Accreditation Report: Flinders University, College of Medicine and Public Health

Medical School Accreditation Committee

March 2025

Australian Medical Council Limited

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Acknowledgement of Country

The Australian Medical Council (AMC) acknowledges the Aboriginal and/or Torres Strait Islander Peoples as the original Australians and the Māori People as the tangata whenua (Indigenous) Peoples of Aotearoa (New Zealand).

We acknowledge and pay our respects to the Traditional Custodians of all the lands on which we live and work, and their ongoing connection to the land, water and sky. The AMC offices are on the land of the Ngunnawal and Ngambri Peoples, and the main campuses of the Flinders University, College of Medicine and Public Health medical program are on the lands of the Kaurna People and the Larrakia People.

We recognise the Elders of all these Nations past, present and emerging, and honour them as the Traditional Custodians of knowledge for these lands.

Executive Summary

Accreditation history

The Flinders University, College of Medicine and Public Health was first accredited by the AMC in 1994. Appendix 1 provides an overview of the AMC's accreditation process in Australia.

Accreditation process

According to the *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2024,* accredited medical education providers may seek reaccreditation when their period of accreditation expires. Accreditation is based on the medical program demonstrating that it satisfies the accreditation standards for primary medical education. The provider prepares a submission for reaccreditation. An AMC team assesses the submission and visits the provider and its clinical teaching sites.

An AMC team (the team) conducted a reaccreditation assessment of the Flinders University, College of Medicine and Public Health's Doctor of Medicine (MD) program, and met with staff (academic and operational), medical students, clinical supervisors and other groups involved in the delivery of the Program. The team visited clinical training sites in Adelaide, rural South Australia and Darwin. The full team member composition can be found in Appendix 2.

When undertaking accreditation the AMC refers to the:

- *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2023* (the Standards)
- *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2024* (the Procedures)

The goals of the report are to:

- Provide an assessment of the provider and program against the Standards, and the reasons behind the outcomes. This includes highlighting commendations, outlining conditions placed to ensure the provider and program meet the Standards within a reasonable time, and offering recommendations to support ongoing quality improvement.
- Give a brief overview of the accreditation context, including key program data, previous accreditation activity and provisions for future monitoring and accreditation activity.

This report presents the AMC's findings against the *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2023*.

Decision on accreditation

Under the Health Practitioner Regulation National Law, the AMC may grant accreditation if it is reasonably satisfied that a program of study, and the education provider that provides it, meet the approved accreditation standards. It may also grant accreditation if it is reasonably satisfied that the provider and the program of study substantially meet the approved accreditation standards and the imposition of conditions will ensure the program meets the standards within a reasonable time.

Having made a decision, the AMC reports its accreditation decision to the Medical Board of Australia to enable the Board to make a decision on the approval of the program of study for registration purposes.

At its 5 March 2025 meeting, the AMC's Medical School Accreditation Committee resolved:

i. that the medical program of the Flinders University, College of Medicine and Public Health substantially meets the accreditation standards;

ii. that accreditation of the four-year Doctor of Medicine (MD) medical program of the Flinders University, College of Medicine and Public Health be granted for three years, to 31 March 2028;

iii. that accreditation of the program is subject to the meeting of the below conditions contained in the accreditation report, to meeting the monitoring requirements of the AMC and to a follow-up assessment.

Conditions on accreditation

Where a month is not specified in the deadline for the condition the College is expected to demonstrate that it has satisfied the condition within the monitoring submission scheduled for that year.

	Condition	To be met by
Standard 1: Purpose, context and accountability		
1	Develop a student-centred and context-specific plan for clinical placements, in collaboration with key stakeholders in the Northern Territory (including Charles Darwin University). (Standards 1.1 and 1.2)	2025 Report on implementation and evaluation until 2030
2	Across the breadth of the program, to fully meet the College's commitment to improving Aboriginal and/or Torres Strait Islander health: a. recruit senior Aboriginal and/or Torres Strait Islander academic and clinical staff, and provide the positions with appropriate financial and staff resources and appropriate authority to effectively develop, steer and influence the curriculum and program. (Standards 1.4.4 and 5.2.3) b. develop, implement and resource a community engagement plan with a focus on Aboriginal and/or Torres Strait Islander health, including the establishment of the reference group. (Standards 1.1.4, 1.2.1 and 1.2.3) c. develop and implement a functional operational structure at all levels of College and Program decision-making and advisory roles. (Standards 1.1.4, 1.3.5, 1.4.3 and 1.4.4)	2026
3	To reflect enhanced understanding of community, consumer and broader sector expectations in program outcomes, curriculum and assessment, develop and implement: a. mechanisms to increase member participation of these groups in levels of College and Program governance, with consideration for diverse representation of underrepresented groups.	2026

	b. a systematic plan to recruit, engage and support community/consumer members and individuals with lived experience to contribute to co-design approaches. (Standards 1.2.1 and 6.1.2)	
4	Evaluate effectiveness of engagement with health jurisdictions and services where the College delivers the Program to implement improved communication and involvement in program development. This engagement should consider the key role of clinical supervisors in program delivery. (Standards 1.2.2 and 6.1.2)	2026
5	Provide evidence of evaluation of the governance structure and implementation plans for change/improvement based on outcomes: a. to ensure contemporary effectiveness at all levels of governance are relevant to strategic approaches, program development, operations, compliance and risk management. (Standards 1.3.1, 1.3.2 and 1.3.3) b. to ensure conflict of interest mechanisms are embedded in all levels of governance and operations of the College and Program. (Standard 1.3.6)	2026
6	Evaluate the effectiveness of the student voice in the governance and decision making of their program with evidence of action steps to be taken to improve identified gaps in communication and feedback mechanisms. Students from all campuses should have the opportunity to participate in this evaluation. (Standard 1.3.4)	2026
Standard 2: Curriculum		
7	Document and finalise constructive alignment of medical program outcomes for graduates to the AMC graduate outcome statements. (Standards 2.1, 2.2.5, 2.2.8, 2.2.9 and 6.2) a. Develop and communicate clearly articulated learning outcomes at the topic/block level for Years 3 and 4. These should be sufficiently detailed to guide clinical educators and supervisors as well as students. (Standard 2.2.9)	2025
8	Develop and implement an Aboriginal and/or Torres Strait Islander health curriculum across all campuses, ensuring: a. constructive alignment across all four years of the MD Program. (Standard 2.2.2) b. leadership and authorship of content by Aboriginal and/or Torres Strait Islander health experts, ensuring a strengths-based framework and appropriate resource allocations. (Standard 2.2.3) c. a program of research and scholarship in Aboriginal and/or Torres Strait Islander health. (Standard 2.2.4) d. alignment to medical program outcomes, learning and teaching methods, and assessment. (Standard 2.2.5) e. learning and supervisory experiences are culturally safe and informed by Aboriginal and/or Torres Strait Islander knowledge systems and medicines. (Standard 2.3.7)	Years 1 & 2 by 2026 Years 3 & 4 by 2027
9	Establish a plan for clinical placements across all campuses in Years 3 and 4 for students to have structured learning opportunities to address differing needs of groups that experience health inequities, including Aboriginal and/or Torres Strait Islander communities. (Standard 2.3.6)	2026
Standard 3: Assessment		
10	Define specific longitudinal assessment of professional behaviours, aligned with the assessment blueprint and learning outcomes. (Standard 3.1.2)	2026

11	Conduct a detailed blueprinting exercise to identify gaps in assessment as part of the alignment to AMC graduate outcomes and provide evidence of systematic blueprinting to learning and teaching activities in the MD Program. (Standards 2.1.1 and 3.1.3)	2026
12	Develop and implement strategies to assess Aboriginal and/or Torres Strait Islander health and culturally safe practice, including communication skills, across the MD Program. This should be undertaken by, or informed by and in collaboration with, Aboriginal and/or Torres Strait Islander experts. (Standard 3.1.6)	2026
13	Develop and implement systematic methods of reporting student cohort performance to academic staff and provide evidence of the effectiveness of methods implemented. (Standards 3.2.3 and 6.2)	2026
Standard 4: Students		
14	Develop and implement discrete cohort targets and Program-led recruitment strategies to support increased recruitment of Aboriginal and/or Torres Strait Islander students, and students from equity groups and rural locations across all campuses. (Standards 4.1.2 and 4.1.3)	2026
15	Develop, implement and resource structured College- and Program-led support systems to support retention and graduation, and ensure the wellbeing of: a. Aboriginal and/or Torres Strait Islander students, including accommodation for cultural leave. b. students from rural and equity backgrounds. (Standards 4.1.3, 4.2.2 and 4.2.7)	2026
16	In consultation with students, evaluate the effectiveness of current services and facilities provided to students with disabilities to: a. identify areas of improvement and implement change to ensure their physical and psychological safety and wellbeing are prioritised, taking into account place-based needs. b. allocate appropriate resources and training to facilitate improvement in physical facilities or staff and educator capability to safely provide students with counsel. (Standards 4.1.4, 4.2.3, 4.2.4, 5.1 and 6.1.2)	2026
17	Develop and implement a College- and Program-wide strategy to improve wellbeing support and resources, consulting with students (past and present), staff and educators from all campuses. Improvements should include: a. safe, accessible and confidential services for students to access needed support. b. ensuring appropriate and timely communication to students about policies and procedures, including the availability of the Disability Access Plan. c. ensuring appropriate application of wellbeing policies and procedures. d. training for staff (academic and professional) providing a service to students. e. transparent management of COIs to balance wellbeing support and academic progression. (Standards 4.2, 4.3.1 and 6.1)	2026
18	Aligning with developments in the MD curriculum, develop and implement policies and procedures to ensure culturally safe practice: a. by students on clinical placement with Aboriginal and/or Torres Strait Islander patients.	2026

	b. for the safety of Aboriginal and/or Torres Strait Islander students. (Standards 2.3.7, 4.1.3, 4.3 and 5.3.4)	
Standard 5: Learning environment		
19	To ensure facilities and infrastructure are fit for purpose, develop and implement a plan to respond to the needs of all students across each campus in South Australia and the Northern Territory, including: a. improving physical facilities on campus for students with disability b. providing culturally safe spaces for Aboriginal and/or Torres Strait Islander students. c. ensuring adequate resourcing to expand lecture, tutorial and learning spaces to accommodate growing student numbers. (Standards 5.1.1 and 5.1.2)	a. 2026 b. 2025 c. Report annually
20	Establish practical and proactive support mechanisms for student requirements for safe and accessible accommodation in all locations and for all years of the MD Program. (Standard 5.1.3)	2026
21	Expand educational expertise in Aboriginal and/or Torres Strait Islander health to develop and deliver curriculum, teaching and learning, and assessment methods, by: a. implementing a sustainable and scalable staffing plan with targets and a recruitment strategy across all campuses that demonstrates appropriate academic capacity to meet required objectives. (Standards 5.2.3 and 5.2.4) b. implementing culturally safe interview policy and procedure, and systems for measuring success of Aboriginal and/or Torres Strait Islander staff, academic and professional. (Standards 5.3.1 and 5.3.3) c. assessing the development and training needs of Aboriginal and/or Torres Strait Islander staff to facilitate and resource required opportunities. (Standard 5.3.3)	2025
22	Develop and implement the Community Engagement Plan with: a. a strategy to recruit, support and train patients and community members to be formally involved in teaching and learning. b. a culturally safe process for the recruitment and development of Aboriginal and/or Torres Strait Islander patients and community members. (Standard 5.2.5)	2026
23	Develop and implement a sustainable and resourced model for development of knowledge and skills in cultural safety for all academic and professional staff involved in delivering the Program, clinical supervisors and students. (Standard 5.3.4)	2026
24	Develop and implement a strategy to strengthen orientation, training, professional development and support for clinical supervisors to deliver the Program across all campuses. (Standards 5.5.2 and 5.5.5)	2026
25	Evaluate the operationalisation of clinical placement agreements to determine ways to facilitate appropriate allocation of teaching time by senior clinicians, and responsibilities of the College and clinical placement sites are practically managed. (Standards 5.5.5 and 6.2)	2025

Standard 6: Evaluation and continuous improvement		
26	Develop and implement a systematic College- and Program-led framework/program of evaluation with mechanisms to manage concerns or risk to the medical program efficiently and effectively. There should be: a. consultation and co-design with stakeholders participating in or delivering the program. b. commitment to regular consultation with stakeholders, including other education providers, in the continuous improvement of the program and its outcomes. c. inclusion of clinical supervisors, educational and topic coordinators, and learning coaches in evaluation and feedback loops. d. inclusion of broad community/consumer perspectives to inform program development and in feedback loops. (Standards 6.1, 6.3.2 and 1.3)	2026
27	Establish a clear and robust governance and administrative structure of the College and Program to ensure accountability of the program of evaluation. Implemented processes should: a. define reporting relationships to the University and Medical Program Board. b. clarify the role of the Evaluation Advisory Group in the governance structure and a membership representative of Program stakeholders. (Standards 6.3 and 1.3)	2025
28	Implement outcome evaluation mechanisms to examine and share the performance of student cohort data with responsible committees. Student cohorts should include those in clinical placements, students living with disability and from equity groups, and Aboriginal and/or Torres Strait Islander students. (Standards 6.2.3 and 6.2.4)	2025

Commendations

A	The University and College have clearly articulated the purpose of the medical program and demonstrate commitment to strategic principles in education, health and social accountability. (Standard 1.1.1)
B	The Elders on Campus have a key role in providing innovative, place-based approaches to knowledge development in Aboriginal and/or Torres Strait Islander health and cultural safety. (Standard 1.1.4)
C	The College has designed a diverse medical program with a program of learning and purposeful curriculum structure that facilitates the student's journey to independent practice. It has a strong foundation to enable the attainment of knowledge, skills and behaviours in basic science and thematic topics. (Standards 2.2.1 and 2.2.7)
D	There is a strong and appropriate focus on research led by the FHMRI and the Prideaux Centre. (Standard 2.2.4)
E	The learning coach initiative is an innovative approach to complement student learning. (Standard 2.2.7)
F	The MDRS program of interprofessional simulations which involve all the health professional students at some rural sites is commendable. (Standard 4.3.3)
G	The College uses broad systems of assessment methodology, and is committed to innovation, introducing new methods such as the progress test, portfolio and learning coach to assess, track and support students' attainment of knowledge and skill. (Standards 3.1 and 3.2.2)

H	There is a commitment to generate a diverse student cohort in the MD Program, supported by related place-based and equity entry pathways, selection guidelines and supported/bonded student places. (Standard 4.1)
I	Topic coordinators and clinical supervisors are a valuable resource facilitating and supporting student academic success. (Standards 4.1.3 and 4.2.1)
J	The academic and professional staff and clinical supervisors in the MDRS program were lauded by students as central supports to their education and wellbeing. (Standards 4.1 and 4.2)
K	The availability of a psychologist for students in the NTMP three days a week. (Standard 4.2.2)
L	There is a commitment to provide students with fit-for-purpose facilities in all main campuses to support them in their learning and recreational activities. (Standards 5.1.1 and 5.1.2)
M	The Intern Shadowing Program creates the opportunity for students to receive mentorship from junior doctors in clinical placement locations. (Standard 5.4.1)

Recommendations for improvement

I	Develop training and feedback opportunities for community/consumer members involved in student interviews and other learning activities. (Standard 1.2.1)
II	Explore ways to expand representation of the Aboriginal and/or Torres Strait Islander role, the community/consumer role, and other relevant roles to ensure a better balance of representation in decision making. (Standards 1.2.1 and 1.3.5)
III	Explore the need for discipline-specific expertise on the Clinical Advisory Group and extending the appointment term of one year on the Curriculum Oversight Group. (Standards 1.3.1 and 1.3.2)
IV	Review the validity of mechanisms to ensure 'equivalence of learning' to determine if any areas of best practice should be reinstated. It would be useful to define what equivalent learning experiences means in the Flinders University context and/or to distinguish equivalent learning from equivalent achievement. Consultation with campus leads, students, clinical supervisors and topic coordinators is recommended. (Standard 2.1.2)
V	Identify ways to actively include topic coordinators and clinical supervisors in curriculum renewal and alignment of learning outcomes. (Standards 2.1, 2.2)
VI	Identify ways to increase opportunities for students to pursue studies of choice that promote breadth and variety of experience. (Standard 2.2.10)
VII	Consider the appointment of an academic lead to advocate for interprofessional learning across the MD Program. (Standard 2.3.3)
VIII	Incorporate structured interprofessional learning opportunities with students in other health professions. (Standard 2.3.3)
IX	Consider sourcing a fit-for-purpose assessment item banking system. (Standard 3.3.1)
X	Explore ways to monitor and evaluate selection and training of coaches in the learning coach initiative, in consultation with students and current coaches. (Standard 3.2)
XI	Improve visibility of the University's Disability Policy and Work Integrated Learning Policy and Procedures for students. (Standard 4.1.4)
XII	Consider ways to share good practice in the support of student wellbeing and students with disability across campuses, including a clear distinction between personal/welfare issues and academic concerns. (Standards 3.2.2 and 4.2)

XIII	Engage with students to improve 'close the loop' mechanisms to improve student awareness of action taken in relation to student concerns or changes to the program. (Standard 4.2)
XIV	Engage with the FMSS, Flinders University Student Association, student groups and the wider study body, to: • improve psychological safety and confidence when providing feedback or seeking resolution to academic or clinical placement concerns (Standard 4.2) • improve current (i.e. Student Evaluation of Teaching [SET] or Student Experience Survey [SES]) or develop alternative feedback mechanisms (Standards 4.2.7, 5.5.3, 6.1.2) • evaluate effectiveness of application of policies and resources to identify, address and prevent bullying, harassment, racism and discrimination. (Standard 4.2.7)
XV	Consult with other medical educational providers to explore good practice in the recruitment and professional development of Aboriginal and/or Torres Strait Islander staff, consumers and community members. (Standards 5.1 and 5.2)
XVI	Consult with students to explore ways to reduce out-of-pocket expenses for transportation and accommodation. (Standards 5.1.2 and 5.1.3)
XVII	Incorporate in evaluation mechanisms regular review of the adequacy of information technology infrastructure and services across all campuses. (Standards 5.1.4 and 5.1.5)
XVIII	Explore the potential of involving Aboriginal Liaison Officers in clinical placements in teaching and learning. (Standard 5.4)
XIX	Consider the capacity of the Evaluation Coordinator to manage an increased scope of evaluation, analysis and operational support. (Standards 6.1 and 6.2)

Monitoring and next steps

As part of the monitoring process, the College is asked to provide periodic (as completed) or annual updates to the AMC on the following:

1. Provide an update to committee or operational roles identified as interim or vacant at the time of the assessment. (Standard 1)
2. Provide a timeline of completion for aligning medical program outcomes for graduates to be consistent with the AMC graduate outcome statement. (Standard 2.1)
3. Provide a timeline of implementation for the Aboriginal and/Torres Strait islander health curriculum. (Standard 2.2.2)
4. Provide an update on the pre-internship term. (Standard 2.3.9)
5. Provide the outcomes of the evaluation and research of the learning coach initiative. (Standard 3.1.2)
6. Provide an update on the improvement to the item banking system and its implementation timeline. (Standard 3.3.1)
7. Provide an update of the implementation of the student success framework. (Standard 4.1.2)
8. Report on regular evaluation of the effectiveness of wellbeing policies and resources. (Standard 4.2)
9. In response to student and staff feedback on information technology services, provide an update on the development and implementation of the plan to improve the effectiveness of the learning management system to support learning, teaching and assessment. (Standards 5.1.4 and 5.1.5)
10. Provide outcomes of the review of clinician engagement and support services to determine equitable support and streamlining across all training sites. (Standards 5.2.1 and 5.2.2)

11. Provide an update on the progress of academic and professional staff recruitment to deliver the SARM Program to the planned student cohort. (Standards 5.2.1 and 5.2.2)
12. Provide an update of clinical placement agreements for the SARM Program. (Standard 5.4.1)
13. Provide an update of the commencement and progress of placements with Aboriginal Medical Services. (Standard 5.4.2)
14. Report on the adequacy of forecasting and progress recruiting and inducting new clinical placements to prepare for the increase in clinical placements required in SARM and NTMP. (Standard 5.4.3)
15. Provide an update on the utility of developments in Placement Expectations documentation on clinical supervisor preparedness and student experience. (Standard 5.5.2)
16. Provide the outcomes of the review of the Indigenous Entry Stream and learning coach initiative. (Standard 6.1.1)
17. Provide an update on changes made to the analysis of student and graduate cohorts in tandem with revisions to the curriculum, and related alignment of learning outcomes and AMC graduate outcomes. (Standards 6.2.1 and 6.2.2)
18. Provide the terms of reference and membership of the Evaluation Advisory Group. (Standard 6.3.1)

Appreciation

The team is grateful to staff and students who prepared the accreditation submission and managed the preparations for the assessment. It acknowledges with thanks to all staff in clinical sites who coordinated the site visits, and the assistance of those who hosted visits of team members.

Summaries of the program of meetings and visits for this assessment are provided at Appendix 3.

Assessment against the Accreditation Standards

Standard 1: Purpose, context and accountability			
1.1	Purpose	Substantially Met	This Standard is Substantially Met
1.2	Partnerships with communities and engagement with stakeholders	Substantially Met	
1.3	Governance	Substantially Met	
1.4	Medical program leadership and management	Substantially Met	

Standard 2: Curriculum			
2.1	Medical program outcomes and structure	Substantially Met	This Standard is Substantially Met
2.2	Curriculum design	Substantially Met	
2.3	Learning and teaching	Substantially Met	

Standard 3: Assessment			
3.1	Assessment design	Substantially Met	This Standard is Substantially Met
3.2	Assessment feedback	Substantially Met	
3.3	Assessment quality	Met	

Standard 4: Students			
4.1	Student cohort and selection policies	Substantially Met	This Standard is Substantially Met
4.2	Student wellbeing	Substantially Met	
4.3	Professionalism and fitness to practise	Substantially Met	
4.4	Student indemnification and insurance	Met	

Standard 5: Learning Environment			
5.1	Facilities	Substantially Met	This Standard is Substantially Met
5.2	Staff resources	Substantially Met	
5.3	Staff appointment, promotion and development	Substantially Met	
5.4	Clinical learning environment	Substantially Met	
5.5	Clinical supervision	Substantially Met	

Standard 6: Evaluation and continuous improvement			
6.1	Audit Activity	Substantially Met	This Standard is Substantially Met
6.2	Compliance reporting	Substantially Met	
6.3	AMC Feedback and reporting	Substantially Met	

ITEMISED OUTCOME OF ACCREDITATION ASSESSMENT

ONE	M	SM	SM	SM	SM	SM	NM	SM	SM	SM	SM	NM	SM	M	M	SM	NM	M	M
	1.1.1	1.1.2	1.1.3	1.1.4	1.2.1	1.2.2	1.2.3	1.3.1	1.3.2	1.3.3	1.3.4	1.3.5	1.3.6	1.4.1	1.4.2	1.4.3	1.4.4	1.4.5	1.4.6

TWO	SM	M	M	NM	SM	SM	SM	M	M	SM	NM	M	M	SM	SM	M	M	SM	SM	M	M	
	2.1.1	2.1.2	2.2.1	2.2.2	2.2.3	2.2.4	2.2.5	2.2.6	2.2.7	2.2.8	2.2.9	2.2.10	2.3.1	2.3.2	2.3.3	2.3.4	2.3.5	2.3.6	2.3.7	2.3.8	2.3.9	

THREE	SM	SM	NM	M	M	NM	M	M	SM	M	M
	3.1.1	3.1.2	3.1.3	3.1.4	3.1.5	3.1.6	3.2.1	3.2.2	3.2.3	3.3.1	3.3.2

FOUR	M	M	SM	SM	M	SM	SM	SM	SM	SM	SM	SM	SM	SM	M
	4.1.1	4.1.2	4.1.3	4.1.4	4.1.5	4.2.1	4.2.2	4.2.3	4.2.4	4.2.5	4.2.6	4.2.7	4.3.1	4.3.2	4.4.1

FIVE	SM	SM	SM	SM	SM	M	M	M	NM	SM	SM	M	SM	M	NM	NM	M	SM	SM	M	SM	SM	SM	SM
	5.1.1	5.1.2	5.1.3	5.1.4	5.1.5	5.1.6	5.2.1	5.2.2	5.2.3	5.2.4	5.2.5	5.2.6	5.3.1	5.3.2	5.3.3	5.3.4	5.4.1	5.4.2	5.4.3	5.5.1	5.5.2	5.5.3	5.5.4	5.5.5

SIX	SM	SM	SM	SM	SM	SM	SM	SM	SM
	6.1.1	6.1.2	6.1.3	6.2.1	6.2.2	6.2.3	6.2.4	6.3.1	6.3.2

Key:
Met
Substantially Met
Not Met

STANDARD 1: Purpose, context and accountability

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.

The Flinders University Medical Program (the Program) has defined its purpose, 'to lead with excellence in medical education, clinical care and research', and clearly articulates the objectives with its strategic plans. At the time of the accreditation visit, the College of Medicine and Public Health (the College) had commenced a consultation process to develop the 2024–2028 strategic plan. This strategic plan will focus on seven priority areas, encompassing excellence in education, building a diverse medical workforce, community engagement and commitment to Aboriginal and Torres Strait Islander health. The team found the Program to be ambitious in its scope, including across idenfitied areas of workforce shortage in rural South Australia and the Northern Territory. The College and Progam have a clear and distinctive purpose, which drives much of its activity and ambition.

The Program is a four-year graduate entry program with a six-year undergraduate pathway via the Bachelor of Clinical Sciences degree. The University and College demonstrate commitment to developing doctors who are competent to practise in various locations, as students may enter the program in South Australia, either at the metropolitan campus or through the MD Rural Stream (MDRS) based in the Limestone Coast, Riverland Mallee Coorong and Barossa Hills Fleurieu regions, and through the Northern Territory Medical Program (NTMP). The MDRS program is transitioning to the South Australia Rural Medical (SARM) Program, where students will study the Program entirely in a rural South Australia location and live within the communities where they will work and study.

The Program anchors itself on patient-centred care, and Years 3 and 4 focus on student experience in clinical teaching settings. The Program also contributes to meeting place-based healthcare needs through the locations of its learning and clinical sites. The team does have some concerns about the quality and accessibility of community and place-based input into the Program. This includes from key Local Health Network (LHN) partnerships and Adelaide metropolitan–based Aboriginal and/or Torres Strait Islander health organisations, discussed further under Standard 1.2.

The proposed medical program by Charles Darwin University (CDU) in the Northern Territory presents a challenge for the College in future. Clinicians and students the team spoke with expressed concern over the scarcity of resources in the Northern Territory and the ability for the region to accommodate student numbers appropriately. Given the Territory's fragile health ecosystem, the College must engage actively with CDU at all levels of governance to ensure collaboration and sharing of finite resources to meet the aims of both programs.

The University, and by extension the College and Program, demonstrate commitment to futhering Aborignal and/or Torres Strait Islander health equity through various means, including through a Reconciliation Action Plan (RAP) and hosting Poche SA+NT. The Program has a specific entry scheme for Aboriginal and/or Torres Strait Islander students through the Indigenous Entry Stream (IES), and the NTMP, in particular, contributes to significant Aboriginal and/or Torres Strait Islander student recruitment, retention and completion. While the team observed a clear overarching purpose and positive steps forward, there were significant gaps identified in the Program's approach to furthering Aboriginal and/or Torres Strait Islander health equity and participation

in the program, particularly from staff and leaders, and advancing cultural safety learning in the curriculum and at teaching sites. There is notably limited inclusion across all levels of the program of Aboriginal and/or Torres Strait Islander staff, and especially in academic leadership in senior faculty roles (see Standards 1.3.5 and 1.4.4).

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.

Stakeholders of the College include clinicians, community members, health services, students, and Aboriginal and/or Torres Strait Islander People and organisations. There is a high involvement of clinicians in the design and implementation of assessment in the Program, and consumer and community involvement in research is strongly supported by the College. Community members and clinicians are represented on domestic interview panels, while selection panels for the IES have at least one Aboriginal and/or Torres Strait Islander member. Clinicians, academics, health services and students are regularly involved in the evaluation of the Program and its outcomes. The College reflects that they and their alumni have strong connections in community and that they remain focused on students being work ready.

While some stakeholder engagement is evident, this tends to be quite heterogenous and not cohesive. The team observed that in a range of instances stakeholders are not able to articulate the governance structure in which they operate or the connection to authorisation and engagement environments and reporting relationships within the College.

The team also observed there is limited direct engagement with community, those with lived experience and Aboriginal and/or Torres Strait Islander People and organisations to facilitate diverse input. There also seems to be greater strength in consumer and community engagement in rural and remote areas, as students are more likely to be embedded in the fabric of smaller communities and regions. This opportunity to engage with community is created through placement opportunities and the generalist experience, rather than a overarching engagement approach by the College. The College does see a variation in relation to engagement with rural and remote communities compared with metropolitan areas in Adelaide.

The team observed stakeholders, including consumers, tend not be involved in the early stages of governance, program development or curriculum. Clinical supervisors, particularly on rural campuses, would welcome opportunities to be involved in curriculum development initiatives. The involvement of stakeholders at later stages undermines the capacity of the College to provide a robustly tested and relevant curriculum. It would be of value for the College to consider broader approaches to engagement, introducing authentic co-design and co-production across all areas of the College's work to reflect an enhanced level of understanding of

consumer and community expectations. This also increases the College's capacity to value and respond to the lived experiences of all its stakeholders.

Consumer engagememt

The team met with a number of consumers during the assessment visit who are complimentary of their engagement with the College and appreciate opportunities for involvement in the Program. Some report participation in sessional activities but do not have a broader awareness of the ongoing consumer-informed work or governance work. The consumers also report there is limited access to debrief opportunities, which can present a risk to psychological safety and wellbeing of those who participate in programs where they share lived experience. Consumers tend to do this debrief externally rather than through the College process itself. No formal process could be identified by the consumers or community members.

Consumers indicate that they also see the students in the hospital environment who have an interest in consumers and ask a broad range of questions. When provided with the opportunity, students are keen to learn from patients and consumers on their placements; however, within the Program structure, opportunities can vary or be limited. There are indications from consumers that although students are engaging in sessions, not all are well prepared or aware of the intent of the consumer-related sessions. As a result of this, students and consumers were left feeling pressured and disheartened by less-than-ideal outcome. Setting expectations and having a shared curriculum understanding for all parties would be beneficial.

In relation to interviewing potential students, the College should consider more training and preparation for those consumers and community members who are part of the panel. While scenarios and questions are provided, it can take time to get familiar with the interview process and elements can be confusing or unclear. This can result in suboptimal participation from consumer or community members.

Engagement with consumers is in early development stages and impacts the capacity for consistent approaches across all areas of governance, program development and implementation. There is an absence of developed approaches to consumer and community-related engagement when considering the needs and opportunities within diverse communities and those communities with a lived experience of disability. Considering the strategic purpose of the College and outcomes of the Program, there is currently limited engagement with communities of diverse perspectives to support understanding of the different needs of each stakeholder group.

The College needs to consider broader approaches to engagement to ensure authentic co-design and co-production across all areas of the College's work that reflect an enhanced and changing understanding of consumer and community expectations that ensures the capacity to be responsive to and provide an informed approach to valuing lived experience.

The team heard there is generally good engagement with the Southern Adelaide LHN and the NT Government; however, it is observed that the College and Program senior management's engagement and governance mechanisms with the senior executive of the Riverland Mallee Coorong LHN is less regular. The team noted there can be a lack of clarity communicated across health services about learning outcomes expected on each rotation. The College should consider ways to engage with health jurisdictions/services on developments of the Program, including in the renewal of the curriulum.

Aboriginal and/or Torres Strait Islander engagement

The engagement with Aboriginal and/or Torres Strait Islander stakeholders is inconsistent, lacking coherence and resourcing across the breadth and diversity of the program. Concerns were raised with the team about the 'deficit' nature of some of the curriculum examples for Indigenous health. With very academically junior staff in Indigenous health and no apparent scholarship of Indigenous health teaching and learning, it might be expected that curriculum design and assessment, evaluation and outcomes of the medical program require some work. While there is significant leadership by Elders on Campus, it is unclear if their scope of responsibility involves significant educational aspects beyond outreach activities. A lack of strategic leadership across the Program is apparent in the lack of coherent Aboriginal and/or Torres Strait Islander curriculum and learning opportunities in Years 3 and 4.

It was not clear to the team that there were consistently mutually beneficial or reciprocal partnerships with Aboriginal and/or Torres Strait People and organisations. There were some examples of mutually beneficial partnerships in the Northern Territory, but there were limited examples in Adelaide and rural South Australia.

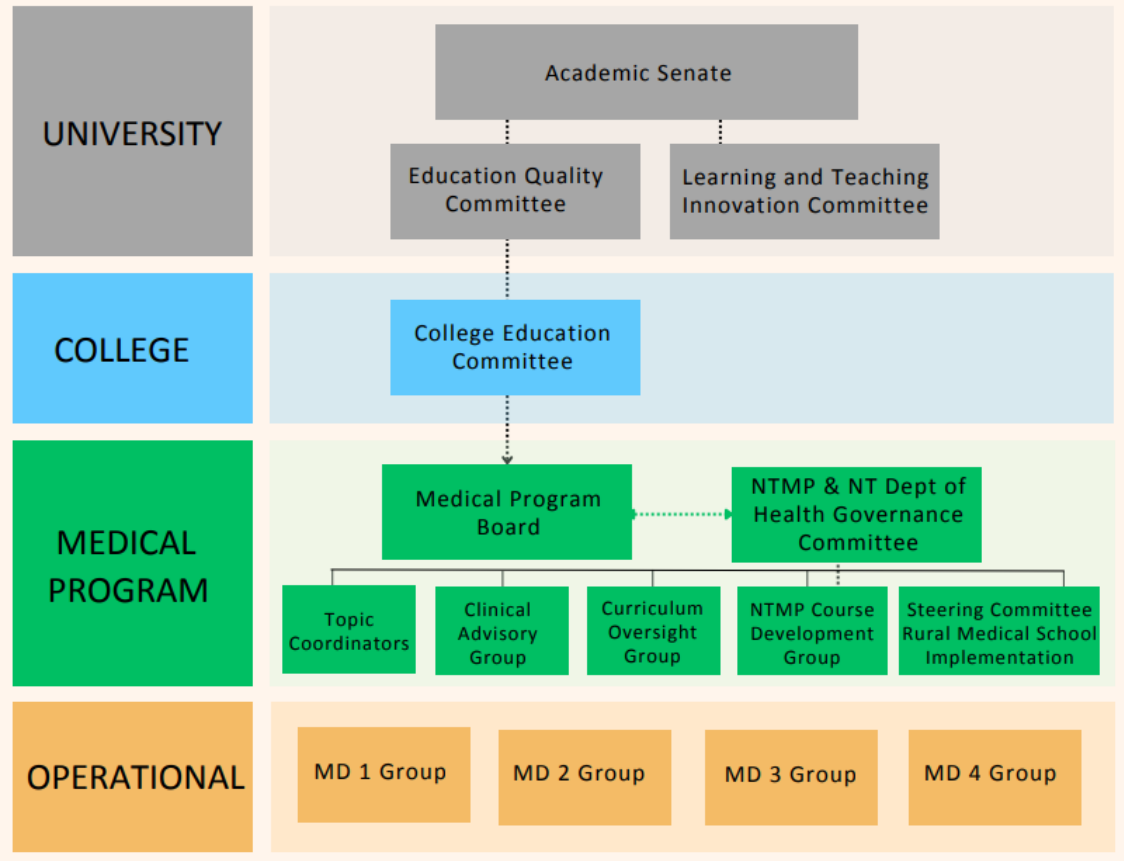
The College indicates a focus in relation to this standard on Indigenous health and are planning to develop a community engagement plan in the next 18–24 months. The College plans to reach out to Aboriginal and/or Torres Strait staff, community organisations, community members and other stakeholders to form a reference group, with the intention to have it running by 2026. The Program should consider approaching this in an agile and timely manner, particularly in areas of Aboriginal and/or Torres Strait Islander governance and input into the program. The work they currently undertake is in the early stages of development.

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.

The medical program has a documented governance structure that looks organisationally adequate, and there are various levels of organisational oversight of the College and Program reporting to a senior executive team, led by the President and Vice-Chancellor. Academic governance is overseen by the College Education Committee (CEC), which reports to the central Education Quality Committee. The CEC is chaired by the Dean, Education and has a membership that includes the University's Pro Vice-Chancellor Learning and Teaching Innovation, College Teaching Program Directors, Director of the NTMP and the Flinders Medical Students' Society (FMSS).

The governance of the Program sits within the College, and the Medical Program Board is the peak decision-making and policymaking body for the Program. Several governance groups sit under the Board, including the Clinical Advisory Group (CAG), Curriculum Oversight Group (COG), Topic Coordinators Group, and the NTMP and MDRS governance structures.

Figure 1: Flinders University medical program governance structure



The team, however, was concerned about the effectiveness of governance operationalisation in various contexts, and that current mechanisms risk attaining only partial effectiveness of academic oversight of the Program. Enhancing clear mechanisms for bidirectional communication between decision makers and those on the ground in teaching and/or operational roles will support improvements. The inability to be heard by decision-makers in the central campus was felt especially by staff (both academic and operational) and clinical supervisors in rural campuses.

The team noted a perception within the College that there is a very top-down approach to academic oversight, which limits opportunities for course-based innovation and excellence. There are also limited opportunities for consumers and community representatives to provide input in the governance of the Program. This is an overarching concern, and the team considers there are particular opportunities to improve the effectiveness of CAG and the COG in the governance structure.

Clinical Advisory Group

The CAG was established in 2020 to provide the Board with expert advice in clinical practice and currency. It comprises a broad and large group of representatives across the metropolitan, rural and remote areas. Members are appointed for a three-year term, though at the time of the assessment, the specific membership of the CAG was not apparent. In the absence of other mechanisms, it is unclear if and how specific groups, such as discipline leads or Aboriginal and/or Torres Strait Islander clinicians, may provide input to this group.

The team noted there was a focus on generalist clinicians from any discipline; however, there may be a need for discipline-specific expertise. This is particularly important as a current work in progress is aligning graduate learning outcomes for the Program with AMC graduate outcome domains (see Standard 2.1.1). It is noted the COG is reviewing this as part of its remit; however, there may be opportunities for both groups to inform each other's scope of work.

Curriculum Oversight Group

The College formed the COG in 2023 to 'plan, review, evaluate, and renew medical curriculum to ensure that it complements course philosophy/underlying principles, complies with regulatory standards, and meets the changing demands of the health environment'. As indicated above, a primary focus of the COG is to align the Program's graduate outcomes with the AMC graduate outcome domains with extensive stakeholder consultation. The composition of the COG is more streamlined than the CAG; however, their appointment term of one year may challenge longevity and oversight of feedback as well as the approach to evaluation.

The team also noted the Aboriginal and/or Torres Strait Islander staff position and consumer/community position have only been recently been filled as of late 2024. There may only be one or two representatives in the COG, and the College should consider ways to ensure a balance of representative voices in its curriculum review. This also applies to other roles on the COG and specific attention should be given to clinician groups in rural South Australia and from the Northern Territory for place-based considerations. There should also be consideration for health jurisdictions/services to provide direct input to curriculum evolution.

Aboriginal and/or Torres Strait Islander engagement

The team noted Aboriginal and/or Torres Strait Islander positions on a number of committees are absent while others have a duplication of membership of other groups, which undermines the capacity of the College to provide diverse representation and broad perspectives. There is no clear organisational structure of leadership to further Aboriginal and/or Torres Strait Islander health, which is currently inconsitent with the College's purpose. Opportunities for strengthening Aborignal and/or Torres Strait Islander engagement, and appointing identifiable leads, are evident and important. As indicated in preceding standards and here, a strategic priority to inform this work is essential.

Student engagement

Students are primarily represented through the Flinders' Medical Student Society (FMSS), as well as throughout the MD governance structure. Both the Medical Program Board and the CEC have MD student membership. The team was impressed with the students they met, who were able to articulate their feedback clearly and in a constructive manner. There is evidence of structured feedback loops through to MD leadership through the FMSS and other student representatives in the Program. There were some examples of how student feedback contributed to improvements in the Program—these tend to be around clinical placements and administrative changes.

While students in the MDRS program are connected to the overall MD governance structure across the four-year program, at rural campuses, the team heard students felt disconnected from the central Adelaide campus in Bedford Park, particularly in Years 3 and 4. This campus does have student representatives, but their connection into the central MD governance structure is less clear and any issues are managed by relevant local staff in rural South Australia or NTMP staff in the Northern Territory. There is some merit to this structure, as students may be provided with direct access to those managing their program. However, there is a challenge in that concerns in rural campuses remain siloed and the general sentiment is that their needs are unheard by central program governance. It also does not support open feedback loops about the quality of programs or concerns about individuals. While the team met many students in rural campuses during site visits, it was understood the opportunity for them to provide formal feedback, either through the FMSS or other mechanisms, was missed.

The University has a Conflict of Interest (COI) Policy, which is applicable to all employees, visiting academics and other individuals performing paid work on behalf of the University. The Program has a COI register to ensure any conflicts are documented and actively managed. The College would benefit from a standardised approach to the documentation, management and oversight in relation to COI. This standardised approach should be implemented across all committees who have governance responsibilities. A central record of COI should also be maintained. COI are also managed for assessment and progression decisions, and during clinical placements if locations are connected with Flinders University staff.

The team found the matrix structure of governance to be confusing at times, and conflicts of purpose in different roles could be difficult to manage. This may add to a perception by some staff and students of a

governance style focused on control rather than supporting autonomy, in turn influencing the culture at lower levels of governance. This sentiment was felt in interactions at University, College and Program levels, where even straightforward administrative support or actions appeared to be unnecessarily bureaucratic. This may contribute to pockets of staff and students feeling undervalued and unheard.

The team have identified opportunities in the governance structure and process require more robust considerations above, and this should extend to compliance and risk obligations for the College and Program.

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.

The University provided documentation to demonstrate it is in a strong financial position with adequate budget to support the implementation and maintenance of core business activities, including the MD Program. There has been significant restructuring within the University to enhance resource allocation and workflows to align with strategic goals.

There is an allocated annual budget for the Program overseen by the MD Director, reviewed by the Dean, People and Resources and College Resource Committee. There is a process for resources to be requested for unplanned activity by the MD Director on behalf of the Program. The MD Director is the dedicated academic head of the Program and has authority and responsibility for program quality and continuous improvement.

The MDRS program is supported by external funding, including Commonwealth supported place (CSP) funding and the Australian Government Rural Health Multidisciplinary Training (RHMT) program, which funds clinical placement and rural immersion activities, and provides the majority of funding for the year-long rural clinical placement in Year 3. This will follow through to the SARM Program, replacing the MDRS, with additional RHMT startup funding to support the Year 1 and Year 2 teaching program until 2026, when the program will be fully CSP funded. The NT Government and Commonwealth Government supports all four years of the NTMP through industry-funded student fee payments. RHMT funding also supports clinical placement and immersion activities in the Northern Territory.

The College leadership team is led by the Vice-President and Executive Dean, and roles in the executive group have oversight of tranches of the College's educational and research activities. These roles include:

- Director, College Services
- Dean, Education
- Dean, Rural and Remote Health
- Dean, Research

- Dean, People and Resources

The MD Program leadership team is led by the MD Director, and includes the Deputy Director; Director, Rural Clinical School (South Australia); and Director, NTMP. Each role has authority over program management and resources.

At the time of the assessment, the Dean, Education role was noted to be interim and the Director, Rural Clinical School (South Australia) was being recruited. In January 2025, the College confirmed that the Dean, Education role has been filled, and the Director, Rural Clinical School role has become the SARM Program Lead and is filled. Significantly, leadership in assessment was provided by a professor in medical education at the University level, who moved on from the University in early 2025. The AMC will be interested in developments related to these roles in monitoring reports.

The College appointed a Program Director, Aboriginal and Torres Strait Islander Pathways in Medicine to support the MD Director and program development. This role currently reports to the Dean, Rural and Remote Health with no clear operational link to the Director, Indigenous Health Leadership (Rural and Remote Health). There are also only a couple of academic leadership positions in Indigenous health, which is inadequate to undertake the tasks of program and curriculum development. It is unclear if there is an identified Aboriginal and/or Torres Strait Islander role at the executive level, though the team notes that the Director, Poche SA+NT, is a member of College executive. The Elders on Campus leadership in Darwin and Riverland locations is particularly notable, as is the Central Australian Cultural Education Team, which manages cultural education for new students in Alice Springs.

As discussed in previous standards, while there is evidence of Aboriginal and/or Torres Strait Islander leadership at different levels, the team observed these tend to be disconnected in the development and implementation of various initiatives, particularly curriculum development. There is evidence of co-design in some areas of the curriculum and graduate outcomes (see Standard 2); however, it appeared to the team that work is siloed to its campus of origin or role in the University/College. As indicated in standards above, the College and Program need to better support the engagement of its Aboriginal and/or Torres Strait Islander staff across the University, College and Program, as well as develop a well-resourced and planned recruitment strategy, including defining Aboriginal and/or Torres Strait Islander leadership at executive level. The University is registered with TEQSA and has the authority to self-accredit and deliver undergraduate and postgraduate courses against the Commonwealth's Higher Education Standards Framework, which underpins the University's Educational Quality Framework. Internal education programs undergo accreditation every seven years, and the Program last underwent internal accreditation in 2022.The University has policies, procedures and information available and accessible on its websites. This includes:

- the Admissions Policy
- Student Admission Procedures
- the international Doctor of Medicine webpage (includes fees and entry requirements)
- enrolment and census dates
- the MD course outline
- Assessment Practice and Assessment Variation Procedures
- the Student Academic Integrity Policy
- the Bullying Prevention and Management Policy
- the Equal Opportunity Policy
- the Sexual Harassment and Sexual Assault Prevention and Response Policy
- the Disability Policy.

Program-related costs and administrative details are accessible via the MD course information page. Enrolled students have access to information on the online learning management system (LMS), Canvas.

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.

The MD Program course learning outcomes provide a blueprint for the design of the medical program, and make explicit the knowledge, skills, capabilities and dispositions medical students need to achieve to practise safely as an intern. There are four domains and these are publicly available in the MD course handbook on the University website:

Domain 1—Clinical Practice: the medical graduate as a practitioner

Domain 2—Professionalism and Leadership: the medical graduate as a professional and leader

Domain 3—Health and Society: the medical graduate as a health advocate

Domain 4—Science and Scholarship: the medial graduate as a scientist and scholar.

The MD course learning outcomes have been broadly aligned with the previous AMC graduate outcomes, and the College has begun to align these with the revised AMC graduate outcomes. While a mapping exercise has begun to link the existing course learning outcomes to the AMC graduate outcomes, there will likely be some gaps identified. For example, it was hard to see where the Program learning outcomes align with the following AMC graduate outcomes:

1.14 Demonstrate competence in the procedural skills required for internship

1.16 Work within the interprofessional team to identify and justify management options, based on evidence, access to resources and services, and on the patient's needs and preferences

1.21 Demonstrate competence in emergency and life support procedures

2.8 Manage their time, education and training demands and show ability to prioritise workload to manage patient outcomes and health service functions.

More specific and topic/block learning outcomes must be articulated to guide clinical supervisors and students to identify learning opportunities and assist independent learning.

The MD course staff estimate the process of rewriting and mapping of course learning outcomes to the AMC graduate outcomes will take at least another 18 months. It is noted it will be some time before the alignment of graduate outcomes is fully realised.

Areas that need focus and work in both learning outcomes and curriculum renewal include:

- aligning the new standards to the Aboriginal and/or Torres Strait Islander health curriculum
- cultural safety and research
- identification of community needs and consumer input
- the emphasis on the transition to practice.

There may be an issue with the level of awareness that stakeholders and co-located schools have of the work happening, in relation to curriculum development. The team observed this seems to have led to a disconnection across schools/campuses and external stakeholder expectations. As mentioned in Standard 1, there would be value in expanding the scope of engagement and transparency to broader stakeholder groups to inform this developing work.

The College and Program have an ethos of ensuring learning experiences are conducted in diverse training sites. The Program is clear on its commitment to ensuring equitable access to learning experiences of comparable quality. Achieving equitable outcomes is well supported by physical and learning resources at each site—this will be explored in later Standards. The Program strives to ensure all of the core curriculum is equivalent across learning sites, in spite of the diversity of settings (metropolitan, rural and remote) and the reality that learning experiences are not identical across sites. An example of this includes the Longitudinal Academic Program (LAP) in Year 3 and the Transition to Internship Program (TIP) in Year 4. The team reviewed good evidence showing that all students meet the same assessment outcomes regardless of learning context. There is routine comparison of end-of-year examination results across all sites.

The team, however, was given examples of where an apparent drive for 'equitable access to learning experiences' has resulted in a decrease of learning experiences and local teaching (highly valued by students and staff) at various rural sites. The team heard of some positive learning experiences at specific sites that were discontinued due to a perception of inequality between sites, primarily when comparing learning experiences between metropolitan and rural sites. The program should consider why this is occurring and identify how these sites can remain equitable through definition of core learning experiences, without removing highly rated learning experiences.

The team notes the fairly recent formation of the Curriculum Oversight Group (COG) and its work to ensure adequate representation. This group may work as an important mechanism for ensuring equivalence of issues, but the processes appear complex and lengthy. The team is concerned that striving for equivalence may stifle innovation (in some cases it already has) and the sharing of best practice. The implementation of the SARM Program and curriculum renewal is an opportunity to explore ways to ensure equivalency while enabling best practice across the program.

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.

The Program has a purposeful curriculum that is based on well-established educational principles and is responsive to the nature of clinical practice. There are clear examples of curriculum integration in the core design of the program, such as basic science material into thematic topics. The team found the curriculum to have a strong foundational base, and to be logical and well structured, supporting students to have diverse learning experiences, and have accountability for their learning. The curriculum enables an integration of skills, behaviours and research opportunities that prepare students for independent practice.

Curriculum governance has been clarified with the recent formation of the COG, with any proposed changes going through this committee, then the Medical Program Board (and if necessary higher University committees). The team was given examples of how innovation would come up from the those on the ground to the program, but there are concerns about the length of time any such changes would take given University requirements and the levels of change/decision making needed.

There are perceived areas of need for curriculum development, in particular the Aboriginal and/or Torres Strait Islander health curriculum in Years 3 and 4, and a focus on generalist and undifferentiated presentations. The College has plans for this, but the frameworks and timelines are not clear.

There is limited integration of Aboriginal and/or Torres Strait Islander health curriculum throughout the MD Program. There is a strong start with a preparation week and clinical yarning session, and a discrete teaching program in Years 1 and 2. There is a recently reviewed and renewed Aboriginal and Torres Strait Islander curriculum in Years 1 and 2 within the Health and Society domain. This work was led and authored by an Aboriginal health expert.

As mentioned above, Aboriginal and Torres Strait Islander health across all sites in Years 3 and 4 is yet to be developed and integrated. There is significant Indigenous health learning experience in the NTMP, included structured teaching and clinical placements. The MDRS also offers teaching and clinical practice, although experiences can vary. This remains a significant challenge at the Bedford Park campus in Adelaide.

There are plans to further this work in Years 3 and 4, with delivery throughout the LAP and TIP. However, the team is concerned that one of the key authors of this recent and proposed curriculum work has left the University. This role has recently been replaced; however, the team considers the College must expand the team developing the curriculum to ensure work is advanced and not further delayed.

The College is active in research and scholarship, including in medical education. Flinders Health and Medical Research Institute (FHMRI) is the research arm of the College and is a highly productive and successful institute. Research performance has grown, with a significant increase in category 1 funding, publications and awards. Many FHMRI research activities will be relocated to the newly completed Health and Medical Research Building at the Bedford Park campus, with increased capacity. The team is informed that the research programs within it have consumer involvement on steering committees, but it is unclear how this translates to active engagement in research.

The Prideaux Health Professions Education Centre (the Prideaux Centre) sits with the College and is a national and international leader in medical education research. The team notes the departure of the current head of the Centre. The College's Teaching and Learning Academy, designed to support medical educators, seems invisible to educators and staff on the ground, and is not as well utilised as it could be.

The team notes the College has recruited leading Aboriginal and/or Torres Strait Islander researchers and intends to align implementation of deliverables in this area with the College's RAP. The University has also established a First Nations Researchers Collective. There is, however, currently a substantive gap in research and scholarship of Aboriginal and/or Torres Strait Islander health to inform the Program. A systematic program of research and scholarship should be developed to inform learning, teaching and assessment.

There is broad alignment between the medical program outcomes, learning and teaching methods and assessments. The curriculum design is across four domains: Clinical Practice, Professionalism and Leadership, Health and Society, and Science and Scholarship. The course learning outcomes are mapped to these, although as above, further work is needed to incorporate and align the course learning outcomes with the AMC graduate outcomes. The College is encouraged to prepare for the incorporation of revised topic learning outcomes with learning and teaching methods and assessments, and to frame them at a level that supervisors and teaching staff can use. There will also be a need to align medical program outcomes, learning and teaching methods and assessments with the implementation of the Aboriginal and/or Torres Strait Islander health curriculum.

The team is aware of the problems that the transition to the new LMS of Canvas has entailed and the inability to clearly map teaching and learning outcomes to particular teaching sessions and assessments. The team was also made aware of clinical teaching staff not being aware of specific outcomes to enable them to develop clear and appropriate teaching and learning activities for students.

The curriculum is well designed to enable students to apply and integrate knowledge, skills and professional behaviours in their transition to subsequent stages of training. There has been careful planning to develop and integrate the four curriculum domains to achieve this. The team was made aware of a number of innovative teaching and learning activities in these areas.

Despite some apparent issues with staffing and resources, the clinical skills program is very highly regarded. However, the decreases to the clinical experience of students in Year 2 (initially a result of COVID-19 restrictions) remain challenging, and students report that they don't feel well prepared for the next transition to Year 3. The team noted the reintroduction in 2023 of the Year 2 ward placement and the Clinical Skills Consolidation Assessment (CSCA), and the changes made in 2023 to the transition to clinical placement block. The Program should consider further development in this area to remain current. Work-integrated learning (WIL) clinical placements in Years 3 and 4 offer an appropriate range and length of clinical placement in all sites, and students have the opportunities to gain relevant skills and competencies. In broad terms, the curriculum in Year 4 is designed for intern preparedness. There is a longitudinal Transition to Internship (TIP), which is a lecture/workshop series. There has been recent introduction of a Professional Induction to Clinical Practice (PICP) module, which includes online modules, lectures and workshops as well as clinical simulations.

The curriculum is designed to enable students to evaluate and take responsibility for their own learning. It has a supported self-directed learning focus, with students taking increasing responsibility for their learning and teaching. However, some students report that there is insufficient direction or internal resources, particularly for foundational learning and for those with non-science backgrounds. The assessment methods, including the individual readiness assurance test (iRAT), support self-directed learning in the preclinical years. However, the lack of clarity and ready access to learning outcomes, particularly in the clinical years, is a source of frustration for students and staff.

The Professional Development and Learning Portfolio is an important way in which students can demonstrate their self-directed learning. The innovative learning coach process strongly supports students' responsibility for their own learning and reflecting on this as they go through the course. This program was highly regarded by both students and learning coaches. However, it may be beneficial to improve the selection process and training of learning coaches to enhance the benefits of the role for students.

The curriculum design and duration are adequate to enable graduates to demonstrate the achievement of course learning outcomes and AMC graduate outcomes. The challenges the medical program faces are the incorporation of the new graduate outcomes into the course learning outcomes, and the enhanced focus on Aboriginal and/or Torres Strait Islander learning in the curriculum.

The course learning outcomes flow down to inform the learning outcomes of the topics, the organisational units of the course. The topic learning outcomes are in the process of being mapped to the course learning outcomes, and the team understands that there are significant challenges in the use of the new LMS (Canvas) for mapping these outcomes for both students and staff. Each theme within the four program domains has its own learning outcomes, which again are broken down into blocks with specific learning outcomes.

While these are well articulated and documented in Years 1 and 2, students are concerned that lecture content and resources provided do not always align with the learning outcomes provided. Learning outcomes are less well specified and structured in the clinical years, and the team had reports from students, staff and clinical supervisors that this was clearly a significant problem and had been so for some time, as graduated and practising doctors from the Program expressed the same to the team. Students reflected that while they appreciated the self-directed learning approach as it provided a level of control over their education, they felt completely responsible for determining their own learning outcomes and felt let down in their MD experience, with little support/direction from the College and Program to guide their learning. There was significant anger, distress and, at times, envy expressed by students when comparing their experience with other campuses—this was most acutely felt by students based in Bedford Park. Students in the MDRS and NTMP expressed similar concerns with Program-centric content but generally expressed greater satisfaction due to strong local support, more direct learning experience with clinical supervisors, and closer connectivity due to cohort size.

Some clinical supervisors also expressed a similar disconnect and felt they were asked to deliver clinical education without clear direction. They also felt that the quality of educational experience and readiness for internship was severely diminished with the current curriculum and lack of clear or up-to-date teaching content. In some areas of the program, topic coordinators have attempted to mitigate these gaps by developing clearer/current curriculum content and have taken the opportunity to escalate these changes to the CEC and/or COG. The College is strongly encouraged to work closely with topic coordinators and clinical supervisors in the curriculum renewal and alignment of learning outcomes to AMC graduate outcomes to ensure a ground-up approach and currency of the curriculum.

There are a number of opportunities for choice throughout the curriculum related clinical setting, the work undertaken in the Advanced Studies component (research and coursework topics) and the possibility of a combined degree. In Year 2 in Personal and Professional Development (PPD), students choose to undertake an elective broadly situated within the medical humanities—either a formal short course or a community undertaking that meets the learning objectives. There is also the possibility of a prearranged or self-selected elective rotation in Year 4. These clinical options are only slowly recovering post-COVID-19, and students feel that this is challenging.

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.

There are a wide variety of teaching and learning methods used within the first two years of the Program, with a focus on team-based learning supported by specialist lectures and practical lab classes. There is a flipped classroom approach with extensive online resources and pre-reading provided before timetabled sessions. It appears this approach seems to work well, although there is some concern from students about the quality and recency of the pre-session material, including the online provision of the specialist lectures and their adequacy in supporting students' learning. Clinical skills are taught through small group workshops in Years 1 and 2.

Years 3 and 4 comprise immersive WIL placements with most clinical skills and teaching and learning occurring there. There are longitudinal programs of learning in each year (LAP and TIP) with some University-led clinical simulation activities. There is some diversity across sites, and it is noted that in the MDRS there is a very comprehensive program of interprofessional simulation activities.

Formal location-based teaching in the clinical years is varied, and although there are strong moves to ensure equity across all sites, this may come at some cost. The team remains unclear about the PBL teaching in Year 3, and the adequate communication of these topics and cases to all clinical educators.

A variety of learning and teaching methods promote safe, quality care. These include a structured program of clinical skills teaching, and teaching and reflective activities in the Professionalism and Leadership and Health and Society themes. There are particular examples of activities designed to promote an understanding of patient perspectives and their experience of the healthcare system, which include the patient journey mapping project in the preclinical years and the opportunities provided by longitudinal attachments.

However, it is not clear how the course focuses on working 'in partnership' with patients. There are some examples where patients and consumer voices are brought into the program, but they do not appear to inform the student teaching more broadly.

There is some difficulty in patients and consumers seeing themselves reflected in the curriculum. When asked if there is a role now or planned for the future that sees health consumers and community representatives directly engaged in all elements of curriculum development of review, the College indicated that this is planned but not yet fully realised.

As discussed in Standard 1, there is currently limited community/consumer representation within governance and curriculum, and this needs enhancement. The College has one consumer representative, who sits on both the COG and on the Medical Program Board. The challenge with the current approach is that it does not reflect the diversity of community and consumer experience and is not broadly indicative of a commitment to consumer and community participation. The College appears to be open to further advice on how to achieve a more mature approach, and the consumers already involved are keen to develop their engagement.

There are a number of teaching and learning occasions in all years and at all sites in which students will learn from and about other health professionals. There is, however, almost no structured learning with students from other health professions. It is recognised that this does happen on an ad hoc basis in clinical placements but it's not a planned activity. The team commends the MDRS program for its interprofessional simulations which involve all the health professional students at some rural sites. The team was concerned that there appears to be no lead for interprofessional learning, or plans to consider further progress in this area in the curriculum review.

There is a well-developed structured program of clinical skills (including procedural skills) teaching in Years 1 and 2 with small groups with tutors. The team noted that this is a significant area where students do learn

from other health professionals, as nurses lead many of these. There are also structured clinical instructional modules (SCIMs) in various disciplines with consultant specialists in these years, with basic life support skills taught there in Year 1. The team understands that the clinical skills unit has experienced some staffing and resource challenges recently which has led to some student disquiet. There is a new skills consolidation assessment at the end of Year 2 to ensure students are ready for their clinical placements.

The Year 3 orientation includes intensive skills workshops. It includes simulation programs in both metropolitan and MDRS with variations in the Northern Territory that include simulation as well as 12 progressive clinical skill sessions. The focus of simulations in the clinical years is the deteriorating patient and acute care, including advanced life support. An acute care assessment is a capstone assessment for acute skills, particularly in terms of readiness for internship, and there is also a block of teaching in the TIP. Clinical skills practice is then part of the experiential learning on placements.

Students have sufficient supervised experience with patients to develop their clinical skills to the required level, and the course is structured so that they have an increasing level of participation in clinical care. This begins with exposure to standardised patient or hospital observations in Year 1, the SCIMs and general practitioner (GP) visits in Year 2 and then immersive clinical placements. While students are expected to be active members of the team and contribute to patient care, this is variable. Students express appreciation of the opportunities for parallel consulting offered in some GP rotations and in the MDRS.

If we focus on the 'supervised' aspect of supervised experience, the team heard that there don't seem to be robust mechanisms for ensuring adequacy of trained clinical supervisors and supervision across all sites. Evaluation of this concern, and subsequent responding to these concerns, should be considered in the curriculum review.

Structured teaching in Years 1 and 2 addresses the issues of differing needs of communities who experience health inequities and Aboriginal and/or Torres Strait Islander communities. In the clinical years, these issues are a focus of both teaching and clinical placements in the NTMP and MDRS but appear to be implicit and ad hoc in the metropolitan campus.

The course tries to ensure that teaching and learning is culturally safe by requiring program staff to undertake cultural awareness training and expecting clinical supervisors to do so. Much of this is developed and run by the University or SA/NT Government health departments.

The Year 1 and 2 Indigenous health curriculum is informed by Aboriginal and/or Torres Strait Islander knowledge, and there are key Aboriginal and/or Torres Strait Islander staff members in the MDRS and the Northern Territory programs.

Students undertake a wide variety of face-to-face experiential learning throughout the course. The team were provided with extensive detail about these in terms of the variety of clinical disciplines, the range of experiences across the life cycle and the range of settings. Starting in Year 1, the course offers an extensive and comprehensive range of experiential learning activities, both clinical and non-clinical. With the curriculum review focused on generalism, it will be important that specialty and subspecialty rotations are structured to give adequate opportunities for generalist experiential learning.

Currently, all students undertake a pre-internship program. Preparation for internship has been a recent addition to the program in response to perceived needs of students and feedback from the Medical Deans Australia and New Zealand (MDANZ) readiness for practice surveys. The program was trialled in 2022 and became mandatory in 2023. The program consists of a four-week transition to practice block at the end of Year 4, which consists of a two-week module of readiness skills with intensive simulations and two weeks shadowing an intern. This is supplemented by a year-long Transition to Internship (TIP) program of lectures, which provides basic content of issues/topics an intern is likely to need. This program runs in the metropolitan region and in the MDRS. In the Northern Territory, there is a separate program, with intern shadowing introduced in 2024. Intern shadowing is up to four weeks in the NTMP and MDRS. It is noted that while students very much appreciate this pre-internship experience, they still feel that that this could be further expanded. Given its recent introduction, the team requests a progress report and evaluation of the new Northern Territory pre-internship program.

The team also notes that they received very warm, positive responses about the quality of Flinders University graduates from LHNs and others who came in contact with them.

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.

The University's Assessment Policy has the following core principles:

- Assessment is integral to learning and encourages, guides and supports learning.
- Assessment is integral to topic (module) and course design and aligned to appropriate academic and pedagogical standards.
- Assessment is communicated effectively.
- Assessment provides valid and reliable evidence of student learning achievements.
- Assessment is fair and equitable.
- Assessment practices accord with the University's academic standards.
- Approaches to assessment are continuously reviewed with a view to improvement.

The MD Program is compliant with these principles.

The Program includes both in-course and end-of-year assessments. In the first two years, in-course assessments consist of written tests, clinical skills assessments and assignments. In the third and fourth years, they involve mini clinical evaluation exercise (mini-CEX) assessments, and the Global Assessment of Progress (GAP) conducted by the clinical supervisor. Some in-course assessments are formative, but in Years 1 and 2, there are seven to nine summative assessments that must be passed. If a student fails a summative assessment, they are allowed to re-sit the exam. However, failing on the second attempt results in failure of the semester.

A progress test runs throughout all years, which is formative in Years 1–2 and summative in Years 3–4.

Moving to programmatic assessment

The Program has goals to move towards programmatic assessment, with current efforts reflected in the adoption of the progress test, the portfolio and the learning coach initiative. Some existing assessment methods are evolving to align better with a programmatic approach, such as proposed changes to the GAP form. The Prideaux Centre houses significant expertise in assessment, particularly in programmatic assessment, with contributions to and references from published literature. The team learned after the visit that one of the key experts in programmatic assessment is leaving. As a result, the program's assessment

policies and processes align with current research. The broader University is aware of and appears supportive of these efforts to move towards a more programmatic approach.

Currently decision making is made based on passing the specified summative assessments and there is little decision making based on longitudinal performance of specified attributes, which would be needed if there were a move to a more programmatic assessment approach.

In relation to fairness, flexibility, equity, validity and reliability, many of the assessments, such as the portfolio and advanced study project, cannot be evaluated using conventional psychometric measures. However, there is good evidence on sufficient reliability of the progress test. The Objective Structured Clinical Examination (OSCE) comprises eight 10-minute stations so is also likely to be sufficiently reliable, although data on this have not been provided. The team had concerns about equity of assessment, particularly for students with Disability Access Plans; this is discussed further under Standard 4.2.

The validity of the OSCE is ensured through a review of proposed stations and the use of experienced station writers. Additionally, there is a system in place for examiner training and calibration. While the range of topics assessed in the OSCE has remained fairly consistent over the years, a formal review of the blueprinting process is currently underway. The validity of the progress test is also maintained through a review of individual questions, with the tests blueprinted against specific areas such as organ systems and health systems.

At the end of Year 2, there is a Clinical Skills Consolidation Assessment (CSCA) which is a 30-minute observation of a student taking a history from a simulated patient and then performing a targeted physical examination. The students state that this seems useful and helps them prepare for Years 3–4 and for the Year 3 OSCE. Students also appreciated the recently implemented prescribing skills assessment.

Training of assessors for the revised GAP is yet to occur. Students who pass assessments with the aid of special assistance are not required to be notified to the Australian Health Practitioner Regulation Agency (Ahpra).

There is a well-developed system to identify students who may be struggling, primarily facilitated by learning coaches. Students meet with their coach throughout the year, typically discussing their performance on completed assessments, which helps them recognise strengths and areas for improvement. Each coach usually works with four to eight students. Continuous evaluation of the program is encouraged, as it is already thought to promote independent learning and help students develop a more internal locus of control. Regular surveys of both students and coaches are conducted, and the system is adjusted based on the feedback received.

While the team heard student experiences may vary depending on the coach and student, the system generally works well. The entire process is overseen by a learning coach coordinator, and if interpersonal conflicts arise between a coach and a student, reassignment is possible, though rare. Recruitment of coaches can sometimes be challenging, but many recent graduates who have benefited from the system are eager to give back by becoming coaches, reflecting the positive impact of the initiative. Although some coaches may also be involved in assessing students, any potential COIs are identified and managed effectively.

On four occasions spread over each year, all students across all levels complete 120-item multiple-choice question (MCQ) progress tests. Their results are compared both to their peers in the same year and to their own previous performance. Students receive their total scores, along with a detailed breakdown of the number of correct, incorrect and unanswered questions, as well as a category-specific analysis based on the test blueprint. This helps students track the development of their knowledge and progress toward achieving the cognitive outcomes of the medical program.

Expected professional behaviours have not yet been clearly defined, and there is no specific, dedicated longitudinal assessment focused on professional behaviours. However, outlying behaviours may be identified through existing assessments. Aligning the assessment blueprint with the AMC graduate learning outcomes could help identify this gap, which in turn may inform ways in which that gap could be filled.

The course and topic learning outcomes have been mapped to the previous AMC graduate outcome domains. While current assessments have been mapped to both the new AMC graduate outcomes and the course

learning outcomes, the reverse—where all AMC graduate outcomes are clearly shown to be assessed—has not yet been done. There is a high-level blueprint covering the four AMC domains.

Conducting a more detailed blueprinting exercise would likely be valuable in identifying gaps, some of which are already known, such as in the assessment of cultural safety and professional behaviours. At present, it is unclear whether all AMC graduate outcomes are assessable within the current assessment system. Consequently, it is also unknown which specific outcomes are achieved at each stage of the program.

The assessment program includes longitudinal components, in-course assessments and end-of-year exams. Students integrate these assessments through the Professional Development and Learning Portfolio. In this portfolio, students are required to synthesise information from all assessments and reflect on their plans, performance and progress in relation to the four AMC domains, though not specifically the AMC learning outcomes. This is then used as the basis for discussions with a learning coach. Part of the learning coach's role is to support students to engage meaningfully with the portfolio and view it as a mechanism to become more efficient and strategic in their learning.

The longitudinal components of the assessment program are:

- the Professional Development and Learning Portfolio and learning coach initiative
- the progress test
- advanced studies.

The in-course components are:

- assessment of clinical examination skills in Years 1 and 2
- Global Assessment of Progress (GAP) during placements
- topic-specific assessment programs
- block tests in Years 1 and 2

There are end-of-year components, including the Year 3 OSCE.

On four occasions, spread over each year, all students across all levels complete 120-item MCQ progress tests. These are formative in Years 1 and 2 and summative in Years 3 and 4.

The advanced studies project is assessed by the supervisors and scored on an eight-point scale. In the final year, all students complete the advanced studies capstone, which may be a presentation of research, clinical audit findings at a conference or an assignment that is reviewed by an expert third party reviewer who marks the students against the learning outcomes.

In Years 1 and 2, clinical skills assessments are conducted using marking checklists. The final decision on whether a student has passed is based on their satisfactory performance across a sufficient number of skills. To ensure consistency among assessors, history-taking and physical examination assessments are video recorded, allowing for moderation by a second assessor if needed. At the end of Year 2, students undergo a CSCA, which includes a marking guide.

In Year 3, students are assessed on their clinical skills using an OSCE-style assessment with eight 10-minute stations. Each OSCE station is created by content experts who have received specific training in writing OSCE stations. These stations are then reviewed by relevant discipline groups to ensure they meet appropriate standards for the examined level. Additionally, during each clinical placement in Years 3 and 4, each student must complete a minimum of three mini-CEX assessments, which are scored on a standard mini-CEX form by the observing supervisor.

Hand-over presentations (ISBAR) are marked using a rubric.

In Years 1 and 2, each topic is assessed through its own specific assessment programs, including assignments and tests, as well as summative block tests, which are typically in MCQ format. These assessments aim to cover the teaching content related to the specific discipline or organ system for that block.

During the clinical rotations in Years 3 and 4, GAP forms are used for in-training assessment based on six criteria. These forms are completed by the student's clinical supervisors and then compiled and reviewed by the topic coordinators. The newly appointed MD Assessment Lead plans to review the current GAP forms to simplify the process for clinicians, enhance reliability and validity, improve equity across disciplines and locations, and ensure alignment with the PGY1 and PGY2 framework.

As expected, there is some variation in ratings depending on the examiner. However, there appear to be enough observations, along with a comprehensive synthesis of overall performance patterns, to ensure sufficient reliability and validity.

In the final year of the MD Program, Year 4 students prepare an executive portfolio summary—a capstone assessment that supports the student to identify and evaluate their achievements across the four AMC domains throughout the four-year MD Program.

Overall, the nature and timing of these assessments aligns with the intended learning outcomes and with the teaching and learning activities. The balance seems appropriate, but this can only be finally determined once all the blueprint gaps against the AMC graduate learning outcomes have been identified.

Standard-setting methodology is applicable for MCQ tests and OSCEs. For the MCQ progress test, standard setting is undertaken for each year level using the Cohen method and this seems suitable. Standard setting for the end-of-year written tests also uses the Cohen method and this also seems appropriate.

In the Year 3 OSCE, students at each station are assessed based on three competency domains. There is no formal standard-setting mechanism in place. With eight stations and three competency domains for each station, there are a total of 24 components. The pass mark is set at 17 out of 24.

One justification for this passing score is based on the concept of a borderline student who has a 50% chance of passing a station. With a requirement of 17 out of 24, the probability of a borderline student passing the OSCE by chance is less than 5% (specifically, 3.31%). However, this method does not account for variations in examination difficulty.

To identify any such variations from the intended difficulty, post-administration analyses are conducted. These analyses assess problematic domains, ensure equivalence across campuses, evaluate the number of successful and unsuccessful students, and examine score distributions. While these analyses can lead to adjustments in the pass standard, changes to the 17 out of 24 requirements are uncommon.

Final results are calculated and announced only after the post-test quality assurance process. This mechanism has been in place for many years and appears to be stable. The post-examination analysis helps guard against variations in examination difficulty that could impact the pass standard. Additionally, the institutional memory of station writers and OSCE organisers can help prevent significant fluctuations in station difficulty. While there is no formal standard-setting mechanism for the OSCE, the current practices and institutional memory likely ensure that standards remain reasonably consistent and appropriate across years.

The assessment of cultural safety and Aboriginal and Torres Strait Islander health is still in its early stages, reflecting the evolving nature of the curriculum. Written documentation indicates that there is an assignment in Year 1 in which students analyse a case study to map the health journey of an Aboriginal and/or Torres Strait Islander patient and their partner living in a remote area. A similar assignment in Year 2 focuses on barriers to health care. However, during discussions with the assessment personnel, these assessment methods were not mentioned, making it unclear how meaningful or visible these assessments may be. It is possible that some aspects of cultural safety are incorporated into certain stations in the Year 3 OSCE, but this area is still under development.

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.

The portfolio and learning coach initiative is a significant strength of the program, likely enhancing student engagement with feedback and promoting lifelong learning. In the portfolio, students regularly write reflections on their experiences, progress, strengths, weaknesses and proposed learning activities. These reflections are discussed during learning coach meetings, for which students prepare an agenda.

The meetings provide an opportunity for students to review feedback from their assessments and evaluate their progress. After each meeting, students are required to write minutes and upload them to their portfolio. This process allows students to reflect on their progress and engagement with their portfolio, as well as consider the feedback provided by their learning coach. The minutes also serve as a starting point for the agenda for the next learning coach meeting.

As part of the team-based learning activities, there are formative weekly iRATs that provide students regular feedback on their progress leading up the test. After the test, students are provided with an overall score and distribution of scores for that test across their cohorts.

In the clinical skills assessments in Years 1–2, students are provided feedback including a rubric of satisfactory/unsatisfactory against key competencies assessed, with qualitative feedback provided in writing against each competency.

Feedback from the progress tests includes individual absolute scores, percentage scores, the number of items answered correctly, the number of items answered incorrectly, the number of unanswered items, scores for each blueprint category, and an overview of the year group's performance. However, a recent change in the LMS has made accessing this feedback more cumbersome.

For students in Years 3 and 4 who are identified as struggling based on their individual results, strategic study coaching is offered to provide additional support.

For the Year 3 OSCE, students are provided with an overall score as well as qualitative feedback for each domain of each station.

There are opportunities for feedback as part of the GAP forms and mini-CEX assessments, but the quality of this feedback can vary.

The learning coach initiative incorporates assessment results to identify students who may need additional support and to help them locate effective resources and activities. Topic coordinators can also identify students who are not performing at the expected level. Progress test results can reveal students who are struggling in the cognitive domain.

In Years 3 and 4, students identified as 'doubtful' by the GAP assessments will meet with the assessment lead and/or their term supervisors. If a clinical placement supervisor has concerns about a student's performance, they are encouraged to discuss these issues with the topic coordinator and to meet with the student midway through the placement to identify areas for improvement before the final summative assessment at the end of the rotation.

GAP meetings are held every six weeks, bringing together representatives from different streams to discuss 'doubtful' students and review the number of doubtful students from each campus.

Timely feedback to students

The team heard of gaps or delays in reporting performance of individual students and of cohorts, resulting in unclear communication, causing distress and disruption to progression. These included delays in informing students of the assessment outcomes leading to progression, which required remediation of the MD year by the student. The team heard of at least two instances, over the course of the assessment, of students progressing into the next MD year, only to be pulled back into the previous year, well into the clinical year. Whether this was due to an extraordinary administrative error or lapse in communication is unclear; however, the College should be aware these incidents were alarming to students, and steps should be taken to address student concerns raised as well as identify steps to mitigate these circumstances.

The Program has already identified a need to strengthen the reporting of student cohort performance to academic staff and clinical supervisors. It is planned that a summary report on student performance on key assessments (e.g. progress tests, block tests, GAPs and OSCEs) will be presented to the topic coordinators and then shared with a wider stakeholder group (e.g. key academic staff including block and theme leads), the CAG, the COG and clinical term supervisors. The team looks forward to learning of the effectiveness of this.

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.

A formal external review of the assessment program was conducted in 2018, resulting in 12 recommendations, most of which have been implemented. These recommendations included making the processes involved in programmatic assessment more transparent for students, increasing the full-time equivalent (FTE) for the head of the MD Program, and appointing an academic lead for assessment across the program.

In 2019, a University-wide review and revision of assessment policies and procedures took place. This process ensured that all assessments are moderated, that review and appeals processes are more transparent and equitable, and that any necessary variations, such as extensions and supplementary assessments, are better regulated and fairer for all students.

Recently, a new MD Assessment Lead has been appointed, and a further review of the assessment system is planned within the next two years. The goals of this review include increasing engagement with students and assessors, refining the GAP form for Years 3 and 4 to focus more on narrative qualitative data rather than quantitative data, enhancing the assessment of interprofessional collaboration, and integrating the assessment of culturally safe practice into key assessments throughout the program. The team encourages the assessment of professionalism to be included in that review.

Review of assessment items, such as OSCE stations or MCQs, occurs through peer review to check for relevance, appropriate level of difficulty and clarity. For large scale assessments, such as the OSCE, block tests or the progress test, there are post-administration psychometric reviews using standard methodologies. These aspects seem robust and appropriate.

The Program personnel are aware of the potential impact of generative artificial intelligence (AI) on how students may answer questions and has begun exploring ways to adapt to this. Staff are already using AI to help generate assessment items.

Improving assessment quality

The MD Program is exploring an alternative solution for the current item banking system to facilitate better quality assurance processes for item generation and evaluation. The current database is shared with two

other universities and has worked well in the short term; however, it was increasingly difficult to source good items for the progress test. Once the new system is in place, the current database will be decommissioned. In addition to this, the Program is also exploring using AI for item production, working with clinicians, and is considering this and other options (i.e. a commercial item banking system) before making a decision.

All students of all year classes from all campuses sit the same progress tests and block tests at the same points in time, have the same amount of time and are governed by the same set of policies and procedures. Students must sit the OSCE in Year 3 at one of two sites (Bedford Park or Darwin) where the assessment uses the same stations at the same time. Post-administration analyses are performed to explore differences by campus.

For workplace-based assessments in clinical placements, supervisors are given a GAP information sheet that describes the assessment domains and outlines processes and expectations. Ratings on these and the mini-CEX assessments may vary, as might be expected, but there is likely to be enough samples to mitigate any systematic effect.

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.

The Program's entry pathways and selection processes align with the College's ethos of recruiting cohorts of students from diverse backgrounds. There are a good number of students who identify as Aboriginal and/or Torres Strait Islander as well as from rural backgrounds, particularly in the NTMP and MDRS. The College publishes an annual domestic application guide, which includes the number of available entry places in South Australia and the Northern Territory.

There has been a rapid increase in student numbers in recent years with further expansion planned, and, especially in the Northern Territory, this appears to have put strain on the existing facilities, clinical placements and staffing. This will likely be exacerbated by the proposed increase in numbers of Flinders University students from 2025 and by other medical programs seeking placement opportunities, including the commencement of the CDU medical school discussed in Standard 1.

There are additional concerns about the ability of the Program to attract sufficient applications from students with the required ability to enter the Program, especially in the Northern Territory, where in 2024 only around 80 potential students applied for the 37 available places. The Program might consider additional outreach and marketing work to publicise the program and encourage applications.

The University has a Student Success and Retention Strategy (2020–2025), developed with student guidance, which aims to ensure students are set up to succeed in their academic pathway. A College-level student success framework is under development, focusing on academic transition points and developing toolkits for academic staff to support student success.

The MD Program has specific subquotas for student selection targets to support increasingly diverse student cohorts. The successful application for additional CSPs in South Australia and expansion of industry-supported places in the NTMP has enhanced the ability of the College to recruit students to the Program. There are a total of 110 CSPs for all students based in South Australia. There will be an increase from 36 to 46 students based in rural South Australia from 2025 onwards. The University has secured additional CSPs under the Increasing Rural Medical Training Initiative for the student cohort commencing in the SARM Program in 2025. This cohort will have a projected 14 additional students, with seven each at the Mount Gambier and Riverland campuses.

SARM Program

The new SARM Program for South Australia–based students offers non-bonded places. There are specific subquotas, including for quotas for students from rural backgrounds, Aboriginal and/or Torres Strait Islander students, and MDRS transition students completing Year 3 in a rural community. The team spoke with a number of students from the MDRS program who were enthusiastic about their current experience and

opportunities in the SARM Program. Many expressed willingness to remain in rural and remote clinical practice into internship and beyond, which was very positive for the team to see.

NTMP

The places for the NTMP are offered under the NT Bonded Medical Scheme, provided by the NT Government, with a Return of Service agreement. Offers are made on the following basis:

Priority 1: Aboriginal and/or Torres Strait Islander students who meet Northern Territory residency requirements

Priority 2: Non-Indigenous students who meet Northern Territory residency requirements

Priority 3: Aboriginal and/or Torres Strait Islander students who do not meet Northern Territory residency requirements

Priority 4: Non-Indigenous students who do not meet Northern Territory residency requirements.

Indigenous Entry Stream

The IES is an alternate pathway for Aboriginal and/or Torres Strait Islander students, with or without a valid GAMSAT score, to enter the program. This is supported by the Preparation for Medicine Program (PMP) and Flinders University Extended Learning in Science (FUELS) program, which is an online program providing learning around concepts in chemistry, physics, biology and numeracy.

The team notes the utilisation targets are not consistently used across the various programs and entry pathways in the MD Program. The overall strategy for recruitment of these cohorts is also not clearly evident and should be articulated to facilitate evaluation as well as continuous improvement of selection policies and admission processes.

There are University-level supports, including health counselling and disability services, Student Success and Wellbeing Advisors, and for Aboriginal and/or Torres Strait Islander students through Yungkurrinthi Student Engagement. The University also has an active Pride Network designed to create a welcoming community for the LGBTQIA+ community.

At the Program level, students in MDRS have dedicated professional staff who check in on student welfare, with clinical educators providing additional support. Students the team spoke with in the MDRS program spoke highly of the support they received locally to succeed in the program, and felt valued by staff and educators. In the NTMP, there were less visible support structures for the students. The team observed that while strategies exist to support Aboriginal and/or Torres Strait Islander students, strategies for students from rural areas and other equity groups are limited, often not highly visible and in many instances are self-directed or provided outside or incidental to the Program.

Current mechanisms for Aboriginal and/or Torres Strait Islander students occur through Indigenous community engagement and partnerships, such as Flinders and Adelaide Indigenous Medical Mentoring, and occur in some situations in the MDRS program and the NTMP. Specific examples for the Adelaide metropolitan campus could not be identified. While there are individuals in the College or MD Program as well as the Elders on Campus that Aboriginal and/or Torres Strait Islander students may look to for support and mentorship, there is no structured approach to cultural support, leaving limited help for students who may be struggling.

There were safety and wellbeing concerns expressed for Aboriginal and/or Torres Strait Islander students by non-Indigenous students, leading the team to believe that proactive measures are essential to secure a safe learning environment. This includes enhanced cultural safety/awareness training and more supportive leave policies to accommodate the unique needs of Aboriginal and/or Torres Strait Islander students.

With the commencement of the CDU medical school in Darwin and transition of the MDRS to the SARM Program, the College and Program should proactively plan to ensure smooth transitions for increased cohorts planned in these rural schools. The team notes there has been some forward planning done to increase spaces for students, particularly in the MDRS. It is imperative, especially for the NTMP as discussed in

Standard 1, this is prioritised alongside important relationship-building with stakeholders to ensure students in co-located medical programs or placement sites are not negatively impacted.

The University has specialised disability services that provide information, and disability advisors facilitating access plans and alternative examination arrangements. The College has its own Disability Academic Advisor, who serves as a point of contact for students with disability and provides advice for academic staff. The MD Program has admitted a number of students with disabilities, which is not a requirement for disclosure at admission, and is a voluntary requirement.

Despite these measures, the team heard there can be variable responses to supporting students with disabilities by University staff, and examples of disparaging remarks made to students were provided. This has fostered a perception among students that the College and Program do not support inclusion, and do not have adequate and accessible systems and infrastructure to retain students living with disability or to help them succeed in the completion of the Program. More on wellbeing is discussed in Standard 4.2, and infrastructure needs under Standard 5.

Current information in the admission guide states that if students with a disability do not meet Program requirements, the College will guide them on study options available. Students indicate providing a link in the admission guide to the University Disability Policy and Work Integrated Learning Policy and Procedures will better support prospective students to make better informed decisions about their choice of study.

The University supports the admission of a diverse student population with the Admissions Policy and Student Admission Procedures accessible on the website. The College's entry requirements, course and application information and student subquotas are clearly articulated and publicly available on the Flinders University website. The team did not hear concerns about bias or discrimination in the selection policy and admission processes.

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.

One of the objectives of the University's Student Success and Retention Strategy (2020–2025) focuses on student wellbeing, which includes 'physical, financial, and psychosocial wellbeing for staff and students.' A University-wide Wellbeing Working Group has been constituted to implement the strategic plan and includes a representative from the College. There are University-level activities, such as student societies and clubs, which may promote personal wellbeing; however, students were agnostic about these activities to promote their wellbeing.

In keeping with University policies and practice, the Program emphasises student wellbeing and inclusion from the outset of the course. In Year 1 of the MD Program, students attend a preparation week, which delivers mandatory presentations on cultural awareness and safety and mental health support. Students attend a meet and greet and are introduced to key staff of the College and Program.

Topic coordinators are identified to provide key support to students throughout the program and liaise with the University's health, counselling and disability services should students require specific supports. The allocation of a learning coach to each student is an integral part of the Program's wellbeing measures with the belief that this identifies students who are having difficulties and enables feedback and assistance where necessary. However, as discussed in Standards 2 and 3, the students indicate that there is considerable variation in the support provided by the learning coaches with some offering considerable guidance and even assuming a mentorship role, while others are less involved.

The implementation of the wellbeing strategic plan at College and Program level will be of continued interest to the AMC, as a range of wellbeing concerns were raised by students.

The University provides counselling services which are well utilised by students. However, it was suggested that the central counselling services have long waiting lists, are able to provide only 'basic' advice, and students are permitted only six sessions before they are advised to seek external help if necessary. These services typically have appointments available only during regular working hours which creates a barrier to Year 3 and 4 students who are expected to be on clinical placements during these times.

The team observed some students expressed a lack of trust in centralised wellbeing services, as these services were identified by students as a source of negative impact on their wellbeing. The team heard students raise a number of instances of poor handling of mental health crises, including a critical incident involving a student on campus. This incident was extremely distressing and had a negative impact on the student cohort with many feeling the University and the College did not have structures in place to manage a similar critical incident proactively or appropriately. The College is generally seen by students as reactive rather than proactive in terms of supporting wellbeing needs, which reflects a general lack of centralised and impartial resources.

Inclusion is an important aspect of the Program in the Northern Territory where there is considerable diversity in the student cohort and the teaching staff. A psychologist is available to students three days per week, and a mentoring program has been implemented to provide students with additional learning support. Medical mentors report to Year 1 and 2 topic coordinators and meet assigned students up to five times a year to discuss academic progress.

Topic coordinators are similarly involved in student academic support in the MDRS and clinical supervisors may raise concerns with clinical educators in rural South Australia.

The Program relies predominantly on self-identification of students who have physical, mental or learning challenges, disability or other conditions. These students will require additional support or reasonable adjustments to enable them to complete the medical program. An individualised Disability Access Plan can be created on advice from disability services, and College Disability Academic Advisors may act as liaison points between academic staff, students with disability and health, counselling and disability services.

Students are expected to declare annually their fitness to practice, whether or not they have a Disability Access Plan. This relies, to an extent, on self-identification by the student concerned. Where a student is determined to be unfit for placement before or during the placement, there are procedures for remediation and, if necessary, exit from the course.

For these and other reasons, students expressed concern that there may be under-reporting of personal problems, learning difficulties or difficulties with clinical experiences as they fear repercussions, and in some cases, disclosure of their Disability Access Plan. This is especially the case in areas where small student numbers or particular incidents which have occurred mean that the reporting student can be readily identified.

Students indicated that there was reluctance to apply for a Disability Access Plan as it was believed that the Program actively discouraged such applications. It was also believed that the adjustments that might be made only related to extra time in written exams. Other examples include:

- Students with disability were allocated to exam rooms involving access by numerous stairs. At Bedford Park, the only access to the campus from the medical centre is via stairs, effectively isolating some students with physical disability. Students believed that there was little to no willingness on the part of the College and Program to make provisions for students with disabilities.
- Some students with Disability Access Plans were placed in an exam room with students for whom English was a second language, who also had been given extra time to complete the assessment. While students are not explicitly told why others are in the same room as them, some felt that this contravened the requirements of confidentiality and privacy, as it was obvious which students had some form of disability.

It is noteworthy that the students claimed that they had no knowledge of any policies for managing students with an impairment when there are concerns that the impairment is impacting the student's ability to undertake placements or future practice. They expressed a belief that the Program was of the opinion that a doctor needed to be 100% fit, and anything less means that a student cannot complete their MD. There were reports that students with an impairment were primarily advised to leave the program for 12 months, seek outside help, and return only if they were completely recovered.

Discussions with clinical schools and placement sites indicated a willingness to implement changes, such as required times for attendance. One example is of a change where Junior Medical Officers were excused from working on night shift. Other modifications, where feasible, would also be considered to enable students with an impairment to study there; however, as this has never been requested at some sites, there is no awareness of the extent to which modifications would be possible. It would be beneficial for all campuses to share information more broadly to facilitate better experiences for students.

There are University and Program policies to support flexible study for students, such as the Disability Policy discussed above. This is supported by the Assessment Variation Procedures and Work Integrated Learning Procedures, which indicate that students with a pre-existing medical or other condition should discuss reasonable accommodations with their topic coordinator. In addition, the MD Program has procedures for students requiring long- and short-term leave from study. This includes sick leave, carer's leave, planned personal leave, and leave for pregnancy. Students returning from long-term leave are supported with a refresher topic, Clinical Practice Preparedness, and remain allocated to the same learning coach from prior to their leave period.

The team did not hear significant concerns about the application of leave policies generally. However, there were concerns about the inclusion of equity groups in these policies, particularly for leave required by the LGBTQIA+ community, parental leave, and cultural leave for Aboriginal and/or Torres Strait Islander students. The Program should review these policies and ensure they are reflective of students' individualised needs.

Topic coordinators and learning coaches form an important layer of wellbeing as well as academic support for students, and fill a crucial gap in wellbeing resources. However, as these roles also determine student progression, it is important to communicate to students how COIs will be managed, and if there is another wellbeing source the student may access who does not have an academic role. It was also discussed in this role that the quality of support from learning coaches is inconsistent for students, and this may also be the case for topic coordinators.

Students were also concerned that there was not always separation between the timing of feedback and student assessment and grading, and they believe that negative or delayed feedback has the potential to adversely affect the student's progress.

The team notes there are University and Program policies and resources in place to identify, address and prevent bullying, harassment, racism and discrimination. The team did not hear of widespread incidents from students in the MDRS and NTMP; however, students primarily based in Adelaide expressed concerns regarding racism and discrimination, particularly in clinical settings. The application of these policies across the board requires greater attention and action to prevent discriminatory behaviours and ensure the safety of students. More could be done to ensure all individuals with an educational role, in or out of clinical settings, are educated in the policies and appropriate behaviours as part of their commitment to teaching students.

Student feedback on their wellbeing

Further to the concerns raised in this Standard, the team heard a similar thread from students across campuses about of a general lack of trust in the College's ability to support them adequately and safely through their program of study. Students raised concerns about a lack of direction in the curriculum and learning objectives (discussed in Standard 2), and the College facilitating appropriate practical support for clinical placements. These educational challenges were exacerbated by experiences of hostility, or a lack of interest shown by staff about their wellbeing and provision of feedback about negative experiences of the program. Some former students and staff the team spoke to also shared these experiences, which signalled to the team a systemic issue.

There was also a sense that application of policies, both academic and wellbeing, were rigidly applied with little consideration to individual circumstances. There were also examples of poor communication to students about academic rules, which had an impact on their wellbeing and sense of belonging to the Program, College and University. While there were also positive environments or situations experienced by students, these were outweighed by negative experiences. Many students expressed to the team a range of emotions from resignation and cynicism to visceral anger about their circumstances or those of their cohort.

The College and Program should work with the FMSS, other student groups and the wider student body to identify practical ways to improve the student experience and wellbeing, providing assurance that they will be well supported throughout their education. Monitoring mechanisms are further discussed in Standard 6.

4.3 Professionalism and fitness to practice	
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.

The placement requirements for medicine define the student responsibility in a clinical placement; students are required to complete compliance checklists prior to commencement of Years 3 and 4. This includes a declaration of fitness for placement. There are two consent forms available for students to complete depending on their placement location—one is for internal WIL placement with Flinders University and the other for placements with other institutions. This information is publicly available on the University website.

As previously noted, the Flinders University MD Program relies predominantly on self- identification of students who have physical or mental impairment, disability or other conditions which may impact their ability to complete placements or to undertake future practice. Where a student is determined to be unfit for placement before or during the placement, there are procedures for remediation and, if necessary, exit from the course. Students indicated that there was reluctance to apply for a Disability Access Plan as it was believed that the Program actively discouraged such applications.

University statutes outline required conduct of students, and the Program emphasises professionalism as all students undertake structured learning in Personal and Professional Development (PPD) in Years 1 and 2 of the Program. Throughout the course there are assessments focused on detecting unprofessional behaviours. Learning coaches have an important role in ensuring that students understand and develop professional behaviour through engaging with feedback they receive, and assisting in development of learning goals and action plans to monitor their progress. Where a student allegedly engages in unprofessional, illegal or unethical behaviour, or is believed to be unable to practice safely, there are procedures in place to prevent them from undertaking a WIL activity and to escalate the concerns.

The College has Academic Integrity Officers, who are academic staff who have been chosen in accordance with the University's Student Academic Integrity Policy to deal with allegations of failure to meet academic integrity standards. Efforts are made to remediate the student, but ultimately, there is a provision for referral to Ahpra.

Culturally safe practice

The team were not able to identify specific policies or procedures referring to culturally safe practice. This should be revised and aligned with the development and implementation of the curriculum in Years 3 and 4 to inform the identification, assessment and remediation of students who struggle with culturally safe practice.

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.

The University has a Risk and Assurance team, supported by the Colleges, which monitors all aspects of student indemnification and insurance. Public liability for all students is provided, as is professional indemnity and medical malpractice insurance. On placements, there is additional coverage for student personal accident and travel.

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.

The main educational facilities and infrastructure for the MD Program based at Bedford Park have been updated over the years since the last accreditation visit and are currently fit for purpose, but increasing student numbers are likely to stretch these. Bedford Park facilities include a variety of spaces for teaching and learning, laboratory spaces, the study of anatomy, simulation labs, library and student study spaces. These facilities are used by the College as a whole, not just the medical program, and require significant timetabling to manage different requirements.

The facilities for MDRS/SARM have been extended to meet the need from additional Years 1 and 2 students, and the University has worked to identify what additional facilities would be necessary to support these extra students, including the use of relocatable buildings.

In the Northern Territory, Charles Darwin University accommodates Year 1 and 2 students, with a lease in place for the CDU facilities until 2035. In Darwin, the facilities within the Flinders University Clinical School are shared and some are multifunctional and therefore can be reconfigured for different purposes.

The Program reports that they have recently refurbished facilities at Casuarina (in Darwin) to accommodate increasing student numbers, and in anticipation of further growth, planning has commenced for further expansion.

The University has facilities to support students with additional needs including support services, ramps and lifts, parenting facilities, a prayer room and a sensory space. Students were appreciative of the facilities and their maintenance but reported that the physical distance and changes in topography between Flinders Medical Centre and the Health Sciences Lecture Theatre Complex is challenging for students living with disabilities. Examples were given where students with disability had been allocated to exam rooms involving access by numerous stairs.

At Bedford Park, the only access to the campus from the medical centre is via stairs, effectively excluding some students with disability. Students believed that there was little to no willingness on the part of the Program authorities to make provisions for students with disabilities.

Further spaces to support Aboriginal and/or Torres Strait Islander students are available at Yungkurrinthi Trruku. Campuses are generally supported with transportation options and/or parking, although at the Bedford Park campus, parking is not free for students.

During clinical attachments, especially in General Practice, students may be required to travel some distance; those in MDRS need their own vehicles and travel subsidisation is provided, although students report that this is sometimes not provided and often insufficient. For shorter attachments in rural areas, access to safe transportation is a priority for students.

Within South Australia, students are expected to find their own accommodation when based at Bedford Park. Students currently in Years 3 and 4 in the MDRS—and in SARM from 2025 and NTMP students undertaking regional clinical placements—are provided with accommodation. Students in Years 1 and 2 in SARM from 2025 will be expected to find their own accommodation, and current students in the MDRS are concerned that this will be difficult as accommodation is scarce and costly. They feel it is inequitable to only provide accommodation for some students. While studying in Darwin, NTMP students find their own accommodation.

Students in the Northern Territory reported difficulty being provided with suitable accommodation across the Territory, especially in smaller centres. This was considered to be a significant concern with increasing student numbers, and the presence of other providers. The students also reported concerns about safety and security. The Manager for the NTMP said this had not been notified to her in recent years but acknowledged that security needed to be front of mind.

While campuses are generally supported with adequate information technology (IT) services and infrastructure, there have been many instances of lack of cohesion of various IT services during the centralisation process. In particular, the move to the Canvas LMS has adversely impacted on student experience and increased workload for staff. Students report that the transition to Canvas has not been entirely smooth and note that the loss of some resources such as previous years' content and phasing out of other resources has been difficult for revision, especially for those students returning after deferral or repeating the year. Students also report that they are concerned about the use of students' own devices during progress tests and that some online resources to support learning are out of date or inadequate.

There have also been reports that the LMS has inhibited the implementation of the learning coach initiative. Developing solutions to manage this issue should be a focus, as learning coaches are a critical element in the development of the academic program.

All students and staff have access to resources and support provided by the Flinders University Library, and clinical educators with academic status are afforded similar access. The library's digital collection of eBooks, journals, videos and databases are available to staff and students on campus, online or based in rural locations.

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.

The Program reports that currently it has adequate academic and professional staff, although these needs may change with increasing student numbers at different sites. In its own self-review, the Program notes that it will review clinician engagement and support services to ensure equitable support and streamlining across all learning sites by mid-2025. This work will be led by MD leadership in consultation with the Director of College Services and the Dean, People and Resources. This review will be important to ensure equitable teaching, learning and supervision opportunities for students in all locations and in every year cohort as they progress through the program.

The team notes the transition from the MDRS to SARM Program is well planned; however, it also notes that a number of academic and professional positions are yet to be filled. The College is asked to provide the AMC with an update on the staffing profile relative to student intake numbers in monitoring reports.

The Program, together with the College and the University more generally, reports having Aboriginal and/or Torres Strait Islander staff in several key positions that contribute to community outreach; student recruitment into the MD Program; student support; various supports for teaching, learning and clinical supervision; and research support. The Elders on Campus project is also notable.

The University can be congratulated on its Indigenous Workforce Strategy, which has a defined target for equivalent 3% FTE Aboriginal and/or Torres Strait Islander staff by 2025. While 3% represents population parity, there are regional differences in these statistics, with much higher populations in the Northern Territory. This needs to be considered within the College and Program, recognising that the University's goal of 3% FTE equivalent may not be representative of the areas served by the Program.

The Program acknowledges that it has found it challenging recruiting and retaining Aboriginal and/or Torres Strait Islander staff within the Program and that current staffing levels are suboptimal, especially across teaching, learning and clinical supervision activities. Its intention is that, by the end of 2025, the MD leadership will work with the Pro Vice-Chancellor (Indigenous), the Dean, People and Resources and other education providers to enhance current recruitment and support strategies, including mentoring and support for junior Aboriginal and/or Torres Strait Islander academics.

Because of the significant challenges experienced to date in this area, the Program should assess its needs for Aboriginal and/or Torres Strait Islander staff, the mix of professional and academic staff needed, their levels and roles. From this assessment, specific roles should be identified, a recruitment plan for those vacancies and a career development plan for existing Aboriginal and/or Torres Strait Islander staff.

The College and the Program have a strong reputation for medical education and career development, and this is offered to staff on the Program. The Program notes several Aboriginal and/or Torres Strait Islander staff who contribute to teaching in the Program, but it is not clear if any have participated in the medical education training offered.

The Program reports that Indigenous teaching and learning methods are being introduced with an example of a clinical yarning session being trialled in Year 1 of the MD.

The Program reports that it uses both standardised and real patients extensively in a variety of teaching sessions, as well as OSCEs. Standardised patients are recruited through the community and real patients are volunteers. Both receive training and are reimbursed for costs. Despite a concerted effort to recruit Aboriginal and/or Torres Strait Islander People as standardised and real patients, the uptake has been poor. The Program reports that it seeks to provide a more diverse range of standardised patients by the end of 2025 and will work on further engagement with Aboriginal and/or Torres Strait Islander community members, informed by the Community Engagement Plan.

Staff are indemnified through Unimutual Ltd and Newline Australia Insurance Pty Ltd. Indemnification is monitored by the University's Risk and Assurance team.

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.

The University has a defined recruitment policy and procedures, and notes that, if possible, an Aboriginal or Torres Strait Islander staff member is on the panel for positions with an Indigenous focus. Likewise, the MD Program is ensuring that all members of a panel recruiting into Indigenous-focused positions will have completed cultural safety training. Further, the program uses the University policy and procedures for promotion. These outline the eligibility and evidence required for continuation and promotion and include, for academic levels A–C, the skill base and qualifications for Aboriginal and/or Torres Strait Islander staff members whose duties involve cultural activities needing Indigenous knowledge and community recognition.

For academic staff, the balance between teaching, research and service is negotiated during recruitment. Clinicians within the Program are encouraged to apply for academic status within the University, although the University policies on academic requirements were noted by some as a potential barrier. The Program notes that all University staff are subject to performance review and staff development processes to clarify expectations, plan goals and monitor progress against these goals. The College and the University provide opportunities for a variety of professional development activities of staff.

The Program notes that as well as having access to the generic University and College staff development resources, Aboriginal and/or Torres Strait Islander staff have access to a dedicated Indigenous Employment website for further opportunities. Additional opportunities are available for Aboriginal and/or Torres Strait Islander staff in the Northern Territory, including team-based activities.

There has been at least one instance whereby an Aboriginal and/or Torres Strait Islander staff member, and graduate of the MD, was recruited and taught in the MD, but not retained by the Program. While unable to comment on employment issues but given the challenges the Program has had recruiting and retaining First Nations staff, especially in Adelaide, it would be expected that a comprehensive strategy for Aboriginal and/or Torres Strait Islander staff development be a priority as part of the recruitment and retainment strategy.

While the MD Program has mandated that staff within the Program undergo cultural safety training, and the University more generally is planning to introduce mandatory cultural safety training for new staff, in its own self-review of the new standards, the Program acknowledges that it is yet to meet this standard. Currently the University training is offered in partnership with Your Mob Learning. However, many staff, especially clinical supervisors in hospital or general practice, were unaware of any training available through the College. Other educators note the need for improved training and resources and the need to foster better understanding and engagement among non-Indigenous staff.

In respect of student engagement with cultural safety teaching and learning, the MD Program notes that cultural safety training has been provided to and encouraged for all MD Program students and has become

mandatory for all Year 1 students from 2024. These students completed online modules for Indigenous Cultural Awareness (foundation and comprehensive) as a core component of their orientation week program. This was in addition to the Indigenous health curriculum in Years 1 and 2 of the Program and the extended curriculum in Years 3 and 4, currently available only to students in NTMP and MDRS.

The MD Program plans to establish a working group, with a project officer, to develop a sustainable model for ongoing professional development in cultural safety for staff, supervisors and students. They also intend that the MD leadership work with Flinders University Elders on Campus, the Pro Vice-Chancellor (Indigenous) and the Office of Indigenous Strategy and Engagement to ensure that this aligns with the University's RAP. The College expects the model to be developed by the end of 2025.

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.

Through the University and the College, the Medical Program has formal relationships with health service partners across South Australia and the Northern Territory, including with SA Health, NT Health, private healthcare providers and GP clinics. These relationships are formalised with WIL placement agreements that outline expectations and respective responsibilities. They provide the foundation for student access to clinical learning environments and supervisor support. Placement agreements are in place for metropolitan South Australia, NTMP and MDRS. Placement agreements necessary for SARM are underway.

Once agreements are in place, topic coordinators ensure that the clinical activities of the site or placement align with the program outcomes. Topic coordinators and discipline supervisors meet annually to ensure that appropriate clinical rotations are available to build student experience longitudinally as they proceed through the program. This is considered for each cohort site. Students are encouraged to provide feedback if they feel that there are issues with their learning experience at their clinical placement, either directly with site or topic coordinators, or indirectly through student representatives.

Recent changes have been made to improve the clinical experiences and improve 'readiness for internship'. These include: the implementation of a new clinical placement model with a focus on achieving graduate outcomes; the development of a standardised Clinical Expectations Template to improve liaison between students and clinical supervisors; and the TIP, which includes the Intern Shadowing Project, in which medical students are assigned a junior doctor as a mentor in clinical placements. This project started in 2021 as an optional two-week rotation in the Southern Adelaide LHN for metropolitan South Australian Year 4 students in their last rotation. Due to its popularity, it was extended across the Central Adelaide and Northern Adelaide LHNs and became a mandatory and assessable component of Year 4 students from 2023. The NTMP has also instigated this initiative but as a four-week rotation, beginning in 2024.

The accreditation standards expect medical programs to provide all students with adequate opportunities to witness, participate in and learn how to provide culturally safe clinical care to Aboriginal and/or Torres Strait Islander or Māori Peoples. This expectation is above and beyond other elements of the curriculum relating to Aboriginal and/or Torres Strait Islander or Māori People's history and health and for staff and students to have a sound knowledge and understanding of cultural safety. By the Program's own assessment, and confirmed in the student report, there is significant geographical variability in meeting this standard, with this being more readily available to students in the NTMP because of both the demography of the Northern Territory and alignment with Aboriginal Medical Service providers. The Program noted that it planned to commence placements at Aboriginal Medical Services for students within the metropolitan South Australia stream by the end of 2025.

Recent Flinders University graduates working in LHNs noted the importance of engagement and liaison with Aboriginal Liaison Officers (ALOs) within the LHNs as an adjunct to learning about culturally safe engagement with and care for Aboriginal and/or Torres Strait Islander patients. The Program may wish to engage more formally with these teams as an integral part of engagement with LHNs.

The College has fostered strong relationships with healthcare facilities and providers that host students from the Flinders University MD Program, including those from other health education providers. Within these relationships, there is the ability to have discussions to ensure adequate clinical teaching and supervision capacity for students to achieve their learning outcomes. Further, these relationships provide a basis whereby the Program can raise concerns and discuss future possible solutions.

The Program provided placement capacity forecasts for the NTMP and MDRS. Metropolitan South Australia sites are reviewed annually and are forecast to accommodate the predicted student numbers, having developed new provider relationships and additional clinical placements to manage the increase in students in clinical years in that stream. Discussions are underway with clinical sites to prepare for the increase in clinical placements required for SARM. Within the NTMP, the Program regularly tracks the capacity for each placement and discipline. Given the proposed increase in student numbers in the NTMP, this forecast will become more important.

Flinders Rural and Remote Health in the Northern Territory has formal relationships with both Deakin University and Australian National University to ensure all groups are able to achieve their learning outcomes. The proposed additional medical students have been funded to study in the Northern Territory through a program at CDU. While the Flinders University NTMP has an existing relationship with CDU, these additional students, together with the projected growth in numbers within the NTMP, mean there will be significant competition for clinical placements. There is an urgent need to build a positive and constructive relationship to manage any challenges that may emerge.

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.

The Flinders University MD Program, through the College, acknowledges the critical role that clinicians play in teaching and supervising medical students in both clinical and non-clinical settings. Since the inception of the Program, considerable effort has been made to build and develop strong linkages with clinicians in South Australia and the Northern Territory. More recently, this network has extended to developing partnerships with other clinical organisations in Northern Adelaide, and at rural sites in the Riverland, Barossa Hills, Fleurieu Peninsula and Limestone Coast regions.

Each clinical placement site has a term clinical supervisor who is the primary contact for students, completes mid-term reviews and end-of-term GAP assessments, and receives feedback or concerns encountered by students during their clinical rotation. There is a commitment to identifying issues with performance and methods for assessing and intervening as early as feasible.

Students learn, develop and practise key clinical and procedural skills before starting placements using simulation as well as standardised patients. Information and resources are provided to students outlining placement requirements, wellbeing resources and how and where to raise concerns.

Generally, when students attend clinical attachments during regular work hours, supervision is shared by the team, whereas after hours, students have a nominated clinical supervisor. The number of students in a cohort at each clinical site is based on ratios of student to clinical supervisor. In Years 3 and 4, these vary from 8:1 to 1:1 in hospital-based settings. However, in some clinical attachments (e.g. in General Practice), a student may be supervised by the same consultant GP for up to six weeks.

The College encourages supervisors to apply for academic status, which provides access to a range of College resources, including further training and access to support teams. The College reports that it promotes the development of supervisors through opportunities to participate in professional development in teaching and learning and assessment through a variety of training activities from the clinical educators' website, resource booklets, workshops, short courses and educational degrees, especially through the co-located Prideaux Centre.

However, the extent of uptake of this training and its effectiveness is unclear. While noting that there were many dedicated clinical supervisors, students reported that the quality of clinical supervision is variable and that some supervisors are unaware of their responsibilities and unprepared for supervision. Indeed, some supervisors themselves, across a number of sites, noted that clinical supervisors lacked information on curriculum and assessment requirements and felt underprepared to meet the expectations of students. Students acknowledged that while mandating a program of orientation and training for all clinical supervisors would create some logistical challenges, it would greatly enhance the student experience.

The College has identified the opportunity to strengthen orientation, training and continued professional development for clinical supervisors within the Program and has begun some initiatives including mentoring and a NT Clinical Academy. Feedback from clinicians was that online modules would be preferable and as an initial step, the College is providing access to resources for clinical educators using website resources from an overseas MD Program.

Further, there has been recent work developing an online Placement Expectations document, outlining the generic and specific placement expectations and requirements of each particular rotation. This has reportedly improved the ability of students to prepare for rotations and provides a standardised document for supervisors. It will be important for the Program to follow up with clinical supervisors about the uptake of this additional information and whether it has had an effect on their preparedness for supervision and on student experience.

The Program monitors the performance of clinical supervisors through feedback provided by students through topic coordinators, learning coaches and clinical placement supervisors. Within General Practice, a new GP Placement Student Experience Survey was trialled in Years 2 and 3 for metropolitan South Australia students in 2024. Some staff and GP supervisors were unaware of the survey and reported that they were keen to be informed of student feedback. The Program should report on findings from this study and implications for continuation, given the other survey noted below.

Students can also nominate clinicians for clinical teaching awards who, in their experience, have contributed as excellent clinical teachers.

Students reported that they were able to provide feedback on individual clinical supervisors as well as supervision in general via their year-level representatives or topic coordinators. However, they identified two significant issues.

- First, their feedback, especially that through College representatives, may not have reached placement supervisors as it did not lead to changes, giving an example of supervisors who were disrespectful to students continuing to supervise

- Second, they were concerned that any negative feedback, even if constructive, would be traced back to the individual student with negative consequences for them. They reported working with the CAG to update the MD Students Placement Feedback Survey planned annually from the end of 2024.

The Program should report on the findings of this survey and any planned actions taken in response to the findings of the survey. It would also be important to ascertain whether this survey could replace the GP Placement Student Experience mentioned above in order to reduce student survey burnout.

The College acknowledges that teaching occurs in a diverse range of formats within the Program, as well as the challenges that supervisors face in balancing their heavy clinical workloads with the desire to provide excellent clinical teaching and learning for students. Clinicians are supported by the Clinician Support Team and an education resource coordinator to optimise teaching activities and scheduling. Despite this support, students note that within most rotations, dedicated teaching time for students is limited, and can be neglected especially within the current constraints of the health sector. Students note that improvements have occurred since the introduction of the CAG and the Clinician Support Team, but they suggest further improvements would enhance the Program.

The College has established agreements with all sites where students undertake WIL. These agreements outline the responsibilities of both the placement organisation and the University. For clinicians who are joint appointments with the University, their position description outlines their key capabilities and responsibilities. Issues raised above about the orientation, training and availability of teaching staff, especially in clinical environments, suggests more needs to be done to ensure these agreements are operationalised.

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.

The College indicates regular review of curriculum, teaching and supervision, and assessment and student progress is embedded regularly within the MD Program.

- The COG will have oversight over curriculum review and provided standardised pathway for academics and clinicians to propose curriculum change.
- Evaluation of assessment occurs through reviewing progress test results and comparison of program sites on key assessment points like the OSCE. Evaluation occurs through the Examinations Board and Student Progress Committee.
- The quality of teaching is monitored through the University Student Evaluation of Teaching (SET) Survey, undertaken per semester. University staff have the opportunity to participate in Peer Review of Teaching.

The team notes there were reviews conducted of the MDRS (2021) and NTMP (2020), which resulted in changes to respective programs.

- The external review of the NTMP resulted in a more robust governance structure and memorandum of understanding with Indigenous Allied Health Australia.
- Evaluation of the MDRS program resulted in 'Stay in Place' to improve the rural South Australia junior doctor pipeline by extending the program into Year 4—a pilot was expanded to 12 placements in 2024. Conversely, it was also noted the alignment of the MDRS to the metropolitan South Australia curriculum through the COG has resulted in some dissatisfaction in the MDRS as discussed in Standard 2.

There was a review of the IES, and a number of quality improvements are now ongoing as a result of this review. In 2023, there was also a survey of learning coaches to identify areas of improvement, and a project to evaluate effectiveness of existing resources to support students' mental health and wellbeing.

While the team recognises there is a commitment to continuous evaluation of the medical program and impact of educational innovations to identify areas for improvement and respond to stakeholder feedback, current mechanisms do not appear to be part of the systematic and proactive College- and Program-led program of evaluation. Some evaluation mechanisms used seem sporadic in nature, and any actions taken may meet immediate needs, but it is unclear how this contributes to the overall purpose, objectives and continuous development of the College and Program.

The capacity to manage concerns and risks quickly and effectively, as they relate to all elements of the medical program, is significantly hampered by a disjointed mechanism of governance oversight of evaluation

and monitoring. This is covered in detail under Standard 6.3. There is an inconsistency in relation to the information quality and performance measures as they relate to continuous review, evaluation and improvement. This is reflected in a divergence of perspectives in relation to the governance priorities, the processes in place and the methods of engagement and reporting.

There also don't seem to be structured opportunities for those delivering the program to regularly provide input or feedback directly to the College or Program, apart from representative roles in governance committees. There is a risk of a misalignment of information communicated, and missed opportunities for a ground-up approach to evaluating the program. The College and Program should develop and implement opportunities for all educational and topic coordinators, learning coaches and clinical supervisors to directly influence program development.

As such, the team considers the current methodology is not fit for purpose or consistent with the expectations of all stakeholders. It is also not reflective of contemporary governance or evaluation practice. Without a robust, trusted and safely held process that is clearly articulated, accessible and authentically reflective of stakeholder expectations, there is a significantly reduced likelihood that evaluation and monitoring will be effective, timely, appropriate or accurate. As a matter of priority, it is essential a comprehensive process of evaluation and review with clear pathways of oversight through to governance be developed to manage concerns and reduce risk in the Program. The development of an evaluation framework/program should be co-produced with stakeholder groups to ensure relevance to expectations and feedback mechanisms.

Engaging with students

The primary formal mechanism for students to provide feedback on the College and Program is through the SET; however, student engagement with the SET is low. This data is supplemented by the SES, conducted annually across 41 Australian universities, and used to benchmark the Program against others. The results of the SES are presented by a dedicated Evaluation Coordinator (funded through the Heaslip Bequest to Medical Education) to the Medical Program Board. The FMSS is a key resource to providing student feedback directly to the College and Program from the students. Other processes relied upon to evaluate curriculum and assessment do not appear to explicitly incorporate student feedback and, due to the low student response rate of the SET, it may not provide a comprehensive source of data.

As indicated in standards above, there would be benefit from students having a greater level of engagement in the development and monitoring of evaluation processes. The FMSS should have a key role in co-designing and co-producing the mechanisms of evaluation and engagement. The burden of delivering on engagement should, however, not be an expectation of the FMSS and should be independently and appropriately resourced by the College and Program.

The use of the SET and SES as key evaluation mechanisms should also be reviewed in conjunction with key stakeholder groups to ensure fitness for purpose and relevance to community expectations, as well as being benchmarked against other Colleges/Schools who have high engagement in these processes.

Engaging with prevocational training providers, health services and communities

SA Health and NT Health are represented on the Medical Program Board to provide direct feedback to the College from a health service perspective. The Southern Adelaide LHN is represented by its Director of Clinical Training on the Board. NT Health is represented in NTMP governance structures, along with the CDU. At the prevocational level, the NT Prevocational Medical Assurance Services is on the NT Course Development Committee and the Dean, Education and MD Director are members on the SA Medical Education and Training Health Advisory Council. The team observed there is a gap in direct and reciprocal representation by the Riverland Mallee Coorong LHN, which may contribute to the disconnect staff, students and clinical supervisors feel with Bedford Park.

There was also evaluation of the 2020 AMC Preparedness for Internship Survey, which led to improvements in the Program to better prepare students for internship. In 2022, feedback gathered from clinical partners in the Southern Adelaide LHN indicated the Program needed to better prepare students for their role as

junior doctors. The 'Work Preparedness of Flinders University Doctor of Medicine (MD)' project was developed as a result.

The team did not observe significant direct community/consumer engagement to inform program development. Current mechanisms of evaluation and review rely on community members within the governance structure.

The team observed, and heard, that current feedback mechanisms for staff and students to report adverse views can be inadequate or viewed as unsafe. To ensure robust evaluation and review, the College and Program must commit to holding a safe space for the provision of feedback; this is essential if stakeholders are to feel able to explore matters of concern with the College. The team heard concerns from staff and students that they do not always feel safe to raise contrary or challenging views, which leads to a reluctance to engage with the College leadership in relation to concerns, matters of equity, program deficit or safety.

Strengthened trusted relationships would better inform the ability for students, especially those who require equitable access, to provide and have appropriately supported and well-considered responses to feedback, requests for support and accommodations.

The College and Program collaborates domestically with other education providers through staff involvement in various professional networks, including the MDANZ, the Australian and New Zealand Association for Health Professional Educators, and the Federation of Rural Australian Medical Educators.

In the Northern Territory, the team notes the College is in the NTMP governance structure with the CDU for the joint Bachelor of Clinical Science. However, the reciprocity of the relationship is yet to be fully explored in the context of the expansion of the Flinders University program and incorporation of the CDU program. There do not seem to be structured mechanisms at this stage for other medical education providers to provide feedback on the Program.

There is evidence of some international collaboration with overseas education providers and engagement with the International Association for Health Professions Education (AMEE). This currently seems to be at University level or led by individuals, rather than part of a systematic continuous improvement approach.

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 performance in relation to student characteristics and feeds this data back to 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.

The capacity to provide thorough evaluation of the curriculum is limited by a lack of comprehensive disclosure of curriculum requirements, details or attainment expectations for students, as discussed in Standards 2 and 3. Evaluation and review of content, quality of teaching, supervision and assessment, and whether it is fit for purpose, can only be effectively achieved with a thoroughly transparent and openly engaged mechanism.

Currently, staff can access the Flinders Intelligence Portal (FLIP), which provides information about the SET, SES and graduate outcomes in relation to employment and other demographic points. This data is used by executive leadership to inform future planning. There is additional tracking for NTMP and MDRS student cohorts, and examination performance by students is analysed by the Examination Board. As discussed in Standard 3.2.3, the Program has already identified a need to strengthen the reporting of student cohort

performance to academic staff and clinical supervisors. The methods and/or parameters used to analyse student cohorts will also need to be updated with the alignment of Program learning outcomes to AMC graduate outcomes.

There is an important body of work to ensure that the experiences of students in different clinical placement sites, Aboriginal and/or Torres Strait Islander students, students with a lived and living experience of disability and those with accessibility requirements should be an area of focus. Evaluation and review of the interview/admission/selection process should be considered. Best-practice approaches from other Colleges and Schools should be considered as part of the review, and stakeholders including students, community and relevant health industry representatives should be more thoroughly engaged to ensure diverse perspectives and their inclusion in the process.

Further work is planned to inform data in relation to cohorts of students from equity groups. For evaluation of Aboriginal and/or Torres Strait Islander and Māori cohorts, and students with a lived experience of disability, the evaluation activity should be independently reviewed and supported by recognised culturally and contextually appropriate experts.

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.

The Educational Quality Framework is the University's overarching framework governing the quality and performance of its educational offerings. The framework provides directives for evaluation and monitoring measured in curriculum and teaching to ensure quality through defined attributes. The Dean, Education reports data to the Educational Quality Committee and Medical Program Board, collaborating with course coordinators on quality improvements needed.

Governance and management of MD Program evaluation

The appointment of a dedicated Evaluation Coordinator for the MD Program is supported by the team, and there is an opportunity for this position to provide pathways to qualitative mechanisms that would more richly inform the evaluation, review and continuous improvement process. While this role provides ongoing evaluation and coordinates projects to review effectiveness, enhancements to the strategic and governance structures supporting and supported by this role would improve outcomes. The Program should also consider if expanding capacity is needed to support the scope of evaluation, analysis and regularity needed for this work.

The team noted an Evaluation Advisory Group was convened in 2021, but had only met once. There are plans for this group to be reinstated in 2025 with a minimum of four meetings per year. Stakeholder membership should be reflective of diverse perspectives, including those of, but not limited to, students, community, lived and living experience, Aboriginal and/or Torres Strait Islander Communities, and heads of discipline; it should also include independent expert evaluation and review-informed members who can support best-practice approaches.

A review of the Evaluation Advisory Group, as well as the requisite evaluation framework, creates an opportunity to bring about a thoroughly co-designed and co-produced mechanism for evaluation. The Evaluation Advisory Group's terms of reference, nature of membership, connection to other governance structures and report-back mechanisms for all stakeholders should be developed and broadly tested.

Sharing with students and those delivering the Program

The Medical Program Board shares decisions made as a result of evaluation through various representatives including the FMSS, clinicians, health services, and academic and consumer representatives. This is primarily

through the Flinders MD Pulse newsletter, which includes outcomes of evaluation, and via online learning platforms to students.

The results of the SET are made available to the topic and evaluation coordinator for analysis, and the MD Director or topic coordinator presents findings to students according to the relevant year. These presentations are reportedly well received by students. The team heard an example of effective local feedback, where students are invited to evaluate the term by the onsite academic. These evaluations are considered, and adjustments are made to the local program, with students being made aware of the way their comments were considered.

Students have identified some benefit would be achieved by the College engaging in a more comprehensive way regarding the context of data gathered. Greater benefit would also be achieved in the development of robust qualitative data collection processes to more appropriately reflect the experience of students.

From 2024, the Program is establishing an annual Course Quality Advisory Group meeting, bringing academic staff, students and external stakeholders to reviews and discussing quality indicators for the Program, and highlighting areas of improvement and quality improvement initiatives. While the initiative is positive, it should not form the entirety of the College's or Program's engagement with these groups, which needs to be more consistent and embedded in an overarching evaluation philosophy.

Evaluation results are discussed with the CAG, represented by senior clinicians teaching into the program, and on the Medical Program Board with health service representation. Current mechanisms do not constitute broad availability of evaluation results to stakeholders and are reliant on individuals represented in College and Program governance, or through appointments on external stakeholder committees or groups.

Consumer and community members are currently not broadly representative enough to determine if feedback and reporting is relevant to them. An enhanced approach to engagement with diverse community and lived and living experience representatives would also allow for broader pathways to feedback and evaluation.

Appendices

Appendix 1: Accreditation in Australia and Aotearoa New Zealand

The purpose of the Medical Board of Australia (the Board) is to ensure that Australia's medical practitioners are suitably trained, qualified and safe to practise. The Board operates in accordance with the Health Practitioner Regulation National Law (the National Law), as in force in each state and territory. One of the objectives of the National Law is to facilitate the provision of high-quality education and training of health practitioners. The accreditation of programs of study and education providers is the primary way of achieving this. The Board has appointed the AMC as the accreditation authority for medicine to conduct accreditation functions under the National Law.

The AMC has responsibility for developing accreditation standards, assessing education providers and their programs of study for the medical profession, and accrediting programs that meet the standards. Accreditation standards are used to assess whether a program of study, and the education provider that provides the program, equips people who complete the program with the knowledge, skills and professional attributes necessary to practise the profession. The AMC develops accreditation standards, which the Board approves.

When the AMC assesses a program of study and the education provider against the approved accreditation standards and makes a decision to grant accreditation, the AMC provides its accreditation report to the Board. The Board makes a decision to approve or refuse to approve the accredited program of study as providing a qualification for the purposes of registration to practise medicine. The Board publishes on its website the accredited programs of study it has approved as providing a qualification for the purposes of general registration.

The Medical Council of New Zealand (MCNZ) is a statutory body operating under the Health Practitioners Competence Assurance Act 2003, which has as its principal purpose the protection of the health and safety of the public by providing for mechanisms to ensure that doctors are competent and fit to practise medicine. It is responsible for both registration of medical practitioners and accreditation of medical education in Aotearoa New Zealand.

The AMC and the MCNZ have a long history of cooperation to assist both organisations in setting standards for medical education and assessment that promote high standards of medical practice, and that respond to evolving health needs and practices, and educational and scientific developments. The AMC develops accreditation standards in consultation with the MCNZ, which adopts the standards.

The AMC and the MCNZ work collaboratively to assess Australian and New Zealand medical education providers and their programs. In the case of education providers offering programs of study in Aotearoa New Zealand, the accreditation assessment team will include at least one assessor from New Zealand, appointed after consultation with the MCNZ. The accreditation report is also provided to the MCNZ to make its accreditation and registration decisions.

The standards and procedures relevant to the assessment and accreditation of primary medical programs and underpinning the accreditation process and findings in this report are:

- *Standards for Assessment and Accreditation of Primary Medical Programs by the Australian Medical Council 2023* (the Standards)
- *Procedures for Assessment and Accreditation of Medical Schools by the Australian Medical Council 2024* (the Procedures)

Appendix 2: Membership of the 2024 AMC Assessment Team

Name	Role
Professor Shaun Ewen (Chair), BAppSc (Physio), MMIL, D.Ed	Deputy Vice Chancellor (Education) and Vice President, Griffith University
Professor Amanda Barnard (Deputy Chair), BA (Hons), BMed (Hons), FRACGP	Independent Chair, General Practice Training Advisory Committee, Ministerial Appointment
Professor Lesley Forster, MBBS, MHP, DipLabRel & Law, FRACMA, FAFPHM	Dean of Rural Medicine, Faculty of Science and Health, Charles Sturt University
Mr Carl Hinschen, BSc	Medical Student, University of Sydney
Kellie O'Callaghan, BA, GDipMtlHlthSc, FAICD	Principal Consultant & Patient Experience Lead, O'Callaghan & Co
Professor Papaarangi Reid, BSc, MBChB, Dip. Obs, Obstetrics, Dip. COmH	Tumuaki - Deputy Dean, Māori, Head of Department, Faculty of Medical and Health Sciences, Te Kupenga Haura Māori, New Zealand. (University of Auckland)
Professor Tim Wilkinson, MBChB, PhD, M ClinEd, FRACP, MD, FRCP, FANZAHPE, FAMEE	Acting Dean, Otago Medical School, University of Otago, Dunedin, New Zealand
Juliana Simon	Head of Accreditation Assessments, Australian Medical Council
Esther Jurkowicz	Program Support Officer, Medical School Assessments, Australian Medical Council
Melissa Johnson	Cultural Strategic Facilitator, Indigenous Policy and Programs, Australian Medical Council

Appendix 3: Summary of the 2024 AMC Assessment Team's Accreditation Program

Meeting	Roles engaged with
Monday 14 October 2024 ***Flinders University Bedford Park***	
Welcome to Country and Smoking Ceremony	Vice-President and Executive Dean, CMPH Dean Research, CMPH Dean Education, CMPH Dean People and Resources, CMPH Dean Rural and Remote Health, CMPH Director MD Program Director NTMP Director of College Services, CMPH
College of Medicine and Public Health Executive	Vice-President and Executive Dean, CMPH Dean Research, CMPH Dean Education, CMPH Dean People and Resources, CMPH Dean Rural and Remote Health, CMPH Director MD Program Director NTMP Director of College Services, CMPH
Aboriginal and / or Torres Strait Islander Strategy – College Perspective	Director Poche SA + NT Indigenous Health Theme Coordinator Program Director, Aboriginal and Torres Strait Islander Pathways in Medicine Director, Indigenous Health Leadership (Rural and Remote Health) Lecturer Indigenous Knowledges and Culture Dean Education, CMPH
Academic Leaders - Curriculum	Director MD Program Deputy Director MD Program and Hepatobiliary Surgeon, FMC Director NTMP MD Curriculum Lead Dean Education, CMPH Portfolio and Learning Coach Theme Coordinator
Community Stakeholders & Survivors Teaching Students	Medical Program Board and Community Oversight Group MD Admission Panel Community members Survivors teaching students

Meeting	Roles engaged with
Standard 1.4, 1.3.5, 2.2, 2.3 and 3.1.6 Aboriginal and / or Torres Strait Islander Staff	Program Director, Aboriginal and Torres Strait Islander Pathways in Medicine Indigenous Health Theme Coordinator Director Katherine Campus Lecturer, Indigenous Knowledges and Culture Indigenous Student Support Officer
Co-Located Schools	Dean, School of Medicine, Charles Darwin University Dean, Adelaide Medical School
Assessment Strategy	Strategic Professor in Medical Education Dean Education, CMPH MD Assessment Lead Director MD Program
Assessment in Practice (Overall and Year 1 and 2)	Strategic Progressor in Medical Education MD Assessment Lead and Year 3 Semester 1 Topic Coordinator, SA MD Progress Test Lead, Rehabilitation Physician, FMC Year 1 Clinical Skills Theme Coordinator Teaching Specialist (Acad) Portfolio and Learning Coach Theme Coordinator Student Progress and Assessment Advisor
Assessment in Practice (Year 3 and 4)	Year 4 Deputy Topic Coordinator, SA Year 4 Topic Coordinator, NT Year 4 Topic Coordinator, Rural SA Senior Lecturer Clinical Educator NTMP (Teaching Specialist-Clinical Practitioner) Year 3 Topic Coordinator, NT Year 3 Topic Coordinator, Rural SA Year 3, Semester 2 Topic Coordinator, SA Year 4 Topic Coordinator, SA Clinical Lead, Year 3 OSCE, Consultant Neurologist, FMC
Student Experience	Flinders Medical Student Society President Flinders Medical Student Society NT President Flinders Medical Student Society MDRS Representative Year 1 to 4 MD Students
Aboriginal and / or Torres Strait Islander Students	Flinders Medical Student Society Aboriginal and Torres Strait Islander Representative Year 1 to 4 MD Students

Meeting	Roles engaged with
Professional Staff – Governance, structure and resourcing	Director of College Services, CMPH Director of Operations, Rural and Remote Health, CMPH Director, Student Life, Flinders University Director, Student Administration Services Manager Clinician Support Senior Manager, Technical Services, CMPH Program Manager, NTMP Program Manager, Rural and Remote Health SA
Debrief with Dean	Vice-President and Executive Dean, CMPH Director MD Program
Tuesday 15 October 2024 ***Flinders University Bedford Park***	
Vice Chancellor and President	Vice Chancellor, Flinders University
President of Academic Board	Chair, Academic Senate
College Executive	Vice-President and Executive Dean, CMPH Dean Research, CMPH Dean Education, CMPH Dean People and Resources, CMPH Dean Rural and Remote Health, CMPH Director of College Services, CMPH
Teaching and Learning Overview (Overall and Year 1 and 2)	Director MD Program Associate Professor Emma Kennedy, Director NTMP MD Curriculum Lead, Year 1, Semester 1 Topic Coordinator, SA and Personal and Professional Development Theme Coordinator Year 1 Semester 1 Topic Coordinator, NT Year 1, Semester 2 Topic Coordinator, SA Year 1, Semester 2, Topic Coordinator, Year 1 Clinical Skills Theme Coordinator, and Portfolio and Learning Coach Theme Coordinator, NT Year 2 Topic Coordinator, SA Year 2 Semester 1 Topic Coordinator, NT Year 2, Semester 2 Topic Coordinator and Year 2 Clinical Skills Theme Coordinator, NT Teaching Specialist (Acad) Portfolio and Learning Coach Theme Coordinator Senior Coordinator, Simulated Learning Environment Indigenous Health Theme Coordinator Year 1 Clinical Skills Theme Coordinator, SA

Meeting	Roles engaged with
	Year 2 Clinical Skills Theme Coordinator, SA Healthcare Law and Professional Ethics Theme Coordinator Public Health Theme Coordinator, SA Public Health Theme Coordinator, NT Behavioural Health Theme Coordinator Advanced Studies Theme Coordinator, NT
Teaching and Learning Overview (Year 3 and 4)	Deputy Director MD Program and Advanced Studies Theme Lead, SA Professor of Medicine and Clinical Discipline Lead, CMPH Year 4 Topic Coordinator, SA Year 4 Deputy Topic Coordinator, SA Year 4 Topic Coordinator, NT Year 4 Topic Coordinator, Rural SA MD Assessment Lead and Year 3 Semester 1 Topic Coordinator, SA Year 3 Topic Coordinator, NT Year 3 Topic Coordinator, Rural SA Year 3, Semester 2 Topic Coordinator, SA, Head of Unit, Department Obstetrics & Gynaecology, FMC
Student Support	Director, Student Life, Flinders University Student Support and Wellbeing Advisor, CMPH Personal and Professional development theme coordinator Portfolio and Learning Coach theme coordinator SA Portfolio and Learning Coach theme coordinator, NT Program Manager, NTMP Program Manager MDRS Yungkurrinthi Student Engagement International Student Advisor Counsellor, NT Senior Lecturer (Teaching Specialist (acad))
Admissions and Selection	Manager Admissions, Flinders University Director MD Program Deputy Director MD Program, Hepatobiliary surgeon, FMC Dean Education, CMPH Program Director, Aboriginal and Torres Strait Islander pathways in Medicine Director NTMP Program Lead, SARM Senior Lecturer, CMPH

Meeting	Roles engaged with
Student Services	College Manager, Student Administration Services Program Manager, NTMP Program Manager MDRS Education Resources Officer WIL Team Leader
Information Technology	Senior IDS Platforms Lead, Flinders University eLearning and Media Support Officer, Learning and Teaching Innovation
Interprofessional Learning	Year 3, Semester 2 Topic Coordinator, SA and Head of Unit, Department Obstetrics & Gynaecology, FMC Lecturer (Teaching Specialist (Clin)), NTMP Interprofessional Educator, Rural and Remote Health SA
Research learning	Deputy Director MD Program and Advanced Studies Theme coordinator, SA Hepatobiliary surgeon, FMC Advanced Studies Theme Coordinator, NT Dean research and FHMRI Director, CMPH Deputy Director FHMRI, CMPH Lecturer Rural Health, CMPH
General Practice	Head of Discipline of General Practice, CMPH Senior Lecturer (Teaching Specialist (Acad)), CMPH Lecturer (Teaching Specialist (Acad)), CMPH Director NTMP Aboriginal Health Clinical Director, Moorundi Aboriginal Community Controlled Health Service Inc Clinic Manager, Pangula Mannamurna Aboriginal Corporation Central Australian Aboriginal Congress Senior Lecturer Clinical Educator NTMP (Teaching Specialist-Clinical Practitioner) Senior Lecturer (Teaching Specialist (Clin)), CMPH Senior Lecturer, NTMP Year 3 Topic Coordinator, MDRS Year 4 Topic Coordinator, MDRS
Metropolitan Adelaide General Practitioners	General Practitioners
Indigenous Health Curriculum	Lecturer, Aboriginal and Torres Strait Islander Health
Aboriginal and / or Torres Strait Islander community stakeholders and engagement	Lecturer Indigenous Knowledges and Culture Deputy CEO Indigenous Allied Health Australia Elder on Campus, Darwin

Meeting	Roles engaged with
	Elder on Campus, Bedford Park Elder on Campus, Alice Springs
Debrief with Dean	Vice-President and Executive Dean, CMPH Director MD Program
Wednesday 16 October 2024 ***Flinders Medical Centre***	
Flinders Medical Centre Executives	Chief Executive Officer, Southern Adelaide Local Health Network Executive Director of Medical Services, Southern Adelaide Local Health Network
Clinical Site Leadership	Professor of Medicine and Clinical Discipline Lead, CMPH Chair Clinical Advisory Group. Deputy Director MD Program and Advanced Studies Theme coordinator, SA Consultant Neurologist, SALHN and Lecturer, Flinders University Rehabilitation Physician, SALHN Senior Consultant Neurologist, SALHN Head of Rheumatology FMC, Professor of Musculoskeletal Rheumatology Medicine General & Upper GI Surgeon FMC, Matthew Flinders Distinguished Professor and Head of Surgery Discipline Flinders University Consultant Physician in Rehabilitation Medicine, FMC, Director of Clinical Training, SALHN and Clinical Lead, Rehabilitation Rural Support Service Clinical Director, Southern Adelaide Mental Health Services and Psychiatry Discipline Lead, Flinders University
Clinical Placement Supervision and Strategy	Director MD Program Deputy Director MD Program Manager Graduate Career Readiness, CMPH Year 3 Semester 1 Topic Coordinator, SA Year 3, Semester 2 Topic Coordinator, SA Year 4 Topic Coordinator, SA Year 4 Deputy Topic Coordinator, SA
Students on placement at Flinders Medical Centre	Year 3 and 4 MD Students
Clinical supervisors and clinical titleholders	Senior Psychiatrist and Addiction Medicine Specialist, FMC and Clinical Director, SALHN Centre for Anxiety and Related Disorders (CARD) and the Improving Access to Psychological Therapies (IAPT)

Meeting	Roles engaged with
	Year 3, Semester 2 Topic Coordinator, SA and Head of Unit, Department Obstetrics & Gynaecology, FMC Academic Head, Department of Paediatrics and Child Health Consultant Nephrologist, FMC General and Upper GI Surgeon, FMC Deputy Director MD Program and Hepatobiliary surgeon, FMC Consultant Physician in Acute and General Medicine, FMC Rehabilitation Physician, SALHN Respiratory and Sleep Physician, FMC Endocrinologist and Clinical Pharmacologist, FMC
Junior Medical Officers	Junior Medical Officers
Aboriginal Liaison Office	Team Leader, Aboriginal Liaison Unit, Flinders Medical Centre
Tour of Facilities	Director MD Program Coordinator Clinician Support
Zoom meeting with Lyell McEwin	Director of Clinical Training, NALHN and Medical Oncologist, LMH Medical Education Officer, Northern Adelaide Local Health Network
Debrief with Dean	Vice-President and Executive Dean, CMPH Director MD Program
Riverland General Hospital and Barmera Medical Clinic	
LHN Executives	RMCLHN, Chief Executive Officer Acting Chief Executive Officer RMCLHN, Director of Medical Services RMCLHN Director of Nursing and Midwifery RMCLHN Director Clinical Innovation and RACE RMCLHN Director of Clinical Training
Clinical Site Leadership	Dean Rural and Remote Health Deputy Dean, Rural and Remote Health SA SARM Program Lead Year 3 Topic Coordinator, Rural SA Year 4 Topic Coordinator, Rural SA Program Manager, Flinders Rural and Remote Health SA Director of University Department of Rural Health SA & NT, Flinders Rural and Remote Health
Clinician Educators and Clinician Supervisors	Clinical Educator, Flinders Rural and Remote Health SA, GP Supervisor Renmark Medical Clinic, ED consultant RGH

Meeting	Roles engaged with
	Clinical Educator, Flinders Rural and Remote Health SA, GP AnACDThetist, RGH, GP Supervisor Loxton Health Centre Inter-Professional Educator, Flinders Rural and Remote Health SA GP Supervisor, Berri Medical Clinic GP, Mount Gambier Family Health GP, Hawkins Medical Clinic GP, Tanunda Medical Centre GP, Talunga Clinic Strathalbyn Family Medical Centre Lecturer Rural Clinical Education, CMPH Lecturer, Interprofessional Clinical Education, CMPH
MDRS students currently on placement	Year 3 and 4 MDRS Students
Barmera Medical Clinic	GP Supervisor, Barmera Medical Clinic Clinical Educator, Flinders RRHSA & GP at Barmera Medical Clinic Practice Manager, Barmera Medical Clinic RMO, Barmera Medical Clinic GP Registrar, Barmera Medical Clinic GP AnACDThetist, Barmera Medical Clinic Program Administrator, Flinders Rural and Remote Health SA
Clinical Placement Strategy and Supervision	Deputy Dean, Rural and Remote Health SA SARM Program Lead Year 3 Topic Coordinator, Rural SA Year 4 Topic Coordinator, Rural SA Program Manager, Flinders Rural and Remote Health SA Program Administrator, Flinders Rural and Remote Health SA
Junior Medical Officers	Junior Medical Officers
Aboriginal Liaison Office (Riverland General Hospital)	Aboriginal health Manager Aboriginal Liaison Officers

Thursday 17 October 2024 ***Flinders University Bedford Park***	
Flinders Allied Health	
Northern Territory Prevocational Medical Assurance Services	A/Manager, NTPMAS
Friday 18 October 2024 ***Flinders University Bedford Park***	
Key Site Visit Findings	Vice-President and Executive Dean, CMPH Director MD Program Deputy Director, MD Program and Hepatobiliary Surgeon, FMC Dean Education, CMPH Senior Project Officer (Education)

Appendix 4: List of abbreviations

AMC	Australian Medical Council
CAG	Clinical Advisory Group
CARD	Centre for Anxiety and Related Disorders
CDU	Charles Darwin University
CEC	College Education Committee
COG	Curriculum Oversight Group
COI	conflict of interest
CSCA	Clinical Skills Consolidation Assessment
CSP	Commonwealth supported place
FHMRI	Flinders Health and Medical Research Institute
FLIP	Flinders Intelligence Portal
FMSS	Flinders Medical Students' Society
FTE	full-time equivalent
FUELS	Flinders University Extended Learning in Science
GAP	Global Assessment of Progress
GP	general practitioner
IES	Indigenous Entry Stream
iRAT	individual readiness assurance test
LAP	Longitudinal Academic Program
LHN	Local Health Network
LMS	learning management system
MCNZ	Medical Council of New Zealand
MCQ	multiple-choice question
MDANZ	Medical Deans Australia and New Zealand
MDRS	MD Rural Stream
NTMP	Northern Territory Medical Program
OSCE	Objective Structured Clinical Examination
PICP	Professional Induction to Clinical Practice
PMP	Preparation for Medicine Program
PPD	Personal and Professional Development
RAP	Reconciliation Action Plan
RHMT	Rural Health Multidisciplinary Training
SARM	South Australia Rural Medical
SCIMs	structured clinical instructional modules
SES	Student Experience Survey

SET	Student Evaluation of Teaching
TIP	Transition to Internship Program
WIL	work-integrated learning

Australian
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