example(s)	Resources
A provider's strategy to support medical student wellbeing and inclusion should include: • An identification of the risks to student wellbeing and inclusion, including those emerging from institutional structures and environments, and how the provider does or intends to mitigate these risks. • The types of support services offered and how students access these services. • How students who require additional supports are identified and receive support.	Documentary evidence could include: - Student wellbeing and inclusion strategy or strategies. - The Disability Action Plan policy or similar policy regarding how provider supports individuals with disabilities. - The number of students, including students with disabilities, receiving additional health and learning support.	*No examples at this time.*	Kemp S., Hu W., Bishop J., et al. (2019) Medical student wellbeing – a consensus statement from Australia and New Zealand. BMC Med Educ. 19(69) Link MDANZ: Inclusive Medical Education – Guidance on medical program applicants and students with a disability (2021) Link

• How flexible study* policies contribute to student wellbeing. • Approaches to address bullying, harassment, racism, and the impact of systemic bias on students. • Crisis management strategies, including a suicide postvention policy/strategy (4.2.1, 4.2.2, 4.2.3, 4.2.5, 4.2.7). 'Accessible' services include accessible to students with disabilities, students with varying study and caring commitments, and students learning in locations geographically distant from university campuses. The medical education provider may offer student support services directly or through arrangements with external organisations (4.2.2). The terms 'reasonable adjustments' in Australia and 'reasonable accommodations' in Aotearoa New Zealand have implications in each countries' and international human rights law. Key legislation in Australia includes the *Disability Discrimination Act 1992* and the *Commonwealth Disability Standards for Education 2005.* Key legislation in Aotearoa New Zealand includes the *Human Rights Act 1993*. 'Reasonable adjustments/ accommodations' in these standards refer to reducing barriers to ensure that people with a disability or health condition have access to medical programs and participate in the academic, occupational and social activities of their education and training. In making reasonable adjustments/ accommodations, providers ensure that the academic integrity of the medical program is maintained (4.2.3 and 4.2.4). Providers should have processes in place to ensure that students from equity groups* and Aboriginal and/or Torres Strait Islander and Māori students who require additional supports or adjustments/ accommodations are identified and provided this support in a timely manner. For	- Agendas and minutes from meetings with and/or correspondence with health services related to medical student/graduate self-disclosure of information processes. - Flexible study policies, including as relevant part-time study policy, return to study policy and/or recognition of prior learning policy. - Descriptions/case studies of how students' individualised needs, including to meet cultural and community obligations, are met through flexible study policies. - Bullying, harassment, racism and discrimination policies. - Descriptions/case studies of how bullying, harassment, racism and discrimination policies function in practice. Interview and observational evidence could include: - Discussions with support staff on the scope and efficacy of the wellbeing and inclusion strategy including support services. - Discussions with students on support services and flexible study policies. - Discussions with Aboriginal and/or Torres Strait Islander and Māori students on their access to flexible study. - Discussions with health service staff on student support need self-disclosure mechanisms.		Tweed, M. and Wilkinson, T. (2022) Making accommodations for medical students' long-term conditions in assessments: An action research guided approach, Medical Teacher 44(5), 519-526 Link MDANZ: Discussion paper – Creating a Culture of Support for medical students and graduates transitioning into practice (2021) Link MDANZ: Consensus Statement on Postvention Planning (2023) Link The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute: National Safety and Quality Health Service Standards user guide for Aboriginal and Torres Strait Islander Health (2017) Link

Aboriginal and/or Torres Strait Islander and Māori students, these processes and additional supports should be culturally safe and allow Aboriginal and/or Torres Strait Islander and Māori students to meet cultural and community obligations (4.2.3). The identification of students who require additional health and learning support and reasonable adjustments/ accommodations and provision of this support should aim to be a proactive process (4.2.3). Providers should explain how this proactive identification of students and provision of supports interacts with the performance improvement program under Standard 4.2: Student wellbeing. Providers should explain the details of performance improvement programs under Standard 3.2: Assessment feedback. The 'safe' voluntary self-disclosure of information by medical students includes the medical program fostering a culture and setting up systems that build up student trust and confidence. Medical programs should develop and evaluate self-disclosure processes in partnership* with students and the health services/prevocational training providers* that commonly employ their graduates (4.2.4). 'Flexible study policies*' should address the needs of students with specific cultural and community obligations, including Aboriginal and/or Torres Strait Islander and Māori students (4.2.5). For providers to ensure that processes for student support provision and for academic progression are 'separated', staff members who are responsible for student support provision should not also have responsibility for academic progression decisions (4.2.6). Staff should be covered and protected by policies around bullying, harassment, racism and discrimination. 'Harassment' also includes sexual harassment (4.2.7).			

Policies, reporting mechanisms and processes around bullying, harassment, racism and discrimination that 'support the cultural safety* of learning environments' should be led by Aboriginal and/or Torres Strait Islander and Māori people and include cultural supports. Specific policies may include anti-racism policies and approaches to creating a welcoming environment.			

4.3 Professionalism and fitness to practise

4.3.1 The medical education provider implements policies and timely procedures for managing medical students with an impairment when their impairment raises concerns about their fitness to practise medicine or their ability to interact with patients, including in a culturally safe way.

4.3.2 The medical education provider implements policies and timely procedures for identifying, managing and/ or supporting medical students whose professional behaviour raises concerns about their fitness to practise medicine or their ability to interact with patients, including in a culturally safe way.

Explanation	Evidence	Example(s)	Resources
'Impairment' is defined by the Health Practitioner Regulation National Law under Section 5 as, "in relation to the person, means the person has a physical or mental impairment, disability, condition or disorder (including substance abuse or dependence) that detrimentally affects or is likely to detrimentally affect… for a student, the student's capacity to undertake clinical training." Many disabilities, conditions and disorders that have some detrimental effect on capacity to undertake clinical training can be accommodated through reasonable adjustments/ accommodations, and providers are expected to support the inclusion of students with disabilities where reasonable adjustments/ accommodations are possible (see Standard 4.1: Student cohorts and selection policies and Standard 4.2: Student wellbeing). Students will require management through formal processes and, where relevant, involving training sites and regulators including the Australian Health Practitioner Regulation Agency, when an impairment may impact on patient safety in terms of the student's fitness to practice medicine and ability to interact with patients generally (4.3.1). Providers' policies and procedures to identify, manage and/or support students whose professional behaviour raises patient safety concerns should be sufficiently robust to protect patient safety. As part of these processes, students should be supported in the aim to address the concerns. These students should be monitored and managed through formal processes involving, where relevant, training sites and regulators including the Australian Health Practitioner Regulation Agency (4.3.2).	Documentary evidence could include: - Policies and procedural documents for managing students with an impairment. - Policies and procedural documents for identifying, managing and/or supporting students with professional behaviour concerns. - Flow diagrams depicting these processes. - Descriptions of mechanisms to involve training sites and regulators in patient safety concerns about student impairment and professional behaviours. - Anonymised descriptions or reports about management of specific student impairments and professional behaviours. - Description of processes for identifying students who may be unsuited to continue in the program and pathways for these students to exit the program. Interview and observational evidence could include: - Discussions with staff on the implementation of impairment policies and procedures.	*No examples at this time.*	*No resources at this time.*

Staff and clinical supervisors* who regularly interact with students should be aware of these policies and procedures, particularly their obligations and reporting mechanisms (4.3.1 and 4.3.2). For both impairments and professional behaviours, considerations around patient safety always include cultural safety*, including for Aboriginal and/or Torres Strait Islander and Māori* people (4.3.1 and 4.3.2).	- Discussions with staff on student professional behaviour policies and procedures. - Discussions with clinical supervisors on raising concerns about impairment and/or professional behaviours with the provider. - Discussions with students on how impairment and professional behaviour concerns are addressed.		

4.4 Student indemnification and insurance

4.4.1 The medical education provider ensures that medical students are adequately indemnified and insured for all education activities.

Explanation	Evidence	Example(s)	Resources
N/A	Documentary evidence could include: - Policies regarding student indemnification. - Descriptions of insurances held by the provider.	*No examples at this time.*	*No resources at this time.*

Standard 5: Learning environment

5.1 Facilities

5.1.1 The medical education provider has the educational facilities and infrastructure to deliver the medical program and achieve the medical program outcomes.

5.1.2 Students and staff have access to safe and well-maintained physical facilities in all learning and teaching sites. The sites support the achievement of both the medical program outcomes and student and staff wellbeing, particularly for students and staff with additional needs.

5.1.3 The medical education provider works with training sites and other partners to provide or facilitate access to amenities that support learning and wellbeing for students on clinical placements. This includes accommodation near placement settings that require students to be away from their usual residence.

5.1.4 The medical education provider uses technologies effectively to support the medical program's learning, teaching, assessment and research.

5.1.5 The medical education provider ensures students have equitable access to the clinical and educational application software and digital health technologies to facilitate their learning and prepare them for practice.

5.1.6 Information services available to students and staff, including library and reference resources and support staff, are adequate to meet learning, teaching and research needs in all learning sites.

Explanation	Evidence	Example(s)	Resources
'Educational facilities and infrastructure' includes classrooms, staff offices and rooms, study areas, simulation facilities, labs, information communication technologies (such as internet access), and other facilities and infrastructure that explicitly facilitate learning and teaching. 'Physical facilities' include the general buildings, general use spaces, toilets, parking, transit hubs, and other facilities that support students and staff but are not explicitly used for learning and teaching. 'Amenities' are services such as accommodation, gyms and food services (5.1.1, 5.1.2 and 5.1.3) Physical facilities that support student and staff wellbeing are appropriate for their needs and inclusive of those with specific and unique additional needs. For instance, students and staff who are parents or carers of young children require appropriate spaces for feeding and	Documentary evidence could include: - Descriptions of educational facilities and infrastructure available to the medical program, including access arrangements. - Descriptions of physical facilities available to the medical program, including how these contribute to student and staff wellbeing. - Descriptions of amenities available to students on placements, including how these support student learning and wellbeing. - Descriptions of major capital works or other initiatives that expand, reduce or otherwise affect access to educational facilities and infrastructure, physical facilities and amenities.	*No examples at this time.*	*No resources at this time.*

changing. Another example is that wheelchair users require accessible facilities (5.1.2). Aboriginal and/or Torres Strait Islander and Māori students and staff should be provided with designated safe spaces to support their wellbeing where reasonable (5.1.2). Technologies that 'support the medical program's teaching, learning, assessment* and research' would include, for example, Learning Management Systems, Assessment Management Systems, curriculum mapping tools and electronic portfolio systems (5.1.4). Amenities that 'support learning and wellbeing', including accommodation, should be safe and reasonably affordable for students who require it. In the case of accommodation, this may require that providers make housing vouchers available or build accommodation (5.1.3). Technology that providers use and ensure access to for delivery of their medical program should be reliable and fit for purpose (5.1.4 and 5.1.5). 'Equitable access' refers to an understanding that not all clinical placement* sites will provide students with access to all technologies used in the curriculum, but that students should have access to core curriculum, teaching, learning and assessment delivery technologies such as the Learning Management System, online information services and any other technology required to achieve medical program outcomes* (5.1.5).	- Student survey questionnaires and analysis of feedback related to educational facilities and infrastructure, physical facilities and amenities, including whether responses differ at varying program sites. - Placement site accommodation provision policy. - Descriptions of clinical and educational technologies available at different clinical placement sites. - Documentation around technical capabilities of technologies used to support teaching, learning, assessment and research, such as the Learning Management System, including policies/guides on their use. - Descriptions of how a Learning Management System and/or curriculum mapping tool is used to support learning and teaching delivery. - Descriptions of how an Assessment Management System and/or electronic portfolio is used to support assessment teams and outcomes. - Descriptions of library, reference resources, and support staff available to students, and how access is distributed across program sites. - Review of policies that outline the process and the frequency of reviews of facilities, amenities, and technologies to ensure continued alignment to medical program outcomes and purpose. Interview and observational evidence could include: - Discussions with students on the nature of educational facilities and infrastructure, physical facilities, amenities, and access to various technologies; including how this may differ across program sites. - Discussions with Aboriginal and/or Torres Strait Islander and Māori students and staff on the provision of safe spaces.		

	- Discussions with academic and professional staff on the program's needs and uses of technology in the delivery of the medical program. - Observation of campuses and key clinical placement sites. - Observation of the educational facilities and infrastructure, physical facilities and amenities. - Observation of library and reference resources.		

5.2 Staff resources

5.2.1 The medical education provider recruits and retains sufficient academic staff to deliver the medical program for the number of students and the provider's approach to learning, teaching and assessment.

5.2.2 The medical education provider has an appropriate profile of professional staff to achieve its purpose and implement and develop the medical program.

5.2.3 The medical education provider implements a defined strategy for recruiting and retaining Aboriginal and/or Torres Strait Islander and Māori staff. The staffing level is sufficient to facilitate the implementation and development of the Aboriginal and/or Torres Strait Islander and Māori health curriculum, with clear succession planning.

5.2.4 The medical education provider uses educational expertise, including that of Aboriginal and/or Torres Strait Islander and Māori people, in developing and managing the medical program.

5.2.5 The medical education provider recruits, supports and trains patients and community members who are formally engaged in planned learning and teaching activities. The provider has processes that are inclusive and appropriately resourced for recruiting patients and community members, ensuring the engagement of community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori communities.

5.2.6 The medical education provider ensures arrangements are in place for indemnification of staff with regard to their involvement in the development and delivery of the medical program.

Explanation	Evidence	Example(s)	Resources
'Sufficient' academic staff refers to the numbers of employed staff, reasonable turnover and vacancy rates for key staff roles, and that employed staff are appropriately skilled and have relevant expertise to cover the range of educational needs of the program, learning and teaching methods and workload and assessment* required for all students to achieve the AMC graduate outcome statements (5.2.1). An 'appropriate profile' of professional staff refers to the numbers of staff and their roles, particularly in addressing curriculum priorities. Key areas include administration, information technology, laboratory support, student wellbeing, and	Documentary evidence could include: - The human resources strategy. - The number of funded academic positions associated with the medical program, currently filled or vacant, expressed in full-time equivalent and numbers of staff. - Details of annual medical program staff turnover and vacancy rates. - For vacant positions, a description of which roles are essential to the delivery of the medical program, how the key responsibilities are covered while the role is vacant, and recruitment processes in place.	*No examples at this time.*	Huria, T., Lacey, C., Pitama, S. (2013) Friends with benefits: should Indigenous medical educators involve the Indigenous community in Indigenous medical education? In, LIME Network: LIME Good Practice Case Studies, Vol 2. FMDHS UoM, Melbourne 35-38. Link

managing engagement with clinical partners* and communities. (5.2.2). Strategies for recruiting and retaining Aboriginal and/or Torres Strait Islander and Māori staff may include: • "Grow your own" processes for creating interest in and opportunities for Aboriginal and/or Torres Strait Islander and Māori students, junior staff and leaders. • Identification of risks, such as cultural safety* concerns, cultural loading and key person risks (5.2.3). 'Educational expertise' can be garnered through a range of qualifications and expertise. The contribution of this expertise should generally be formalised through identified educational and teaching roles, and access to continuing professional development (5.2.4). Details of professional development opportunities available to staff should be reported under Standard 5.3: Staff appointment, promotion and development. Learning and teaching activities should be informed by and, when relevant, directly engage patients and community members to meet these standards and ensure graduates achieve the AMC graduate outcome statements. Providers should understand barriers to participation and work to mitigate these where possible. Patients and community members from community groups who experience health inequities* and Aboriginal and/or Torres Strait Islander and Māori* communities should be involved in learning and teaching activities: • In a culturally safe manner. • Respecting and acknowledging their lived experience.	- Descriptions of how the provider tracks the sufficiency of academic staff and the profile of professional staff. - If the numbers of academic and/or professional staff are or are intended to be reduced, an impact analysis of the reduction on student and staff experience, which includes stakeholder views, and the ability of the provider to achieve its purpose and implement and develop the program. - Organisational charts/flow charts outlining the overall structure and reporting lines of academic and professional staffing and teams. - Descriptions of the general role and duty allocations of clinical titleholders and conjoint appointments. - The recruitment and retention strategy for Aboriginal and/or Torres Strait Islander and Māori staff and implementation progress reports, which may be part of the overall human resources strategy. - Numbers and roles of Aboriginal and/or Torres Strait Islander and Māori staff. - Numbers and roles of staff requiring expertise in medical education as a component of the position description. - Descriptions of recruitment, support and training arrangements for patients and community members engaged in learning and teaching activities, including measures taken to ensure the engagement of community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori communities. - Documentation related to staff indemnification. Interview and observational evidence could include:		

• Only when fully informed of the scope and purpose of activities, and only engaged when they have the relevant knowledge and the resilience to share it (5.2.5).	- Discussions with academic and professional staff on the resourcing approach to staff recruitment and retention. - Discussions with Aboriginal and/or Torres Strait Islander and Māori staff on their recruitment and retention. - Discussions with community stakeholders on their involvement in learning and teaching activities.		

5.3 Staff appointment, promotion and development

5.3.1 The medical education provider's appointment and promotion policies for academic staff address a balance of capacity for teaching, research and service functions. The appointment and promotion policies include a culturally safe system for measuring success of Aboriginal and/or Torres Strait Islander and Māori staff.

5.3.2 The medical education provider appraises and develops staff, including clinical title holders and staff who hold a joint appointment with another body.

5.3.3 The medical education provider provides Aboriginal and/or Torres Strait Islander and Māori staff with appropriate professional development opportunities and support. Aboriginal and/or Torres Strait Islander and Māori staff have formal opportunities to work together in teams and participate in mentoring programs across the medical program and higher education institution.

5.3.4 The medical education provider ensures that staff, clinical supervisors and students have training in cultural safety and participate in regular professional development activities to support ongoing learning in this area.

Explanation	Evidence	Example(s)	Resources
A 'balance of capacity' for teaching, research and service should be fostered by providers through balanced role descriptions and teaching loads in practice (5.3.1). Appointment and promotion policies that 'include a culturally safe system for measuring success of Aboriginal and/or Torres Strait Islander and Māori staff' acknowledge: • Growing demands on these staff, including additional cultural expectations and cultural loading. • The impacts of colonisation, racism and bias on Aboriginal and/or Torres Strait Islander and Māori staff (5.3.1). 'Appropriate' professional development opportunities and support for Aboriginal and/or Torres Strait Islander and Māori staff are best defined by these staff, as supported by good practice and case studies. The facilitation of work in teams and mentoring for Aboriginal and/or Torres Strait Islander and Māori staff usually relies on the provider having (an) Aboriginal and/or Torres Strait Islander and Māori education unit(s) (5.3.3).	Documentary evidence could include: - Appointment and promotion policies, including recognition and reward for teaching, research, curriculum development and service contributions. - Performance appraisal policies. - Descriptions of the renewal and appointment processes for academic staff, including clinical title holders and conjoint appointments. - Descriptions of professional development opportunities available to academic staff and the level of participation in these opportunities in practice. - Descriptions of training and professional development opportunities for professional staff to support skills development needed for supporting the medical program. - Descriptions of professional development opportunities and support for Aboriginal and/or Torres Strait Islander and Māori staff.	*No examples at this time.*	LIME Network: Best Practice Approaches to Supporting Indigenous Health Academics in Medical Schools (2020) Link

Training in cultural safety* should be: • Led, designed and assessed by Aboriginal and/or Torres Strait Islander and Māori experts (following also from standards 2.3.7 and 3.1.6). • Relevant to the context of the program. • Continuous. • Where possible, accredited by a recognised training accreditation authority (5.3.4).	This includes both specific opportunities and how general opportunities are tailored to be more appropriate. - Descriptions of initiatives and outcomes from teamwork and mentorship opportunities, particularly for Aboriginal and/or Torres Strait Islander and Māori staff. - Descriptions of how clinical title holders and conjoint appointments are involved in the program and appraised and developed by the provider. - Documentation relating to cultural safety training, including the system used to track staff, clinical supervisor and student participation in this training. Interview and observational evidence could include: - Discussions with academic staff on the appointment and promotion processes and the efficacy and accessibility of development opportunities. - Discussions with professional staff on appraisal processes and the efficacy and accessibility of development opportunities. - Discussions with clinical title holders and conjoint appointment role holders on appointment and promotion, professional development and opportunities through the provider. - Discussions with Aboriginal and/or Torres Strait Islander and Māori staff on appointment and promotion, professional development, support and opportunities for teamwork and mentorship.		

5.4 Clinical learning environment

5.4.1 The medical education provider works with health services and other partners to ensure that the clinical learning environments provide high-quality clinical experiences that enable students to achieve the medical program outcomes.

5.4.2 There are adequate and culturally safe opportunities for all students to have clinical experience in providing health care to Aboriginal and/or Torres Strait Islander and Māori people.

5.4.3 The medical education provider actively engages with co-located health profession education providers to ensure its medical program has adequate clinical facilities and teaching capacity.

Explanation	Evidence	Example(s)	Resources
The provider should demonstrate the quality and efficacy of their relationships with health services and other partners*, and relate this to the quality of students' clinical experiences* (5.4.1). Providers should explain under Standard 5.4, Clinical learning environment, how their relationships enable high-quality clinical experiences. Providers should explain the details of those relationships, particularly how they are formalised, under Standard 1.2: Partnerships with communities and engagement with stakeholders. Providers should explain student opportunities to learn with and learn from diverse patient groups; and learn in diverse healthcare settings, under Standard 2.3: Learning and teaching. In ensuring 'adequate and culturally safe opportunities for all students to have clinical experience in providing health care to Aboriginal and/or Torres Strait Islander and Māori people', providers should recognise that Aboriginal and/or Torres Strait Islander and Māori people seek and are provided care in all healthcare settings, not only in community controlled health settings. While community controlled health settings will have the most concentrated opportunities for students to gain this clinical experience, the AMC recognises that these settings have limited capacity and resources to both facilitate student learning and provide appropriate care to their patients. Providers should implement structured and culturally safe opportunities in Aboriginal and/or Torres Strait Islander and Māori	Documentary evidence could include: - Descriptions of how the clinical learning environments enable students to achieve the medical program outcomes through high-quality clinical experiences. - Descriptions of how relationships with health services and other partners ensure high-quality clinical experiences. - Agendas and minutes from meetings with health services and other partners on clinical experience quality. - Descriptions of how teaching opportunities and service responsibilities are balanced, both for clinical supervisors and for the learning environments themselves. - Descriptions of the opportunities for students to have clinical experience in providing health care to Aboriginal and/or Torres Strait Islander and Māori people. - Descriptions of how these opportunities are mapping to learning outcomes and the Aboriginal and/or Torres Strait Islander and Māori health curriculum.	*No examples at this time.*	*No resources at this time.*

health across their clinical sites, including tertiary and community settings. Where providers partner with community controlled health settings to place students in those settings, providers should ensure there is benefit for those health settings such that their overall resources are not diminished (5.4.2; see Standard 1.2: Partnerships with communities and engagement with stakeholders). The AMC does not specify minimum contact hours or types of experiences that form 'adequate' clinical experiences in Aboriginal and/or Torres Strait Islander and Māori health. Students should be able to meet all AMC Graduate Outcome Statements related to Aboriginal and/or Torres Strait Islander and Māori health and cultural safety*, and their clinical experiences should reinforce cultural safety training (see standard 5.3.4) and other cultural learning as part of the Aboriginal and/or Torres Strait Islander and Māori health curriculum (see standards 2.2.2 and 2.2.3).	- Agendas and minutes from meetings with co-located health profession education providers on clinical facilities and teaching capacity. Interview and observational evidence could include: - Discussions with health services and other (clinical placement) partners on how their relationship with the provider supports high-quality clinical experiences. - Discussions with academic, clinical and professional staff responsible for clinical placements on the relationships that support clinical experiences. - Discussions with students about their learning across the range of diverse learning environments encountered including the adequacy of their opportunities to have clinical experience in Aboriginal and/or Torres Strait Islander and Māori health. - Discussions with students on the quality of their clinical experiences. - Discussions with community controlled organisations on the scope of clinical learning opportunities for students. - Discussions with co-located health profession education providers, including medical programs, on engagement with the provider on clinical facilities and teaching capacity.		

5.5 Clinical supervision

5.5.1 The medical education provider ensures that there is an effective system of clinical supervision to ensure safe involvement of students in clinical practice.

5.5.2 The medical education provider ensures that clinical supervisors are provided with orientation and have access to training in supervision, assessment and the use of relevant health education technologies.

5.5.3 The medical education provider monitors the performance of clinical supervisors.

5.5.4 The medical education provider works with healthcare facilities to ensure staff have time allocated for teaching within clinical service requirements.

5.5.5 The medical education provider has defined the responsibilities of hospital and community practitioners who contribute to delivering the medical program and the responsibilities of the medical education provider to these practitioners.

Explanation	Evidence	Example(s)	Resources
An 'effective system of clinical supervision' refers to a system where the supervision arrangements are clear, explicit and accountable. Supervisors* guide the students' clinical experience* and clinical training. Supervisors should have the appropriate competencies, skills, knowledge and commitment to the program. This includes knowledge of the program requirements, understanding of the principles of learning, the ability to provide constructive and actionable feedback to students, and responding appropriately to identified concerns. Supervisors must behave professionally and appropriately, including in a culturally safe manner. The system should be sufficiently organised and centred around education to allow students to continuously learn and progressively achieve learning outcomes (5.5.1). Providers should explain under Standard 5.5: Clinical supervision, the overall system of clinical supervision and the specific details of each clinical site, such as clinical supervisor* to student ratios, requirements around student feedback time, and after-hours availability. Providers should explain how students are develop and practice procedural skills before applying them in a clinical setting, and have	Documentary evidence could include: - Descriptions of the overall system of clinical supervision and how the specific features of this system differ across sites. - Policies around supervisory requirements, including minimum supervisor to student ratios, student scope of practice and what students are able to do without close supervision to provide different types of care in the different phases of the program, and after-hours supervision. - Ratios of supervisors to students in different sites, broken down by supervisor profession and seniority. - Descriptions of how patient safety and student safety is ensured through the system of clinical supervision. - Descriptions of content and delivery of orientation for supervisors. - Syllabi for supervisor training courses in supervision, workplace based assessment and the use of relevant health education technologies. - Numbers of supervisors who undertake the various training courses made available by the provider, against the total number of supervisors. - Descriptions of supervisor monitoring and performance recognition processes.	*No examples at this time.*	*No resources at this time.*

increased involvement in patient care as their skills develop, under Standard 2.3: Learning and teaching. The paramount concern referred to with 'safe involvement' of students in clinical practice is patient safety. The safety of students must also be ensured. Safety, for both patients and students, implies physical, psychological, emotional and cultural safety*, as particularly but not exclusively described in quality and safety frameworks, legislation and clinical guidelines; as well as occupational health and safety principles and legislation. Patient safety will be protected through an effective system of supervision (5.5.1). Training for clinical supervisors may be offered in partnership* with a health service and may include topics such as clinical assessment*, giving feedback, assessment quality, fostering culturally safe learning environments, and obligations and duties of supervisors including professionalism. Clinical supervisors having 'access to' training includes that this training is readily accessible and that supervisors are aware of the availability of this training. While not a formal requirement in the standards, AMC strongly encourages providers to ensure that clinical supervisors undertake training in the areas of supervision, assessment and the use of health education technologies (5.5.2). Orientation for clinical supervisors should cover provider policies around supervision and raising concerns, provider expectations of supervisors, provider responsibilities towards supervisors, monitoring and performance recognition processes, and training and professional development opportunities (5.5.2). 'Monitor[ing] the performance' of clinical supervisors means collecting individual and collective data, such as student and peer feedback, that allows a provider to monitor professionalism including cultural safety of supervisors and	- Sample data collected as part of the supervisor monitoring process. - Descriptions of how the provider works with healthcare facilities to ensure that facility staff have sufficient time for teaching within clinical service requirements to maintain an effective system of clinical supervision. - Correspondence with and agendas and minutes from meetings with healthcare facilities on facility staff time for teaching and supervision within clinical service requirements. - Policies and written agreements, such as agreements between the provider and health facilities and contracts between the provider and individual supervisors, that outline the responsibilities of practitioners who contribute to the program and the responsibilities of the provider towards those practitioners. These responsibilities may include minimum time requirements and adherence to provider policies; and access to professional development and rights that academic status confers, respectively. Interview and observational evidence could include: - Discussions with staff who coordinate clinical supervision on how the system of clinical supervision ensures safe involvement of students in clinical practice. - Discussions with clinical supervisors on their responsibilities vis-à-vis the provider, including provision of orientation and access to training. - Discussions with health care facilities on providers' engagement with them on the system of clinical supervision, including around time allocation within clinical service requirements. - Discussions with students on the system of clinical supervision.		

make informed determinations on professional development and training needs, as well as allowing for recognition of performance. This performance monitoring does not need to fall within the formal provider performance appraisal system for staff (this formal system for the provider's staff is required under standard 5.3.2). The provider should work in close partnership* with clinical sites to monitor the performance of supervisors (5.5.3).			

Standard 6: Evaluation and continuous improvement

6.1 Continuous review, evaluation and improvement

6.1.1 The medical education provider continuously evaluates and reviews its medical program to identify and respond to areas for improvement and evaluate the impact of educational innovations. Areas evaluated and reviewed include curriculum content, quality of teaching and supervision, assessment and student progress decisions. The medical education provider quickly and effectively manages concerns about, or risks to, the quality of any aspect of the medical program.

6.1.2 The medical education provider regularly and systematically seeks and analyses the feedback of students, staff, prevocational training providers, health services and communities, and uses this feedback to continuously evaluate and improve the program.

6.1.3 The medical education provider collaborates with other education providers in the continuous evaluation and review of its medical program outcomes, learning and teaching methods, and assessment. The provider also considers national and international developments in medicine and medical education.

Explanation	Evidence	Example(s)	Resources
'Continuous evaluat[ion] and review' refers to a cyclical approach to evaluation* and review that is ongoing rather than relying on ad-hoc activities and/or only occurring at a particular point in time. The AMC does not specify the frequency or method of particular evaluation and review activities, but the cycle of evaluation and review should include a variety of measures, be supported by evidence and demonstrate that the provider makes the necessary changes to the curriculum and program as a result of the evaluation to manage concerns about, or risks to, the quality of the program (6.1.1). 'Communities' include experts with lived experience of local health care, particularly those from communities who experience health inequities* and Aboriginal and/or Torres Strait Islander and Māori* communities. Feedback from all relevant stakeholders* may be collected through different means that reflect the needs of different stakeholders, such as surveys, focus groups or consultations, as long as this feedback is authentically, regularly and systematically sought (6.1.2).	Documentary evidence could include: - Policies, strategies and frameworks around the process of continuous evaluation, review and improvement, indicating the areas evaluated and reviewed. - Descriptions of the continuous evaluation and review process and governance that demonstrate how these ensures that the provider can responsively and effectively manage concerns about or risks to program quality. - Descriptions of the range of evaluation methods used, key findings and how the evaluation informs decisions about change. - Reports from recent curriculum/educational reviews. - Reports from other evaluation activities of different elements of the program. - Agendas and minutes from key evaluation-related governance meetings. - Descriptions of how feedback is regularly and systematically sought from students, and how the	*No examples at this time.*	*No resources at this time.*

Providers should explain under Standard 6.1: Continuous review, evaluation and improvement how student, community and other stakeholder feedback is sought and analysed in the service of evaluation. The outcomes of this feedback process for communities, including how communities contribute to the program through evaluation, should be explained under Standard 1.2: Partnerships with communities and engagement with stakeholders. The details of student representation processes should be explained under Standard 1.3: Governance. Providers should take care that feedback, particularly student feedback, is appropriately handled to maintain confidentiality or provide avenues for deidentified feedback when relevant, maintaining a focus on program evaluation and improvement (6.1.2). 'Other education providers' refers mainly to those who provide primary medical programs. Providers may also consider collaborating with prevocational training providers*, specialist training providers, and other health profession education providers on continuous evaluation and review, where relevant (6.1.3).	provider ensures the views of broad student cohorts are captured through this process. - Descriptions of how feedback is regularly and systematically sought from staff, prevocational training providers, health services and communities. - Documents related to evaluation and continuous improvement containing analysis of feedback. - Descriptions of the collaborative links between the provider and the program, and other education providers, including the nature of the links, exchanges of students and staff, and research collaboration. - Descriptions of the process for considering national and international developments in medicine and medical education, and how this influences and informs the program. Interview and observational evidence could include: - Discussions with staff responsible for continuous evaluation and review on how these activities are undertaken in practice. - Discussions with student leadership, students, staff, prevocational training providers, health services and communities, on how their feedback is sought and contributes to the program.		

6.2 Outcome evaluation

6.2.1 The medical education provider analyses the performance of student cohorts and graduate cohorts to determine that all students meet the medical program outcomes.

6.2.2 The medical education provider analyses the performance of student cohorts and graduate cohorts to ensure that the outcomes of the medical program are similar.

6.2.3 The medical education provider examines student performance in relation to student characteristics and shares these data with the committees responsible for student selection, curriculum and student support.

6.2.4 The medical education provider evaluates outcomes of the medical program for cohorts of students from equity groups. For evaluation of Aboriginal and/or Torres Strait Islander and Māori cohorts, evaluation activity is informed and reviewed by Aboriginal and/or Torres Strait Islander and Māori education experts.

Explanation	Evidence	Example(s)	Resources
'Determin[ing] that all students meet the medical program outcomes*' across 'student cohorts and graduate cohorts' refers to evidencing that phase/year cohorts of students and graduates are consistently achieving all the expected skills, knowledge and behaviours of medical students at different stages of the program (6.2.1). Providers define the graduate outcomes under standard 2.1.1, and outline learning outcomes for each stage of the program under standard 2.2.9. 'Ensur[ing] that the outcomes of the medical program* are similar' across 'student cohorts and graduate cohorts' refers to ensuring that phase/year cohorts of students and graduates are consistently performing in, progressing through and graduating from the program. The analysis should be sufficient to reveal any differences in performance and allow the provider to understand and address root causes (6.2.2). 'Student characteristics' refers to key student demographic, entrance qualifications, and entry pathway features. These characteristics should be relevant to the nature of the student	Documentary evidence could include: - Descriptions of the student cohort and graduate cohort performance analysis process, including for consistency of medical program outcomes achievement and similarity of outcomes of the medical program. - Descriptions of processes applied to identify and address any deficit in medical program outcomes achievement and similarity of outcomes of the medical program. - Pass rates for each phase/year and major component of the program, and graduation rates, for at least the last three years, including for cohorts of students from equity groups and Aboriginal and/or Torres Strait Islander and Māori students. - Assessment performance for key assessments and components of the program, including for cohorts of students from equity groups and Aboriginal and/or Torres Strait Islander and Māori students. - Descriptions of the mechanisms and tools used to track graduates, both internal (e.g. provider graduate	*No examples at this time.*	*No resources at this time.*

cohort, as outlined under standard 4.1.2, and groups of students who may require additional health and learning support, as referred to under standard 4.2.3; along with other relevant demographic and admissions data regularly captured by the provider (6.2.3). The evaluation* of outcomes of the medical program for cohorts of students from equity groups* and Aboriginal and/or Torres Strait Islander and Māori* communities should be linked to the consideration of infrastructure and supports for these groups and communities under standard 4.1.3 (6.2.4). 'Aboriginal and/or Torres Strait Islander and Māori education experts' can be staff of or external to the provider. Experts should have experience with and/or qualifications in education and/or evaluation (6.2.4).	surveys) and external (e.g. the Medical Schools Outcomes Database). - Evaluation reports resulting from analysis of consistency of medical program outcomes achievement and similarity of outcomes of the medical program, including for cohorts of students from equity groups and Aboriginal and/or Torres Strait Islander and Māori students. - Descriptions of how Aboriginal and/or Torres Strait Islander and Māori experts inform and review evaluation of including for cohorts of students from equity groups and Aboriginal and/or Torres Strait Islander and Māori student cohorts. Interview and observational evidence could include: - Discussions with staff responsible for outcome evaluation on how these activities are undertaken in practice. - Discussions with staff on student selection, curriculum and student support committees on the outcome evaluation data they receive and how it is used.		

6.3 Feedback and reporting

6.3.1 The outcomes of evaluation, improvement and review processes are reported through the governance and administration of the medical education provider and shared with students and those delivering the program.

6.3.2 The medical education provider makes evaluation results available to stakeholders with an interest in graduate outcomes, particularly prevocational training providers, and considers their views in the continuous evaluation and improvement of the medical program.

Explanation	Evidence	Example(s)	Resources
The 'shar[ing]' the 'outcomes of evaluation*, improvement and review processes' refers to providing detailed outcomes and accessible summaries of these outcomes directly to students and the staff, clinical supervisors* and community members contributing to program delivery (6.3.1). Stakeholders* with an interest in graduate outcomes may include: • Prevocational training providers, particularly those who train many of the provider's graduates. • Training sites. • Health jurisdictions. • Community groups. • Aboriginal and/or Torres Strait Islander and Māori people, communities and organisations. 'Mak[ing] evaluation results available' refers to providing the overall results to key individual representatives/ leaders of stakeholder groups. 'Consider[ing] their views' refers to being responsive to feedback on the processes of continuous evaluation and improvement of the program (6.3.2). The provider should explain under Standard 6.3: Feedback and reporting how stakeholders are provided with the results of	Documentary evidence could include: - Descriptions of the process for reporting and sharing the outcomes of evaluation, improvement and review processes. - Descriptions of the process for sharing evaluation results with stakeholders. Interview and observational evidence could include: - Discussions with members of admissions and course advisory committees on the governance reporting processes. - Discussions with students, staff, clinical supervisors, and community members contributing to program delivery on their awareness of the outcomes of evaluation, improvement and review processes. - Discussions with prevocational training providers on their	An example from **Notre Dame School of Medicine:** Notre Dame University School of Medicine is placing an increased focus on reporting evaluation findings to the student cohort to ensure students are aware of evaluation results and improvements made based off feedback given. Evaluation findings are provided to stakeholders for review and consideration with an expectation that improvements and changes to the program will be identified and reported. These findings are subsequently made available to the students through various avenues including: • Orientation week quality presentation which outlines the evaluation plan for the year ahead; purpose of quality activities; and recent outcomes of evaluations, including changes and improvements to the student learning experience. • Bi-annual summary of evaluation results and identified improvements presented in infographic format and published on the Learning Management System for student review. • Quality presentation at the staff-student liaison meetings.	*No resources at this time.*

evaluation and how their views on the continuous evaluation and improvement processes are considered. The provider should explain under Standard 1.2: how stakeholders directly contribute to evaluation processes.	awareness of evaluation results, and the provision of feedback on evaluation and improvement processes.	• Student representation on the School's National Quality Committee which discusses quality initiatives and evaluation development. • Summary of changes to the program in the course outline summary. Contact – School of Medicine som.quality@nd.edu.au	