Accreditation Report: Griffith University, School of Medicine and Dentistry

Medical School Accreditation Committee

December 2024

Australian Medical Council Limited

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Australian Medical Council Limited
PO Box 4810
KINGSTON ACT 2604

Email: amc@amc.org.au
Home page: www.amc.org.au
Telephone: 02 6270 9777

Contents

Acknowledgement of Country

The AMC acknowledges the Aboriginal and/or Torres Strait Islander peoples as the original Australians, and the Māori as the original people 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 Australian Medical Council offices are on the land of the Ngunnawal and Ngambri Peoples. The Griffith University, School of Medicine and Dentistry main campuses are located on the lands of the Yugambeh and Kombumerri peoples (Gold Coast campus), and the Kabi Kabi and Jinibara peoples (Sunshine Coast campus). The Program operates across many lands across Queensland and New South Wales.

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 Griffith University, School of Medicine and Dentistry (the School) was first accredited by the AMC in 1994. Appendix 1 provides an overview of the AMC's accreditation process in Australia. The School's accreditation and monitoring history is provided below:

Accreditation process

According to the Australian Medical Council's (AMC) *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 Griffith University, School of Medicine and Dentistry's 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 on the Gold Coast, Sunshine Coast and Tweed Heads. The full team member composition can be found in Appendix 2.

When undertaking accreditations 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.

AMC Directors at their 30 January 2025 meeting resolved that:

i. that the medical program of the Griffith University, School of Medicine and Dentistry substantially meets the accreditation standards;

ii. that accreditation of the four-year Doctor of Medicine (MD) medical program of the Griffith University, School of Medicine and Dentistry be granted for six years, to 31 March 2031;

iii. that accreditation of the program is subject to the meeting of the below conditions contained in the accreditation report and to meeting the monitoring requirements of the AMC.

Conditions on accreditation

Where a month is not specified in the deadline for the condition the School 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	Strengthen the broader community stakeholder engagement with groups that experience health inequities. (Standard 1.1.2)	2027
2	Provide evidence of appropriate Aboriginal and/or Torres Strait Islander representation at all levels of medical program governance and management, through: a. Identifying and ensuring appropriate Aboriginal and/or Torres Strait Islander representation on School of Medicine and Dentistry committees, and where relevant within the Health Group, that can give expert advice and guidance on medical education curriculum, research, external engagement with Aboriginal and/or Torres Strait Islander stakeholders and other service opportunities as identified. (Standard 1.1.4 and 1.3.5) b. Reinstate the Aboriginal and/or Torres Strait Islander executive committee/advisory group within the School (or at a Health Group level) to demonstrate full participation in the medical program. (Standard 1.1.4) c. Investment in recruitment to the senior academic position in First Peoples Health, retained within the Executive team, to support the building of capability and capacity for the Aboriginal and/or Torres Strait Islander team. (Standard 1.4.4 and 5.2.3)	2026
3	Develop and implement a documented strategy that enables the MD Program to work alongside Aboriginal and/or Torres Strait Islander communities and identified equity groups as stakeholders, and clearly document the purpose of these interactions and expected outcomes for both the Program and the communities involved. (Standard 1.2.1).	2026

Standard 2: Curriculum		
4	For Phases 2 and 3 of the new medical programs: a. Finalised learning outcomes include mapping to the AMC graduate outcome statements. (Standard 2.1 and 2.2.9) b. Documented constructive alignment between the medical program outcomes, learning and teaching methods and assessments. (Standard 2.2.5) c. Detailed plans for the incorporation of Aboriginal and/or Torres Strait Islander knowledge systems and medicines and how this will be delivered in a culturally safe environment. (Standard 2.3.7)	2027
5	To ensure the medical program integrates Aboriginal and/or Torres Strait Islander health content in the new curriculum and demonstrate constructive alignment throughout each Phase: a. It is expected that resources are made available to the Aboriginal and/or Torres Strait Islander teaching team to implement the planned curriculum to meet this AMC standard. (Standard 2.2.2) b. Develop and implement an Aboriginal and/or Torres Strait Islander health curriculum with an evidence-based design in a strengths-based framework, led and authored by Aboriginal and/or Torres Strait Islander health experts, for Phase 2 and 3 of the new program. (Standard 2.2.3)	2026 (Phase 2 by 2026, Phase 3 by 2027)
6	Establish a program of research in Aboriginal and/or Torres Strait Islander health learning and teaching to inform the medical curriculum. Adequate time and support should be allocated for staff to undertake both research and teaching responsibilities. (Standard 2.2.4 and 5.3.3).	2027
7	In all clinical placements to develop independent practice, establish in the new medical program: a. Interprofessional learning and work through the implementation of formal and authentic practical experiences that are available to all students across each of the clinical placement sites in Phases 2 and 3 of the new programs. (Standard 2.3.3.) b. Process to systematically assess core competencies such as cannulation prior to independent performance of the procedure. (Standard 2.3.5 and 3.2.1) c. Opportunities for students to learn and address the differing needs of community groups who experience health inequities and Aboriginal and/or Torres Strait Islander communities to increase the inclusivity of health services for these groups. (Standard 2.3.6).	2026
8	In developing a pre-internship (PRINT) program for students a. Provide plans for the pre-internship program planned for implementation in Phase 3 (Year 4) of the new curriculum in 2026, detailing demonstration of students' time spent in clinical-based learning and simulation-based learning. Consultation with stakeholders, students, junior doctors and pre-vocational training providers should be undertaking to ensure the PRINT program aligns with intern requirements. b. Implement PRINT program, report on plans for or outcomes of evaluation, improvement and review processes. (Standard 2.3.9)	a. 2025 b. 2026
Standard 3: Assessment		

9	Provide the strategy for the assessment of Aboriginal and/or Torres Strait Islander health and culturally safe practice, including communication skills, across the program. (Standard 3.1.6).	2026
10	Develop and implement systematic evaluation of assessment items, accuracy of blueprinting and fitness for purpose of the system of assessment in the new MD program. (Standard 3.3.1)	2027
Standard 4: Students		
11	Define clear targets for recruiting Aboriginal and/or Torres Strait Islander, and students from equity groups to support increased participation of these students in the MD Program. This includes: a. Reviewing and amending the criteria and requirement of entry for the undergraduate pathway for students who are from (1) rural areas, (2) equity groups, and (3) lower socio-economic areas. (Standard 4.1.2) b. Complementing rural student targets with strategies for support and infrastructure, including allowing rural students to preference return to site, remote follow-up services, and a check-in framework for rural students over their degree. (Standard 4.1.3)	2026
12	Review selection policy and admission processes to identify improved methods to support the achievement of student selection targets through reasonable accommodations for Aboriginal and/or Torres Strait Islander students, students with rural backgrounds and students from equity groups to support increased participation of these students. (Standard 4.1.5)	2026
Standard 5: Learning environment		
13	Implement regular evaluation of the effectiveness and efficiency of existing IT platforms/services to determine opportunities for continuous improvement to ensure contemporary practice. (Standard 5.1.4 and 6.1.1).	2027
14	Develop and implement policy and/or processes to ensure: a. Regular review and management of academic staff workloads for capacity to undertake research and fulfil requirements of 40-40-20 contracts. (Standard 5.3.1 and 2.2.4) b. Formal professional development opportunities are provided for faculty in all teaching sites, including for clinical title holders. (Standard 5.3.2) c. Compliance with cultural safety training and regular development activities to support ongoing learning for all academic and professional staff (permanent and sessional), clinical supervisors and students. (Standard 5.3.4 and 2.1.1) d. All material unprofessional behaviours are documented and managed in a timely and proportionate way, including demonstrating awareness of the implications for providing a culturally safe workplace and environment. (Standard 5.3.4)	a. 2026 b. 2027 c. 2026 d. 2026
15	To ensure capability-building and growth of strategies related to improving Aboriginal and/or Torres Strait Islander health, and in consultation with relevant stakeholders: a. Develop and implement a staffing plan to demonstrate appropriate academic capacity to develop and deliver the Aboriginal and/or Torres Strait Islander curriculum for the current and new program. (Standard 5.2.3, 5.3.3 and 2.3.7)	2026

	b. Review process of developing position descriptions and the selection process of Aboriginal and/or Torres Strait Islander academic staff to demonstrate acknowledgement of the importance of having relevant cultural knowledge experience, beyond traditional measures of academic performance. (Standard 5.2.3) c. Review promotions policy and procedure to ensure a culturally safe system for measuring success of Aboriginal and/or Torres Strait Islander staff. (Standard 5.3.1) d. Develop and implement formal professional development mechanisms for Aboriginal and/or Torres Strait Islander staff. (Standard 5.3.3) e. Develop and implement culturally safe opportunities for all students to experience providing health care to Aboriginal and/or Torres Strait Islander people in clinical placements. (Standard 5.4.2)	
Standard 6: Evaluation and continuous improvement		
16	Provide an action plan for development and improvement of the areas identified in the external review the School is undertaking. (Standard 6.1.1).	2026
17	Develop and implement a systematic plan to evaluate all phases of the new medical program, including: a. Student and graduate outcomes from all phases of the new medical program and for cohorts of students from equity groups, including Aboriginal and Torres Strait Islander cohorts. b. Share analysis with identified internal and external stakeholders, including relevant committees and decision makers. (Standards 6.2.2, 6.2.3 and 6.2.4)	2026

Commendations

A	The Program is located in a range of sites representing a diverse range of communities, enabling its students to experience health care delivery in a range of loci with diverse cohorts/populations. (Standard 1.1.2) • The outstanding engagement and sustained relationships with the health service providers which host clinical placements. (Standard 1.2.2) • The leadership of the Dean of Medicine, who facilitates a positive learning and working environment for students and staff; and rewarding engagement with stakeholders. (Standard 1.4.2)
B	The exceptional leadership and work of the GUMURRII unit in active recruitment, retention, and support of Aboriginal and/or Torres Strait Islander students into the medical program. (Standard 1.4.6)
C	The achievement of academic and profession staff of the GMS in designing and delivering a comprehensive new curriculum framework, including conducting research and scholarship to inform learning, teaching and assessment. (Standards 2.2 and 3.1)
D	The General Practice Longitudinal Program initiative that aligns with the medical program purpose and provides comprehensive longitudinal, whole-patient care learning experiences in primary health care in Years 1, 2 and 4. (Standards 2.1, 2.3.5 and 2.3.8)
E	The introduction of the capstone clinical readiness block in Phase 2 is an impressive addition to the curriculum to support student transition to clinical and research practice. (Standard 2.3.4)

F	The development and delivery of the new Aboriginal and/or Torres Strait Islander health curriculum in Phase 1 of the new program by Indigenous faculty members. (Standards 2.2.2 and 2.2.3)
G	The integration of First Peoples Health content and story-telling activities in the RMEA rural program in activities developed and delivered by a local Indigenous expert. (Standard 2.3.7)
H	The program of reflective practice skills development that scaffolds the development of skills in self-evaluation, lifelong learning and professional identity formation. (Standard 2.2.7)
I	The development of clinical scenarios with diverse patients, and LGBTQIA+ Allyship Training for Phase 1 students, creating a safer environment for students from the LGBTQIA+ community and developing safe practitioners in the LGBTQIA+ space. (Standards 2.1.1 and 2.3.6)
J	The consideration of staff and student wellbeing in the redevelopment of the new medical program structure utilising centrally administered university systems. Students are assured sufficient time for vacation, study and remediation, and the School-led and funded near-peer mentoring program is innovative. (Standard 2.2)
K	The strategies implemented to support students, allowing repeat of only blocks failed before progression in the course, and addressing OSCE feedback to provide individual personalised feedback to the whole cohort. (Standard 3.2)
L	The commitment to continuous improvement around blueprinting and benchmarking with other medical programs via ACCLAiM and AMSAC. (Standard 3.3.1)
M	The GUMURRII unit provides specific support for Aboriginal and/or Torres Strait Islander students on campus and allocates a student support officer for the medical students. The scaffolding and support provided by the staff at GUMURRII is commended and provides an exemplar of how retention can be supported. (Standard 4.1.3)
N	The 24/7 central Griffith University Mental Wellbeing Support Line, and the level of student awareness and comfort in accessing this resource across various clinical sites, as well as comfort using this resource, and follow-up from it. (Standard 4.2.2)
O	The weekly Solution Squad is an innovative approach to proactively identify and manage student issues. (Standards 4.3.1 and 4.3.2)
P	The high quality of clinical placement experiences facilitated by the medical program, involving: • Access to state-of-the-art anatomy facilities at the Gold Coast and the outstanding simulation facilities at the Sunshine Coast campus. (Standard 5.1.1) • The strategic use of Service Agreements to provide leadership in disciplines at clinical teaching sites. (Standard 5.2.1) • The central role played by Medical Student Placement Managers in the organisation and support of students on placements. There is exemplary support provided by professional staff to both academics and students (Standard 5.2.2 and 5.5.2) • The Rural Longlook program operates in well-supported environments. (Standard 5.4.1)

	• The collaborative relationship between the health services and the University. (Standard 5.4.1) • The commitment of clinical supervisors at all sites to provide safe involvement of students in clinical practice. (Standard 5.5.1) • The structured, paid roles of the Sub-Deans and Discipline leads which ensures coordination and engagement with clinicians at health sites such as GCUH and SCUH. (Standard 5.5.4)
Q	There is commitment to the improvement of health, equity and safety of Aboriginal and/or Torres Strait Islander Peoples through: • The comprehensive delivery of Aboriginal and Torres Strait Islander health curriculum by stellar Indigenous Level B academics across multiple sites. (Standard 5.2.3) • The First Peoples Health Unit, a small team creating and delivering authentic learning and awareness that build understanding, encourage collaborations and nurturing connections. (Standard 5.3.4) • The exemplary GUMMURRII Unit in providing culturally safe support and mentoring and academic tutoring to Indigenous students with dedicated support by the Dean and Phase 1 lead. (Standard 5.2.4) • The differing and complementary cultural safety training offered from a national perspective, complementing place-based training, specific to the University locations. (Standard 5.3.4)
R	The undertaking of external review to benchmark the MD curriculum and assessment against international standards, identify areas for further improvement and initiative to commence work on recommendations. The willingness to openly share the report is an exemplar in transparency and commitment to continuous improvement. (Standard 6.1)
S	The evaluation and continuous improvement activities have resulted in identification and imminent implementation of revised weightings that have more appropriately distributed the assessment load by adding WBA weighting and reducing the weighting of end of year MCQ exams and OSCE assessments. (Standard 6.1.1)
T	The implementation of an information communication technology disaster recovery planning scenario implemented annually. (Standard 6.1.1)
U	The First Peoples Pathway to Medicine introduced in 2023 has had a positive impact on the selection and admission process for Aboriginal and/or Torres Strait Islander peoples. (Standard 6.2.4).

Recommendations for Improvement

I	Consider separating the role of Dean of Medicine from the role of Program Director to better support strategic and future planning from external engagement and relationships with the operational running of committees and student management. (Standard 1.4.2)
II	Identify ways to include more student representation on appropriate MD Program committees, ensuring students have opportunities as stakeholders to have systemic input into the medical program. (Standard 1.3.4)

III	Review the current program Year 3 and 4 learning and teaching methods to identify new learning and teaching opportunities for the new program Phases 2 and 3, aligned with the new program changes already introduced for Phases 1 and 2. (Standard 2.3.1)
IV	Consider separating assessment and evaluation committee and academic portfolios/roles to ensure any conflicts of interests are appropriately managed. (Standard 3.1.1, 3.3.1 and 6.3.1)
V	Consider mechanisms to systematically document incidences of lapses in professional behaviours to assess patterns and areas of improvement in professionalism. (Standard 3.1.2)
VI	Evaluate the following initiatives for continuous improvement: a. The effectiveness of the First Peoples pathway into the MD Program for graduate students and the ongoing support provided. (Standard 4.1.2) b. The impact of changes to the Bachelor of Medical Science pathway to improve the access for Aboriginal and/or Torres Strait Islander, rural, Education Access Scheme and local region students. (Standard 4.1.2)
VII	The appropriateness of ATAR adjustments for Aboriginal and/or Torres Strait Islander peoples utilising the Bachelor of Medical Science pathway. (Standard 4.1.2 and 6.2.4).
VIII	To support improvement of wellbeing of medical students: a. Encourage all students and staff to complete mental health first aid training, including considering enabling the training to be a freely accessible and compulsory component of the mental health clinical block in Phase 2. (Standard 4.2.1) b. Identify a dedicated student support officer role for medical students, separate to the academic staff, who are responsible student wellbeing. (Standard 4.2.6)
VIIII	Review terms of reference for key role-based educational appointments to improve clarity for key responsibilities. (Standard 5.3.3)

Monitoring and next steps

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

1. Provide an updated academic calendar that includes the planned structure and scheduling for Year 3 and Year 4 of the new program. (i.e. an updated Figure 7 from the GU Report). (Standard 2.2.8)
2. Provide an update on staff participation and/or attendance at Aboriginal and/or Torres Strait Islander professional development activities (potentially including AIDA, LIME or PRIDOC). (Standard 5.3.3)
3. Provide an update on resourcing to enable the continuing work undertaken by the First Peoples Health Unit. (Standard 5.3.4)

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	Met	
3.3	Assessment quality	Substantially Met	

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

Standard 5: Learning Environment			
5.3	Staff appointment, promotion and development	Substantially Met	
5.4	Clinical learning environment	Substantially Met	
5.5	Clinical supervision	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	Met	

ITEMISED OUTCOME OF ACCREDITATION ASSESSMENT

ONE	M	SM	M	SM	SM	M	SM	M	M	M	SM	SM	M	M	M	M	SM	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	SM	SM	SM	SM	M	M	M	SM	M	M	M	SM	M	SM	SM	SM	M	SM
	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	M	M	SM	M	M	SM	M	M	M	SM	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	SM	SM	M	SM	M	M	M	M	M	SM	M	M	M	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	M	M	M	SM	M	M	M	M	SM	M	M	M	SM	SM	NM	SM	M	SM	M	M	M	M	M	M
	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	M	M	M	SM	SM	SM	M	M
	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 School of Medicine and Dentistry's (the School) purpose is well defined and appropriately includes learning, teaching and research. The School's strategic plan further expands on the social and community responsibilities with a focus on service. Within the Health Group Charter, in which medicine is located, there is a commitment 'to having a safe, inclusive and equitable workplace, championing wellbeing, and creating a culture of authentic and respectful interactions, including with students.'

The values of Griffith University (Griffith) and the School's strategic plan report the importance of place-based needs of the communities it serves. This is reflected in the external relationships it holds, and the student placement sites. There is engagement and teaching in Aboriginal and/or Torres Strait Islander health. Advancing health equity could be strengthened through broader community stakeholder engagement with equity groups; for example, the disability sector, LGBTQIA+ sector, culturally and linguistically diverse communities and low socioeconomic status groups.

The School is currently 'teaching out' the previous Doctor of Medicine (MD) curriculum, and the team found external stakeholders were very complimentary of Griffith MD Program (the Program) graduates as being 'work ready' upon graduation. The development and implementation of Phase 1 of the new curriculum is commended, as it has a strong focus on competency-based acquisition of skills (which will be enhanced when the Preparation for Internship program [PRINT] module is implemented and evaluated), while also including a critical review and consolidation of curricular content. These foci provide confidence that the Program does produce doctors who are ready to practise in both Australia and Aotearoa New Zealand under supervision as interns.

The School has an exceptional team of Aboriginal and/or Torres Strait Islander staff who are committed to the School's purpose, the design, development and implementation of the medical curriculum, and in the recruitment and retention of Aboriginal and/or Torres Strait Islander students in the Program. There is concern about the lack of Aboriginal and/or Torres Strait Islander representation on executive committees (including admissions) to ensure there is clear Aboriginal and/or Torres Strait Islander governance and voice in strategic planning and decisions.

There was strong support from staff for the Aboriginal and/or Torres Strait Islander executive committee/advisory group to be reinstated within the School or at a Health Group level to demonstrate full participation in the program. This committee/group's terms of reference should align with building capacity and capability within Aboriginal and/or Torres Strait Islander staff and students, provide a culturally safe space to discuss strengths and gaps in the current medical education program, and provide advice/guidance to the School's curriculum committee and Dean.

There was concern that the current advertised position for a senior Aboriginal and/or Torres Strait Islander academic has remained unfilled for a long period. It is strongly recommended that the recruitment strategy be reviewed. The School is encouraged to consider broadening the criteria for the vacant position to emphasise Aboriginal and/or Torres Strait Islander knowledges as a key selection criterion and considering

health professions other than doctors for this role. A commitment by the School to support the building of capacity both for this new staff member and for the medical education professional development of all Aboriginal and/or Torres Strait Islander staff is encouraged.

The GUMURRII Student Success Unit staff are commended for their passion and support for Aboriginal and/or Torres Strait Islander students.

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.

The School does not currently have a broader community stakeholder engagement strategic plan, though a model does exist in the public health program that could be replicated for the medical program. The engagement with community groups experiencing health inequities is an important pathway to ensure the medical program is meeting its purpose of serving the needs of the local community.

The School has effective partnerships to support the education and training of medical students in various health services, and those overseeing prevocational training in the region. Stakeholders spoke fondly and with respect of the Program, and this included specific complimentary remarks about the Dean and the MD Program Director. It is obvious that staff work hard at ensuring their health service delivery partners are informed, engaged and can be part of co-design (curriculum and research) and access support and services as required to support student placements. Formal relationships with identified equity groups would also strengthen the School's current position within the region (see Standard 1.1.2).

There is a gap in Aboriginal and/or Torres Strait Islander health partnerships to provide all students with clinical experience in Aboriginal and/or Torres Strait Islander health; however, within some sites there are some excellent examples of how this is happening. At the Sunshine Coast site, shadowing of an Aboriginal Liaison Officer (ALO) is integrated into the clinical years. The relationship with Kalwun Health and Wellbeing Services is important and the challenges of placing students at this one busy clinic were noted. The Program is encouraged to explore other options, both for partnerships in the region with other Aboriginal and/or Torres Strait Islander organisations where possible, and for andragogy to increase opportunities for students' exposure to a clinically relevant Aboriginal and/or Torres Strait Islander curriculum.

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.

There is a clearly documented governance structure, which illustrates how the Program and School are positioned within the Health Group, and how the line management for the oversight of the medical program is organised.

The governance structure provides the authority and capacity to plan, implement, review and improve the Program, to achieve the program outcomes and the purpose of the School. The team makes special note of the role of the Clinical Sub Deans and other professional staff positions allocated on each campus, which enables equity for students regardless of geographical location. The team is confident that the current governance structure enables appropriate and effective academic oversight of the Program.

The Program has a staff–student consultative group that is inclusive of the wider student body and provides a forum for the students to give input and influence the delivery of the Program. Student feedback on the rollout of the new program demonstrates how the Program can collect, respond, value, redesign and pivot as required to student experiences. Students noted the impact their feedback had on Phase 1 of the new curriculum, and this supported their confidence that they have a role to play in quality and assurance of the Program. Students are also included in the membership of the Medical Program Committee; however, it is noted that their role is non-voting. The School should consider more student representation on appropriate committees to ensure students as stakeholders have opportunities for clear systemic input into the Program.

The School 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 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.

Within the GU structure, the School is allocated a budget through the Head of School to support business-as-usual expenses. The team did not observe significant concerns about the resources allocated to the Program, and current resources are supporting both the teach-out of the old program and the rollout of the new curriculum. The process for acquiring additional resources is clear and requires advocacy through the Dean of Medicine directly to the Head of School.

The School has a dedicated and clearly defined academic head of the medical program who has the authority and responsibility for managing the Program. This position is titled Dean of Medicine. The current Dean is well respected by his team, key stakeholders including Prevocational Medical Accreditation Queensland (PMAQ), health services that host Griffith medical student clinical placements, and students. He is noted as being an active listener, responsive, as having an inclusive leadership style, and bringing his team and stakeholders alongside him in the new curriculum rollout. His commitment to being available to the School's staff, students and stakeholders reflects the values of Griffith and the School. However, to keep momentum on the current Program gains and to enhance ongoing strategic planning, it is recommended that the Dean of Medicine role is separated from the Program Director role. This will allow a separation of strategic and future planning and external engagement and relationships with the operational running of committees and student management and facilitate a more balanced workload.

The Dean is supported by a dynamic and effective leadership team with dedicated and defined roles who have appropriate authority, resources and expertise to support the Program. This was evident at all campuses and was further reinforced by leaders having clear understanding of roles, responsibilities and strategic lines of reporting.

The leadership team does not currently include a senior Aboriginal and/or Torres Strait Islander staff member. A position is currently advertised, and the team notes the position will be a member of the School of Medicine and Dentistry executive team. It is expected that this senior position will be retained on the executive team going forward to demonstrate that the criteria of this standard is met.

The level of the qualification delivered is assessed against national standards and is an approved Australian Qualifications Framework (AQF) Level 9 degree.

The Program provides accurate, relevant information about its policies, and its requirements are available and accessible to the public, applicants, students, staff and clinical supervisors. This includes information necessary to support delivery of the Program. The team notes that the students applying for the Griffith program may also be applying for other medical schools both in and out of state. The materials provided by the School on their multiple pathways into the Program are clear and concise. The team also notes and commends the work of the GUMURRII Unit, which provides 'pre-orientation' opportunities to Aboriginal and Torres Strait Islander students to support recruitment and retention of these students at Griffith and in the Program.

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 new MD curriculum is founded on the principle of 'student-centred learning for patient-centred care', placing the needs of patients and communities at the heart of the curriculum.

- The mapping of learning outcomes is completed for Years 3 and 4 of the current teach-out curriculum, and Years 1 and 2 of the new MD curricula.
- The learning outcomes for Year 3 of the new curriculum have been drafted, and the Year 4 learning outcomes are not yet developed.

The team notes the School has mapped the Program outcomes against the AMC graduate outcome statements for the current program and Years 1 and 2 of the new MD program. Once learning outcomes for Years 3 and 4 of the new MD program are finalised, it is expected that mapping for the entire new curriculum to the AMC Graduate Outcomes is completed.

Access to learning

During Years 1 and 2 (Phase 1 and the first block of Phase 2) of the new MD program, students are located at either the Gold Coast or Sunshine Coast campus. In Years 3 and 4 of the current program (second block of Phase 2 and Phase 3 of the new program), students undertake placements at the Gold Coast University Hospital (GCUH), Sunshine Coast Hospital and Health Service (including Sunshine Coast University Hospital [SCUH] and Gympie Hospital), Logan Hospital, Tweed Valley Hospital, Queen Elizabeth II Jubilee Hospital (QEII), Wesley Hospital and/or as part of the Rural Longlook program at various rural sites. The experiences at these clinical sites provide diverse educational experiences, supported by appropriate resources, and the achievement of comparable assessment outcomes.

The teaching team is structured so that each course has a Gold Coast and Sunshine Coast Course Convenor who, together with the Clinical Sub Deans, ensure consistency across sites. Both academic and professional staff are distributed across and travel between the campus and clinical sites to deliver and support the program, as well as being available online. It was evident to the team that the School actively listens to and makes concerted efforts to reasonably respond to student feedback when any apparent inequities arise.

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.

Transition to the new MD program

Informed by consultation with internal and external stakeholders, the key drivers for the new MD program include a transition to contemporary pedagogies (e.g. team-based learning [TBL], longitudinal integrated clerkship [LIC], reflective practice portfolio); revised program structure to enhance integration, student wellbeing, remediation and progression; improved alignment with institutional processes and support systems; and an increased focus on Aboriginal and/or Torres Strait Islander health and community-based health care and practice.

The current and new Griffith medical programs are both four-year graduate-entry programs. The duration and total credit point requirement of the current and the new programs remain the same.

The School is in the process of implementing the new MD curriculum. At the time of the team's visit in September 2024, Year 1 and Year 2 students were in the new MD program and Year 3 and Year 4 students were in the current medical program being taught out.

The new MD program is structured as follows:

- Phase 1: Foundations (1.5 years) is organised into three courses (Clinical Practice; Community Medicine and Professional Practice; Foundations of Medicine) delivered in Blocks 1–3 that focus on the science of medicine, core clinical and communication skills, laboratory experiences and general practice placements. LGBTQIA+ Allyship is introduced as part of communication skills modules in Clinical Practice (Phase 1) with a designated topic 'Conversations on Gender Diversity and Sexuality'.
- Phase 2: Transitions (1.5 years) commences with Block 1 comprising three capstone courses (Transition to Clinical Practice; Applied Communication, Leadership, Law and Ethics [ACLE]; Preparation for Research) and Blocks 2 and 3 composed of clinical placements (General Medicine, General Surgery, Child Health, Women's Health, Mental Health, Aged Care and Cancer Care) that form Year 3 of the current program. The goal of Phase 2 is to transition students from a primarily coursework-focused program into clinical practice, while providing them with opportunities to extend and apply their critical thinking and clinical skills.
- Phase 3: Preparedness for practice (1 year) comprises the Year 4 current program clinical rotations in General Practice, Emergency Medicine, Critical Care/Orthopaedics as well as an elective and selective. In the new program a new PRINT block and a new Scholarly Project block will be incorporated as well as additional clinical experiences in Medicine and Surgery.

The focus of the new final year is on transition to clinical practice and intern preparedness. The four themes (i.e. Doctor and Patient; Doctor and Knowledge of Health and Illness; Doctor and Health in the Community; Doctor and Law, Ethics and Professional Practice) of the current program, in Years 3 and 4, will not be continued in the new MD program.

A variety of learning, teaching and assessment methods are employed to achieve the medical program outcomes. The course profiles published on the Griffith University website are used to communicate course learning outcomes to staff and students and document constructive alignment. Course profiles for the new and current programs delivered in the 2024 academic year, together with the draft course profile for the new Year 3 planned for 2025, were made available to the team. However, the draft course profile for the new Year 4 planned for 2026 was not yet available. Once finalised, it is expected that the School completes the mapping of the new medical program to the AMC graduate outcome statements (see Standard 2.1).

Courses are reviewed on an annual basis to guide potential enhancements to course design and delivery via the published course profiles. In addition, learning goals for topics and clinical placements within a course are available to staff and students on the Learning Management System (LMS). The School has been responsive to student feedback to ensure that the current program continues to develop; for example, it has initiated an online lecture series for Year 3 in May 2023, organised teaching collaborations across clinical rotation sites, coordinated each clinical rotation to commence with a clinical skills review and practice, realigned assessment and teaching, and allocated rostered days off for students between clinical blocks. Student evaluations in response to the changes have been positive.

A range of opportunities are available to students to provide a variety of learning experiences across all four years of the program.

Integration and transition

The new MD program has provided an opportunity to enhance vertical and horizontal integration and design purposeful curriculum activities that support student transition to subsequent stages of training. This is achieved by the creation of three new courses each in Phase 1 and Phase 2 of the new MD program. For example, the Phase 2 Transition to Clinical Practice course is undertaken in community clinical environments and builds on the community placements introduced during Phase 1, to provide students with an opportunity to progressively develop core skills through participation in patient care. There are plans to develop a new PRINT block for Year 4 of the MD program.

To ensure safe transition to subsequent stages of training, each Phase 1 and 2 course is regarded as core (referred to as a designated course) and needs to be satisfactorily passed for students to progress to the subsequent block. Students who fail a course are permitted to enrol in and repeat only that course and progress to the subsequent block upon successful achievement of the course requirements. A directed elective is provided for students who failed to satisfactorily complete a clinical placement block in Years 3 or 4.

Alignment of the new MD program with the academic calendar

The development of the new medical program has provided the School the opportunity to adjust the number of teaching weeks for each year level to better align with the university academic calendar and take advantage of centrally supported activities such as examinations. In addition, it has made it possible to create greater consistency in the number of clinical placement weeks in the final two years of the program and provide study and holiday breaks to support student success and wellbeing.

In the new Year 3 of the medical program, to be implemented in 2025, the placements will remain the same, but a number of structural changes are planned to support student success and wellbeing. The current six clinical placement blocks of seven weeks' duration will be reduced to six weeks to enable the School to schedule four vacation weeks during the academic year, and a two-week study block prior to end-of-year assessments. This change also allows for a directed elective to be completed at the end of Year 3 (instead of at the end of the current Year 4), for students who failed to satisfactorily complete a block.

In the new Year 4 of the medical program, to be implemented in 2026, the current five clinical blocks of seven weeks' duration will be divided into three blocks of 12 weeks that will facilitate the incorporation of

additional clinical experience in Medicine and Surgery (in the form of Medical and Surgical Specialties blocks), a four-week elective block and a PRINT block.

The 2024 academic calendar showing the structure of the new Years 1 and 2 and current Years 3 and 4 was made available to the team. The details of the new Year 3 and Year 4 curriculum were not available at the time of the visit and so the team was not able to assess whether the revisions to the curriculum design and duration would enable the achievement of program and AMC graduate outcomes.

Studies of choice

In the current Year 4, both elective and selective opportunities are available. At the present time, the Year 4 elective consists of seven weeks full-time placement in a clinical or non-clinical setting located in Australia or overseas. This includes advanced surgical and clinical anatomy and medical education options offered at Griffith, and a rural research or education option available in Toowoomba. The Year 4 selective encompasses a seven-week clinical placement in a teaching hospital or affiliated facility that provides clinical intern roles, including rural options. The electives and selectives will continue to be available in Phase 3 of the new program but will be changed to four weeks' duration.

Students can apply to undertake paid roles in the School, including anatomy tutor, prosector or near-peer mentor. In these roles, students are provided with training and have an opportunity to develop their knowledge and skills, as well as contribute to the learning of their peers. Students acknowledged the positive outcomes of the peer mentoring and appreciated the coordination between university staff and Griffith University Medicine Society (GUMS) to provide academic and wellbeing support to students throughout the medical program.

Aboriginal and/or Torres Strait Islander health curriculum

Current MD program

In the current program, Aboriginal and/or Torres Strait Islander health is embedded in the Doctor and Health in the Community theme during Years 3 and 4 with a focus on the analysis of how social and health system factors influence First Peoples' health and improve outcomes and equity. In the rural program, First Peoples' health is integrated as a core component of the hub days utilising an Aboriginal pedagogy that includes art, narrative, storytelling, music and reflection (see Standard 2.3.7).

New MD program

The School outlined purposeful plans to progress the integration of Aboriginal and/or Torres Strait Islander health content in Phase 1 of the new program, but the details of the curriculum for Phases 2 and 3 were not available at the time of the 2024 assessment visit. The plans to integrate Aboriginal and/or Torres Strait Islander health content into Years 3 and 4 of the new program are not clear. Clarity on the integration of cultural safety into the new program is required.

In Phase 1 of the new program, First Peoples' health forms parts of the three Community Medicine and Professional Practice (CMPP) courses to facilitate integration with topics such as law, ethics and professional practice. Learning activities include a range of lectures, self-directed activities and workshops, and assessment includes short-answer question exams and written assignments.

The Aboriginal and/or Torres Strait Islander health curriculum for Phase 1 of the new program has an evidence-based design and is positioned within a strengths-based framework. The curriculum was led and authored by the School's First Peoples staff who have developed learning and assessment resources and teach face-to-face workshops at both the Gold Coast and Sunshine Coast campuses as part of the Phase 1 CMPP courses. Topics throughout the curriculum focus on understanding history and racism and their impact on First Peoples' health, applying social and emotional wellbeing approaches, recognising and avoiding deficit discourses in favour of strengths-based approaches and communication skills, strengthening health and wellbeing for First Peoples, and strengthening the delivery of culturally appropriate care.

The curriculum for Phase 2 and 3 has not yet been developed due to a lack of senior academic leadership at this stage (see Standard 5.2.3). The AMC accreditation team are concerned about the ongoing sustainability of the curriculum development and teaching in Aboriginal and Torres Strait Islander health, which currently

relies on two Level B Aboriginal and/or Torres Strait Islander academics. To meet the expectations of the AMC accreditation standards and enable appropriate constructive alignment and assessment of the Aboriginal and/or Torres Strait Islander health curriculum, investment in senior Aboriginal and/or Torres Strait Islander leadership is required. The team did, however, note the Aboriginal input to the rural program during Years 3 and 4 of the current program that is provided by a local Aboriginal expert and coordinated by Rural Medical Education Australia (RMEA) (see Standard 2.3.7).

The two First Peoples faculty members employed within the School have high teaching workloads and teach across several programs. Despite the limited capacity of the First Peoples teaching team, the curriculum development and implementation are of a high standard. However, the AMC accreditation team are concerned about the ongoing sustainability of this resource to meet the expectations noted in the AMC accreditation standards. To enable appropriate constructive alignment and assessment of the Aboriginal and/or Torres Strait Islander health curriculum, investment in senior Aboriginal and/or Torres Strait Islander leadership is required (see Standard 5.2.3).

Research and scholarly activities

The School provided evidence of a range of research and scholarship activities that inform learning, teaching and assessment with a focus on curriculum design and general practice education. A strength of this work is the collaborations with other institutions. The School outlined plans to develop a program of research within the School that includes medical education. An important factor for success will be ensuring that staff have adequate time to commit to research activities in addition to their education activities.

It was recognised that an area for improvement is in research relating to Aboriginal and/or Torres Strait Islander health learning and teaching. This can be addressed by providing sufficient time and support for current First Peoples staff to engage in research activities together with the appointment of a First Peoples Health Lead (see Standard 1.4.4).

Culture of reflective practice and development

A culture of reflective practice is integrated throughout all years of the medical program to build and support student capacity to take increasing responsibility for their own learning as students and future doctors in addition to guiding the development of their professional identity. A range of reflective activities in a variety of formats (e.g. written reflective journals, conversations with a critical companion, silent reflection undertaken by both individuals and groups are progressively scaffolded. The group reflection sessions in Year 4 Clinical Learning through Extended Immersion in Medical Simulation (CLEIMS) are of particular note to enable students to build awareness of shared challenges and create a culture of peer sharing and support.

Another initiative employed in the Program is that students are responsible for signing into all compulsory curriculum activities and to track and monitor their own progress. This also encompasses monitoring of participation; for example, completion of TBL assessments, clinical placement performance-based assessment items and National Prescribing Service modules.

Through continuous feedback of individual and cohort performance, students are provided with the relevant information to aid their identification of areas for development and improvement.

Rural clinical program

The School's rural clinical program is operated by RMEA and encompasses:

- Year 3 Rural Longlook program
- Year 4 Rural Longlook program
- Year 4 Rural Shortlook general practice clinical block.

The Rural Longlook programs operate as a LIC in a rural hospital. The Year 4 Rural Shortlook consists of a seven-week clinical block with a general practitioner.

As the rural program transitions to Phases 2 and 3 of the new program, a high-level Rural Taskforce has been set up to consider delivery of the rural program into the future, and how the LIC can operate alongside revisions to the placement process and new curriculum development.

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.

The medical program employs a range of both in-person and digital learning and teaching methods across both the Sunshine Coast and Gold Coast campus sites. It was evident that staff seek to ensure that the most relevant learning and teaching methods available and feasible in their context are used to achieve the learning outcomes. For example, although the Sunshine Coast campus does not have access to body donors, students are given opportunities to study body donors through scheduled visits to the laboratories at the Nathan campus. Similarly, the digital anatomy learning and teaching methods developed for use at the Sunshine Coast campus are used to benefit the learning environment at the Gold Coast campus.

As part of the implementation of Phase 1 of the new program, a number of new learning and teaching methods have been introduced with a focus on flipped classroom pedagogy. These include TBL, workshops with a focus on group-based authentic hands-on learning, and lectorials. Clinical placements in a variety of community-based settings have been initiated from the beginning of the program to scaffold student preparation for the transition to clinical rotations in Phase 2.

In Years 3 and 4 of the current program, the majority of learning and teaching occurs as part of clinical placements. For students undertaking rural placements, rural hub days are provided to bring students together for shared learning activities. The learning undertaken at clinical placements is complemented by an online lecture program and resources that are made available to students across all sites. Staff indicated

that the current learning and teaching methods used in the current program Years 3 and 4 will be continued in the new program Years 3 and 4.

Support for progressive development

The learning and teaching methods are designed to support progressive development of student knowledge, skills and attitudes in authentic learning environments, commensurate with student experience, across the four years of the program to promote safe, quality care.

The development and implementation of a set of mandatory workplace-based assessments (WBAs), supported by a WBA platform similar to the logbook currently used at the Tweed Valley clinical placement site, will provide a system for the demonstration and assessment of core competencies prior to students being required to perform the clinical skill independently.

Students progressively become more independent and work increasingly like interns. The School outlined that they intend to continue this model of learning in the new program with the addition of a new PRINT block (see Standard 2.3.9).

Current MD program

In the final two years (Years 3 and 4) of the current program, students undertake work-integrated learning during clinical placement blocks where they participate in ward rounds that involve observation and practice of clinical skills with patients. In this environment they are expected to take a history and examination of a patient on their own to present to their supervisor and complete the OSCAR, mini clinical evaluation exercise (Mini-CEX) and ITA requirements for each block. Students reported that supervised assessment of core competencies (e.g. IV cannulation) is not consistent prior to independent performance of the skill (see Standard 3.2.1).

When students transition to Year 3 (in the current program, future Phase 2 of the new program), each clinical site provides orientation sessions such as workshops to consolidate clinical skills and prepare for commencing clinical placements. Similar sessions are coordinated for students at the start of each rotation to provide dedicated opportunities for practice and feedback prior to beginning participation in patient care. Students undertaking the Year 3 Rural Longlook program have scheduled hub days throughout their placement with a focus on practising core clinical skills.

When students are in Year 4, they are expected to demonstrate greater responsibility to independently perform history taking and physical examination and practise clinical reasoning, investigations, management and minor procedures. The level of student independence is adapted to align with each individual student's competencies at that time with gradual increases in expectations to work independently as they progress to the final year.

During placements in Year 4, students undertake simulation activities to develop and practise skills before using them in clinical settings. At the Gold Coast site this occurs during the CLEIMS in the General Practice block and at the Sunshine Coast site is part of the PRINT program during the Critical Care block. Year 4 Rural Longlook students undertake simulations and skills sessions, case-based learning and intern preparation scenarios (e.g. ward calls) during the scheduled hub days.

Initiatives such as the General Practice Longitudinal Program (GPLP) provide a scaffolded structure to support student progression and provide them with immersive authentic opportunities for learning in partnership with a diverse patient group. The GPLP began on the Sunshine Coast campus in 2019 and, following a successful implementation, was expanded to include the Gold Coast campus. The GPLP is a distinctive feature and highlight of the Program that aligns with the program purpose and recognises the comprehensive longitudinal, whole-patient care learning experiences offered by primary health care. Staff and student feedback indicated the GPLP is a highly valued component of the medical program.

New MD program

The purposeful introduction of clinical placements from Year 1 in the new medical program gives students early experience of working in partnership with doctors, other health professionals and patients that is progressively built upon in successive years. As part of the GPLP in the first two years (Phase 1 and Phase 2)

of the new medical program, students begin with observation of patient appointments and then progress to undertake supervised involvement in patient care (e.g. history taking, physical examination) with increasing levels of participation commensurate with their level of skill development.

In Phase 1 of the new program, students learn, practise and are assessed on history taking, physical examination, procedural skills and communication. Concurrently, students attend General Practice placements as part of the GPLP, which provide them with an opportunity to observe and begin to apply these skills in a supervised clinical setting and to prepare for undertaking hospital-based clinical placements during the future Phases 2 and 3.

At the beginning of Phase 2, the Transition to Practice and ACLE capstone courses use case-based learning to progress students into more sophisticated clinical reasoning and diagnostic skills from those developed during Phase 1 sessions such as TBL. Students value the work the School has undertaken to provide practical workshops in procedural skills, communication skills and physical examinations, together with the use of simulated patients and peer-to-peer examination, to create realistic learning environments.

Interprofessional learning

At the present time, interprofessional learning has a primarily theoretical basis that is yet to be realised in practical opportunities at each site.

In the current Years 3 and 4 (future Phase 2 and Phase 3 of the new medical program), interprofessional work and learning is largely opportunistic when students are working in teams during clinical placements. Practical experiences for students to work with and learn from other health professionals are yet to be fully realised. At the Gold Coast campus, CLEIMS includes dedicated learning experiences for students to undertake authentic interprofessional team activities under supervision with integrated feedback and reflection. Student evaluations of this activity have been very positive and demonstrated the effectiveness of this approach in combination with students' work-integrated learning experiences during clinical placements. While the challenges of scheduling students from different programs and different institutions are recognised, expansion of this type of learning activity across all sites would ensure all students can experience interprofessional learning and consolidate and extend their knowledge, skills and attitudes to working with and learning from other health professionals.

In the new MD program, the Clinical Practice course during Phase 1 introduces students to the different health professions and the concept of interprofessional learning. This is associated with some practical experiences of working with other healthcare professionals in the GPLP. This is further extended in Phase 2 with interprofessional simulation activities creating realistic scenarios for students to collaborate across health professions using clinically focused scenarios with simulated patients.

Clinical placements

During each year of the program, students are provided with a range of clinical placement opportunities in diverse community, hospital and rural settings. Both the current and new programs have a focus on face-to-face experiential learning in a range of clinical disciplines.

Current MD program

In Years 3 and 4 of the current program, students undertake placements across a range of specialties including Child Health, Women's Health, General Medicine, General Surgery, Mental Health, Aged Care and Cancer Care in their third year of study; and transitioning to Emergency Medicine, Critical Care (including Intensive Care, Anaesthetics, Orthopaedics) and General Practice in their final year.

New MD program

There are a number of new initiatives that the School is introducing as part of the new program to enhance and extend student experiential learning throughout all years of the program and to increase student participation in community-based health care.

In Phases 1 and 2 of the new program, a distinctive feature is the introduction of community-based placements from Year 1 focused on health service delivery, health promotion and prevention, and a

phlebotomy placement in addition to general practice placements as part of a newly created GPLP. This reflects the vision of the new medical program to focus on patients and community. These new placements ensure that experiential learning and person-centred, community-based medicine are purposefully integrated for all students from the beginning of the medical program.

In Phases 2 and 3, the School outlined that clinical placements in Years 3 and 4 of the current program will continue in addition to Medical and Surgical Specialties blocks, which extend the clinical experiences of General Medicine and General Surgery undertaken in the third year, together with the addition of a new PRINT block and Scholarly Project block to support students' transition to internship on graduation.

In the final year of the program, the School plans to introduce LIC learning experiences to enhance student experience and participation in patient continuity of care and multidisciplinary health care.

Rural placements

Up to 25 domestic students per cohort have the opportunity to undertake Year 3 and/or Year 4 of the program at a rural hospital (Toowoomba, Dalby, Kingaroy, Stanthorpe, Warwick, Beaudesert) through the year-long Rural Longlook programs that operate as LICs. In addition, approximately 65 students each year will spend part of their final year General Practice block (Rural Shortlook) in a rural general practice in locations such as regional cities (e.g. Toowoomba) or in more remote parts of southern Queensland and the Darling Downs (e.g. Jandowae). It is not clear yet what impact the new Phase 2 and 3 of the program will have on the Rural Longlook programs. A high-level Rural Taskforce has been set up to consider future delivery of the rural program and how the LIC can operate alongside revisions to the placement process and curriculum development in Phases 2 and 3 of the new program.

Aboriginal and/or Torres Strait Islander and community health

Aboriginal and/or Torres Strait Islander teaching staff have made a dedicated commitment to ensure that learning and teaching in the new program is culturally safe and informed by Aboriginal and/or Torres Strait Islander knowledge systems and medicines. This has been successfully developed and implemented for Phase 1 of the new program as part of the CMPP courses. The School described development and delivery of this curriculum has been led by First Peoples staff.

The learning and teaching relevant to Years 3 and 4 of the current program was not outlined and the plans for Phases 2 and 3 of the new program were not provided, so this is clearly an area that the School needs to address. The team noted and applauded the integration of First Peoples' health content and storytelling activities on hub days in the rural program in activities developed by RMEA in conjunction with a local Aboriginal historian, artist, linguist and lecturer.

Current MD program

During clinical placements in Years 3 and 4 (including the Rural Longlook program) of the current program, students are exposed to diverse patients and involved in their health care. It was evident to the team that patient diversity is broader at some clinical placement sites compared to others and therefore there is not an opportunity for all students to work with diverse patients. For example, some but not all students are able to undertake clinical placements at Aboriginal Community Controlled Health Organisations (ACCHOs) or with ALOs. There are obvious opportunities available that need to be capitalised upon; for example, the low socioeconomic status, First Peoples and elderly communities in the region served by the Tweed Valley Hospital. To achieve this outcome, it will be important to leverage faculty from across all clinical placement sites to support First Peoples staff and staff representing health inequity backgrounds to achieve this standard.

New MD program

During Phase 1 (CMPP) and Phase 2 (ACLE) of the new medical program, there are dedicated activities that provide a strong theoretical basis for students to learn about the differing needs of community groups who experience health inequities as well as Aboriginal and/or Torres Strait Islander communities. However, the experiences of students at different sites during the Year 3 and 4 clinical placements in the current medical program are inconsistent.

In Phase 1, the study of First Peoples' health is encompassed in CMPP courses. During the CMPP course, students also explore the differing needs of people with a variety of complex social histories such as trauma, alcohol and drug dependency, homelessness, disability, and diverse cultural and linguistic backgrounds, as well as persons that might face adversity in their communities and in healthcare settings, such as people with infectious diseases, refugees and people with mental health conditions. Workshop activities are designed to facilitate the integration of medical law, professional guidelines and the principles of ethical decision making to develop student awareness of power imbalance, systemic disadvantage, bias and stigma in health care. Importantly, students are introduced to strategies to combat these issues and provide inclusive, culturally safe and respectful care for all.

During the Phase 2 ACLE and Transition to Practice courses, students participate in workshops and placements, respectively, where they explore the application of these principles in health care as well as the consideration of more complex situations.

Pre-internship program

The current medical program does not have a dedicated pre-internship program across all sites, but the School has indicated that one is envisaged to be developed and implemented as part of Phase 3 (Year 4) of the new curriculum in 2026.

In the current program, the Year 4 Rural Longlook functions as a PRINT block with the medical students integrated in teams and functioning a pre-interns. This model is the optimal training for internship. In non-rural sites, there are some activities designed for intern preparedness as part of CLEIMS at the Gold Coast site and PIP at the Sunshine Coast. However, the lack of a dedicated pre-internship program across each of the sites in the current program means that this standard is not currently being met.

It was evident that the length and content of the pre-internship program planned for the new program is still under development. Preliminary plans provided indicate that the intention is to incorporate the PRINT block within one of the three 12-week streams that will form the structure of Phase 3 in the new program. Therefore, rather than all students undertaking the PRINT block at the end of the final year, students will complete the PRINT block at different times during the year. The School indicated that the PRINT block is likely to incorporate both simulated and real clinical opportunities relevant to working as an intern.

For final year students in the teach-out program, the School may consider an interim program building on the existing CLEIMS and PIP to undertake relevant pre-internship activities. It would also provide an opportunity to pilot the planned pre-internship program for Phase 3 of the new program in 2026.

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 MD program offers an integrated curriculum that promotes learning in authentic contexts, which facilitates the sequential development of the professional knowledge, skills and attitudes required for effective clinical practice. The assessment system in the MD program reflects this, with students required to demonstrate competency progressively across the courses. The goal is to determine progression and, ultimately, eligibility to graduate.

The team notes there is a documented system of assessment which ensures that students have attained minimum acceptable levels of understanding and competence at each year level. The principles of equity, fairness, validity and reliability are evident, and there are clear policies and procedures to ensure this. The assessment is supported by continuing professional development and involvement in constant renewal and upskilling. An example of this was the 2021–2022 assessment review, which identified issues with the objective structured clinical examination (OSCE).

The MD Program Guidelines are reviewed and updated annually and are made available to all students on the LMS at the start of the year. The MD Program Guidelines describe the assessment rules, requirements and processes employed to assess student achievement and determine progression through the MD program, consistent with the above policies and procedures.

Assessment in the MD program, guided by the Assessment Strategy and Assessment Principles, are regularly reviewed by the Assessment and Evaluation Committee and the MD Program Committee endorsed by the School Committee. There is potential conflict of interest with the Head of Assessment also being the Head of Evaluation and it is recommended that these roles and committees are separated.

Demonstration of progress

The MD program consists of a system of varied assessment types which enables students to demonstrate their learning, competency and eligibility to progress both within courses/phases, and across all four years of the degree, to graduation. The assessment types reflect the increasing requirement to demonstrate higher levels of authentic performance in practice in Miller's pyramid. As the last two years of the new MD program have yet to be implemented, the team is interested in plans for modifications of WBAs and other entrustable professional activities (EPAs), which demonstrate program outcomes. External review has suggested a program of assessment which is supported by the team.

The progression rules have been modified with the change to the structure of the Program, from year-long courses to 10–20-unit courses. Students are required to complete all courses in the previous block before they progress to the next block. If they fail one or more courses, they need to repeat this course(s) in the next available offering. Until they have passed the failed course, they need to take leave of absence. The changes in progression rules which allow students to repeat only those blocks which they have failed before progression in the course is commendable.

Assessments at the end of each year have had disproportionately large weightings, which the School has been addressing. More emphasis on a program of assessments with assessment as and for learning may enhance the ability of students to demonstrate progress towards and achievement of the required learning outcomes. Assessment of professional behaviours occurs over multiple courses and in a variety of formats across the years, assessing both the ethics and law related to professional behaviour and the demonstration of professional behaviour during placements and in clinical assessments. The team would recommend systematic documentation of all professionalism lapses, including multiple minor professionalism issues. Ideally this would be collected and collated in an ePortfolio.

Assessment blueprinting

There is a system of assessments across the medical program already developed for Phase 1, and being revised for Phases 2 and 3 of the new medical program. Constructive alignment of learning outcomes with teaching and learning activities and assessment has been developed for the courses in Phase 1 and presented to students in a consistent fashion on the LMS across the courses.

In the teach-out of Years 3 and 4 of the current program, the assessments are aligned to the four themes, outlined in handbooks with different levels of relevance indicated by Level 1 (highly relevant) to Level 3 (moderately relevant). The team heard from students about the vast number of learning outcomes and were unclear whether there is mapping to teaching and learning activities to assist students' learning. Alternatively, there could be indications that certain topics are part of student 'independent learning'.

It is commendable that the School engages in continuing professional development around blueprinting as evidenced by the workshop run by an external academic in 2023.

Assessment methods

The system of assessments is varied in formats and methods, which include tests of knowledge, interpretation of data and demonstration of learning (e.g. OSCEs and WBAs). The Program uses a combination of various assessment methods, both within courses and across phases, throughout the degree. This includes multiple-choice and short-answer questions, written assessments (essays, case studies), oral assessments/presentations, and practical assessments such as OSCEs and WBAs (OSCAR, Mini-CEX, ITA). The team will be interested to review the plans for the PRINT term assessments in Year 4. Formative and summative assessments are used across the program and the students expressed a desire for more formative assessments which reflect the blueprinting of summative assessments.

Currently a range of platforms are being used for each different assessment type, which is introducing complex processes and inefficiencies. ExamSoft is used for written assessments with results transferred to the LMS, and eOSCE, which is suboptimal for student experience, continues to be used for OSCEs. Most other assessments are submitted via the LMS. WBAs are recorded on paper and uploaded onto the LMS. Ideally, to gain a detailed view of the development of competencies in an individual student and the cohort over a longitudinal time course, an ePortfolio is needed. IT platforms such as risr/assess & risr/advance would provide the ideal fit-for-purpose platform to ensure a range of assessments are collected and collated.

Standard-setting methods

Validated methods of standard setting are used to establish the criteria for determining whether a student's performance meets a predetermined level of proficiency or competency. These methods ensure that assessment results are reliable, valid and fair. The Ebel method is a recognised standard-setting method for written assessments and is used in the MD Program. Marking rubrics are used for other assignments such as essays and oral presentations, with the passing criteria determined by agreement of experts. For OSCEs,

Borderline Regression is used for standard setting, which is common practice in the majority of medical schools in Australia and Aotearoa New Zealand.

Assessment of Aboriginal and/or Torres Strait Islander health

The Phase 1 assessment of First Peoples' health primarily occurs as part of assessment for the three CMPP courses in the form of short-answer questions, and integration into written assignments. The model answers and answer guides were reviewed and written by the previous First Peoples Health Lead. In the current program, assessment is part of 8003MED and 8004MED sitting across the four themes, by multiple-choice questions. The team is interested in the development of assessment of First Peoples' health in Phases 2 and 3 of the new program.

Communication principles with First Nations People is taught in Phase 1 in workshops with Aboriginal and Torres Strait Islander people. It appears that principles of communicating with Aboriginal and Torres Strait Islander people is covered but not specifically assessed. The team looks forward to details of assessment of Aboriginal and/or Torres Strait Islander health and culturally safe practice integrated across the program and informed by Aboriginal and/or Torres Strait Islander health experts in Phases 2 and 3 of the new program, particularly communication.

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.

MD program assessment is feedback oriented, and feedback to students is moulded to maximise its impact on student learning. Assessment feedback is generally timely, constructive and individualised. The MD program provides feedback on both written and practical assessment such as OSCEs. This includes cohort feedback and individualised feedback via ExamSoft's strengths and opportunities reports and OSCE feedback reports. Individual, personalised feedback to the whole cohort was implemented in 2024 on their 2023 OSCE performance.

A breakdown of the results and passing scores per station was implemented in 2022, and general feedback to the whole cohort was implemented in 2023. Other strategies to improve feedback included increased reading/marking time for OSCE stations, so examiners had more time to provide feedback for each student per station (from two minutes to three minutes), and centralised prompts to improve the quantity and quality of feedback, implemented and studied in 2023. The changes to OSCE reading time were studied systematically and found that increasing the reading/marking time to three minutes in OSCEs reduced student anxiety, and examiners provided a 2.1x increase in feedback. The accreditation team was impressed with the strategies to address OSCE feedback.

Students also receive regular feedback from clinical assessments in Years 3 and 4 including for OSCARs and Mini-CEXs. More global assessments of student performance occur for clinical placements and a satisfactory report is required, and if unsatisfactory, there is an opportunity to complete a Directed Rotation at the end of the year. Competency of procedural skills in clinical practice is not consistently assessed prior to independent performance of the respective skill; this could be rectified with practice in a simulated environment (e.g. IV cannulation). Students reported that there were a range of WBAs they could choose to be assessed on that didn't include the mandatory core competencies. It is recommended that WBAs systematically assess core competencies such as cannulation prior to independent performance of the procedure.

There is an opportunity to improve the quality, quantity and timeliness of feedback with the use of an IT platform such as risr.

Student performance improvement

The Program has clear processes to identify students who are not performing to the expected level and providing them with timely support and performance improvement programs. The process typically involves a combination of assessment, monitoring, communication and intervention strategies.

The MD program uses data analysis tools from ExamSoft and the LMS to identify patterns and trends in student performance to identify students who are consistently below the expected level.

Early warning systems automatically flag students who may be at risk based on attendance, grades or other indicators, including students who perform poorly in mid-trimester assessment and students returning from a leave of absence. Once at-risk students are identified, targeted intervention strategies are implemented, including near-peer remediation, university library study skills workshops, relevant wellbeing support services or personalised learning plans, especially for students returning from a leave of absence. There are in-person meetings for personalised learning plans and pastoral care.

Staff and students can monitor assessment progress in the LMS Mark Centre. By implementing a combination of these strategies, the MD program effectively identifies struggling students early, and aims to provide timely support while creating a learning environment conducive to positive engagement and academic improvement.

Feedback to academics and clinical supervisors

The performance of student cohorts is analysed in detail by Course Convenors and School Assessment Boards prior to final grades being recommended. As part of this process, Course Convenors provide data to the School Assessment Board. School Assessment Board meetings communicate cohort performance information to relevant academic staff, which allows them to review the data, ask questions and engage in discussions on the assessment and student performance. Academics have access to information about students' performance on ExamSoft as well as access to psychometric data on questions they have written. Having the risr/assess platform would further allow students and academics/clinicians to access similar feedback on their OSCE stations and student performance.

Finally, the introduction of ExamSoft has also allowed for comparisons to be drawn between cohorts and visually represented for the purposes of evaluating assessment outcomes and cohort performance.

3.3 Assessment quality	
3.3.1	The medical education provider regularly reviews its system of assessment, including assessment policies and practices such as blueprinting and standard setting, to evaluate the fairness, flexibility, equity, validity, reliability and fitness for purpose of the system. To do this, the provider employs a range of review methods using both quantitative and qualitative data.
3.3.2	Assessment practices and processes that may differ across teaching sites but address the same learning outcomes, are based on consistent expectations and result in comparable student assessment burdens.

The School regularly reviews its system of assessments and employs a range of review methods using both quantitative and qualitative data. It is very involved in benchmarking with other medical programs via Australasian Collaboration for Clinical Assessment in Medicine (ACCLAiM) and Australian Medical Schools Assessment Collaboration (AMSAC), which is commendable.

Quantitative analysis of assessment data is conducted to evaluate the reliability and validity of the School's written assessments. Assessment guidelines, assessment communication to students and assessment task descriptions in course profiles are regularly reviewed by the Assessment and Evaluation Lead. Regular surveys are conducted among students, faculty and stakeholders to gather feedback on various aspects of assessment, including the student experience survey and the recent OSCE survey. Qualitative insights via group discussions with student and faculty members are also conducted.

With the introduction of the new MD program, with changes to the suite of assessments, there is an imperative to introduce systematic evaluation of assessment items, accuracy of blueprinting and fitness for

purpose of the system of assessment. The accreditation team strongly recommends that the evaluation and assessment portfolios are separated, both for avoidance of conflict of interest of the same person evaluating their suite of assessments and for workload considerations.

Assessment practice across sites

Although there are multiple sites, the team considers assessment to be standardised across the various teaching and clinical sites. Careful training, calibration and moderation of assessors, both academics and clinicians, involved in assessment ensure consistent expectations. There is careful selection of assessors with recommendations by Discipline Leads. Standardisation involves setting clear criteria for assessors as well as calibration meetings to ensure there is a uniform understanding of the criteria and how to apply them. There are detailed documents, rubrics and guidelines to assist assessors. Quality assurance of the performance of assessors is undertaken as part of internal and external reviews and evaluation to identify areas of improvement.

Evaluation of success of these strategies is measured by assessment outcomes across the different sites, stakeholder feedback, internal reviews, external reviews and accreditation.

Of importance, there are no significant differences in assessment performance, irrespective of teaching/clinical site. Therefore, it can be concluded that despite small variations in the teaching and learning opportunities available across various sites, students' ability to achieve the program outcomes is not significantly impacted by location.

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 School has over 900 students across all four years of the MD at Gold Coast and Sunshine Coast sites. There has been a consistent intake of students in Commonwealth Supported Places (CSPs), Bonded Medical places and Bachelor of Medical Science places; a trend of low attrition rates for international students has also been identified. The introduction of a new Graduate Medical School Admissions Test (GAMSAT)–free pathway in 2023 has increased the number of Aboriginal and/or Torres Strait Islander student enrolments. The School did not indicate significant concerns with resourcing the medical program. The team was satisfied with the size of the intake defined and the School's capacity to resource all stages of the program confirmed at the time of the assessment visit in 2024.

Infrastructure for student retention and graduation is only provided centrally at Griffith with no student support services at the level of the Health Group, School or the MD program. Student support defaults to Course Convenors who can then refer students on to central support services. More on medical school–specific student support separated from the academic staff is detailed in Standard 4.2.6.

Recruitment and retention of Aboriginal and/or Torres Strait Islander students

The targets and strategies for recruiting Aboriginal and/or Torres Strait Islander via the graduate pathway were recently introduced.

In 2023, there were successful admissions of five Aboriginal and/or Torres Strait Islander students into the MD program, with nine offers made in total and two students deferring to start in 2025, while two other students declined the offer.

In the 2024 intake year, for students starting their studies in 2025, a further 11 students applied for the First Peoples Pathway to Medicine, with students offered interviews that were conducted in late September 2024. Eight prospective students accepted their offers, with six who were new applicants and two who had deferred their 2024 offer.

The success of the new admissions approach and changes to entry requirements via the First Peoples Pathway to Medicine involve Aboriginal and/or Torres Strait Islander students completing a Bachelor or other key degree with a GPA of 5.0 or higher with no requirement to sit the GAMSAT. Interviews are coordinated and conducted via the GUMURRII Student Success Unit. The improved pathway for Aboriginal and/or Torres Strait Islander students is currently not supported by a medical school–ratified First Peoples student intake target, but rather an informal target to interview around 20 students a year.

The GUMURRII centre provides specific support for Aboriginal and/or Torres Strait Islander students on campus and allocates a student support officer for the medical students, as well as an individual near-peer

mentor for each First Nations medical student. This near-peer program engages senior MD students who apply centrally to the university for employment and is also utilised for students who are at risk of needing remediation. Students and staff speak highly of the program, and it appears to be well integrated into academic and mentoring support for ensuring students reach graduation criteria. On top of this, there is currently funding available for 10 students on the First Peoples pathway per year, which provides retention support and a pathway to graduation through partially mitigating financial hardship factors for First Nations students throughout their degree.

Recruitment and retention of students from rural and remote communities

The team did not see evidence of any significant or effective strategies for students with rural backgrounds and equity groups to be supported in applying and being selected into the MD program. Griffith University Admissions does apply Incremental Adjustment Factors that can accumulate 0.05 ATAR for each condition outlined below:

- Rural adjustments—additional 0.05 points to applicants assessed by Queensland Tertiary Admissions Centre (QTAC) as Rural
- Educational Access Scheme (EAS) adjustments—additional 0.05 points to applicants assessed by QTAC as having a Minor to High EAS case and 0.10 points to applicants assessed by QTAC as having a Very High or Extreme EAS case
- Location adjustments for the Gold Coast campus offering of the Bachelor of Medical Science—additional 0.05 points to residents of Queensland and residents of northern New South Wales
- Location adjustments for the Nathan campus offering of the Bachelor of Medical Science—additional 0.05 points to residents of Queensland.

The maximum additional ATAR bonus possible for a rural student with Very High or Extreme EAS adjustments and being locally adjusted for the Gold Coast or Nathan campus, is thus 0.02. Griffith believes this is predicted to increase the intake of these groups by 10 per cent to supplement a ratified rural students intake target of 22 per cent. The impact of this change should be evaluated and reported in the future. It should also be recognised that ATAR scores are not optimal as the only means of assessing students suitable for the medical program. Griffith should explore more equitable entry pathways for rural students and students from equity groups into the Program through the Bachelor of Medical Science assured undergraduate feeder pathway.

There are no identifiable support structures for students on the rural pathway or from certain equity groups. There does not appear to be follow-up or specialised support to rural students (e.g. accommodation support for students in a cost-of-living crisis, and a lack of preferencing special considerations for return to home for students wanting to partake in rural placements). It is worth commending the allyship training provided to students and staff to provide safe environments for LGBTQIA+ students, and to graduate empathic and considerate doctors.

Support for students with disabilities

The central Griffith University Student Disability and Accessibility service connects and links in with students who self-identify as having a disability with support and there is one staff member who specifically provides expertise in accommodations in medical student assessments. There is a Griffith University Students with Disabilities Policy the School complies with, and from 2025, a revision of the selection criteria for the Bachelor of Medical Science program will see incremental adjustments applied to the EAS in Queensland. At the time of the visit, the team did not observe significant concerns with support for students with disabilities.

Selection policy and admissions

The team considered the selection policies and admission processes to be transparent and fair, and to prevent racism, discrimination and bias. The selection guidelines and policies are detailed and published on the university website. While the selection policies may be transparent and fair for a standard applicant, the team questions aspects of their equitability in the following areas:

- The ATAR adjustment factors for students from some backgrounds is either not enough or an inappropriate adjustment measure, as identified through the changes to the First Peoples Pathway to Medicine in removing the GAMSAT and GPA requirements, leading to a greater intake of Aboriginal and/or Torres Strait Islander students.
- There are no formal targets for students in the new First Peoples pathway. There are currently no published student selection targets.
- The general selection policy and admissions processes are based solely on academic and interview performance.

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.

Griffith has outlined a commitment to providing an inclusive and supportive environment for student learning and development that promotes positive mental health and wellbeing for the Griffith community. The Student Mental Health and Wellbeing Strategy works through seven strategic goals that include diversity, inclusion, student wellbeing access and crisis intervention. This is further promoted specifically within in the Health Group and the School, through Griffith's alignment and engagement with the 2024 Medical Deans Australia and New Zealand (MDANZ) workplan. Furthermore, the strategy extends into curriculum design through encouraging peer support and mental health promotion.

Overall, Griffith provides accessible centralised student wellbeing services, including a 24/7 wellbeing helpline, but there is a need for the School to provide specific services to address the needs of students experiencing stresses in certain areas. Students (and staff) should be encouraged to complete Mental Health First Aid, potentially in the Mental Health block in Phase 2. Integration with Doctors' Health in Queensland (DHQ) was a specific resource identified for medical students, and the Doctors' Health Advisory Service can be a relevant resource with potential for longevity through a student's medical career. With regard to financial support, particularly for medical students, there is currently no significant financial levy or financial

support application process through the medical school or centrally. There are scholarships available for students and there is space for dedicated emergency financial support for students—options that are particularly relevant for rurally placed students and international students.

Support for students on Sunshine Coast and other campuses

Students on the Sunshine Coast can access Griffith services remotely, as well as University of the Sunshine Coast wellbeing resources locally. The team observed there was a lack of awareness among Griffith students about the availability of these services in the Sunshine Coast. Information on services is provided in a handbook during orientation, but students are generally not connected with the service while onsite.

Rural students in Gympie, as well as medical executive staff in Gympie, also commented on the lack of resources for rural students, especially being financially isolated at times, with rural placements being financially inaccessible for some. There is culturally informed and personalised support for First Peoples students via the GUMURRII Unit, and this is available in-person at the Nathan, Logan, Gold Coast and Southbank campuses, but remotely as well for Sunshine Coast students.

Students needing additional support

There is a proactive effort made to identify students who are struggling academically or with their wellbeing. The central University disability services rely on students self-identifying and enrolling in their service. The support provided is comprehensive and students can enrol in this service at any time during their course. The service provides for modifications in learning materials and assessments as required. For students who may need reasonable adjustments due to living with disabilities or having certain access needs, there is a Students with Disabilities Policy and potential to follow up with the Griffith central Student Disability and Accessibility service to provide adjustments for clinical placement, exams or other assessments.

Academically, students who have concerning performance in the mid-trimester assessments, and/or WBAs are identified and provided opportunities to review assessments with their Phase Lead or Course Convenor. Additionally, early intervention for students identified as being academically at risk occurs through connection to near-peer tutors via the School near-peer mentor tutoring service.

Phase Leads and Course Convenors are obligated to keep student information confidential when communicating with other staff about student-specific accommodations and placement selection or special consideration around placement allocation. Students are also encouraged to build good relationships with primary care health providers to receive access to care, and this is discussed in Phase 1 courses.

Flexible study policies

During Phase 1, leave of absence applications are regulated and guided by Griffith's central Enrolment Procedure. During clinical placements, there are five days available for applied leave per clinical seven-week block. The new MD program allows for increased flexibility with respect to students taking leave from the program and is to be commended. Students have access to a variety of leave types during the program that are adapted to their specific needs and circumstances.

Managing bullying, harassment, racism and discrimination

Griffith has a number of policies to support students available in its Policy Library, available publicly on its website. Relevant policies include the:

- Student Charter
- Code of Conduct
- Student Conduct, Safety and Wellbeing Policy
- Students with Disabilities Policy
- Equity, Diversity and Inclusion Policy
- Students Complaints Policy and Procedures
- Health, Safety and Wellbeing Policy

- Student Critical Incident Management Policy
- Student Reports of Bullying, Harassment, Discrimination and Sexual Harm Procedure.

Confidential and accessible reporting mechanisms

The MD program had a student support officer, and this position was lost in the road to sustainability restructure and noted to be a significant deficit in medical student wellbeing and support services. In the MD program, the academic staff are now tasked with identifying and managing students requiring support. There are no Health Group, School or Program-specific student support officers. This strategy has inherent potential for conflict of interest that may prevent a student seeking help, as academic staff responsible for assessment and progression are the first student support point of contact. Student wellbeing and inclusion is supported by central university student support services with no specialised support for medical students.

At the clinical level and at clinical sites, in the situation that a student wanted to make a disclosure or report around clinical safety and/or clinical supervisors, the GUMS has advocacy officers at each clinical site who aid in facilitating confidential reports, as well as confidential student self-reporting. There is a heavy reliance on the GUMS structure and student advocacy to assist with declarations.

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 Program has clear policies and procedures for managing medical students with an impairment, referring the student for further support if required. There are appropriate 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.

There is a Griffith Health Local Protocol—Fit for Professional Practice (the Protocol), which outlines all options for management of students with an impairment, including escalation to notify the Australian Health Practitioner Regulation Agency (AHPRA). If immediate or emergent concerns arise, the Protocol allows for timely action.

An innovative, proactive approach to pre-empting or managing emerging issues with students is the Weekly Solutions Squad, a meeting between the Dean and managers at each of the clinical sites to discuss student issues or concerns.

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.

Griffith maintains insurance to meet its legal obligations and to provide funds for the replacements of assets damaged or destroyed. Griffith has a comprehensive insurance program to cover:

- damage or destruction of assets or income-producing activities
- injury to staff, students or third parties
- legal liability of staff and students from Griffith University activities.

The policies that cover medical students undertaking education activities include:

- public and products liability with an Insured Sum of $20 million for any one Occurrence happening during the Period of Insurance and limited in the aggregate during the Period of Insurance in respect of any liability arising from Products
- professional indemnity with a limit of liability for $20 million on any One Claim and $40 million in the aggregate during the Period of Insurance
- personal accident insurance for students
- travel insurance.

On top of these, students are also linked in with Medical Defence Organisations (MDOs) and encouraged to sign up for free medical student cover with these organisations. These MDOs contact students through GUMS events and sponsorship and through presentations run centrally via the School.

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 facilities at both the Gold Coast and Sunshine Coast campus are outstanding, with large and small teaching spaces that are fit for purpose. The extensive Gold Coast anatomy facilities are state of the art, with a wet lab, Anatomy Learning Centre, surgical skills lab and histology lab. At the Sunshine Coast there are comparable anatomy facilities without a wet lab, including plastinated anatomy specimens as well as plastic models and an Anatomage Table which provides virtual dissection. Students at the Sunshine Coast campus also visit the Nathan wet lab as part of their Foundations of Medicine course. The Sunshine Coast has extensive simulation facilities which can provide a vast number of clinically relevant scenarios.

The clinical sites at both Gold Coast and Sunshine Coast hospital are modern and extensive as tertiary health services go for the area. There are additional sites such as Tweed, Logan, QEII and Wesley hospitals which have adequate facilities for all students. Tweed Hospital has been redeveloped and provides modern facilities as a major referral hospital in the Tweed/Byron area.

The rural sites are part of the rural clinical program run by RMEA and include eight smaller hospitals including Toowoomba and Roma, and many rural general practice sites across the Darling Downs and South West Queensland. Students report high satisfaction with both the experience and the facilities related to the rural clinical program, specifically the Rural Longlook program.

The students and staff have access to safe and well-maintained facilities in all sites. This is particularly pronounced at the two major clinical sites on the Gold Coast and Sunshine Coast. In the student submission there was some concern raised about inadequate facilities at one of the rural sites, but on questioning during the site visit, these issues seem to have been resolved. Of note, a well-renowned advocate for diversity and inclusion in medical education, a graduate of Griffith, was provided with appropriate access to all facilities at the Gold Coast campus to complete his MD as a quadriplegic.

There are also policies and procedures to ensure safety of the staff and students including Campus Support and Safe Campuses, the latter providing resources for student safety and wellbeing. Wellbeing support for First Nations students is effectively provided by GUMURRII, along with access to a tutorial network. All students have access to the School Bullying and Harassment Officer, as well as to peer support via meetings with GUMS Officers and site advocacy officers. Staff wellbeing was recognised as an area of concern, with discussions of heavy workload and negative impact on work–life balance of staff noted by the assessment

team. Planning and delivery of services, as well as workload, were outlined to have been negatively impacted on one occasion of leave approval, whereby one staff member covered the workload of three colleagues. At each of the clinical training sites, large and small, there are adequate amenities and facilities to support learning and wellbeing. These are extensive at the larger sites such as Sunshine Coast HHS, Gold Coast HHS and the new Tweed Hospital. The placements away from the Gold Coast and Sunshine Coast provide adequate facilities and accommodation.

Digital and information resources

In 2023, a successful transition to a new LMS (previously Blackboard) occurred. This has resulted in the design of engaging and comprehensive digital learning spaces for students and staff by Course Convenors. Program staff also use Griffith's systems for enrolment, course profile development, approvals for assessment variations (special consideration, extensions, etc.), and grade management. In addition to the LMS and Griffith resources, students in the Rural Longlook program can access the RMEA online platform.

ExamSoft and eOSCE are used to the best of their capacity for assessment, but do not provide the functionality required for all aspects of assessment feedback and provision of an ePortfolio. There is a need for more contemporary, fit-for-purpose IT systems to improve efficiency, quality and timeliness of feedback as well as providing a platform for WBA submission and a longitudinal ePortfolio. Examples of such IT platforms are risr/assess and risr/advance.

The School has introduced a Digital Attendance record which has streamlined recording and monitoring of attendance. This is of great value in identifying students at risk based on poor attendance. Course Convenors can clearly identify students who are absent to provide timely support.

Students have equitable access to software and digital health technologies to support their learning. All students have access to Griffith University and/or University of the Sunshine Coast library resources. The library offers a range of study and assignment skills support services, including in developing study skills, digital skills, research and writing skills, and other workshops.

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 team notes Griffith recruits and retains sufficient academic staff to deliver the medical program, including paid academics and clinicians on fractional service agreements, which is a commendable initiative to ensure disciplines have a champion at each site for educational oversight. The School has an appropriate

profile of professional staff who are committed and provide exemplary support for academics and students. This was evident at both university sites and at Gold Coast HHS and Sunshine Coast HHS.

Recruitment and retention of Aboriginal and/or Torres Strait Islander staff

The team identified a major gap in senior leadership in First Peoples' health in Standard 1, and this impacts on the leadership and impact of Aboriginal and/or Torres Strait Islander staff across the medical program and curriculum (Standard 5.2.3). The Aboriginal and/or Torres Strait Islander senior academic position at Level D has remained vacant for a significant amount of time despite advertising on multiple occasions. To support identifying an appropriate candidate for the role, the team suggests the School review position requirements to privilege cultural knowledge and experience over traditional measures of academic performance.

The team met with two First Peoples staff at Level B who are providing the teaching of the Aboriginal and/or Torres Strait Islander health curriculum and are working at capacity without clear academic leadership. In spite of this, they are to be commended on comprehensive teaching of the Aboriginal and/or Torres Strait Islander health curriculum across multiple sites. These lecturers deliver the First Peoples' health curriculum and do not have oversight of the entire medical course, which decreases visibility of other First Peoples content, scaffolding of knowledge for students and the presence of duplication in the MD. Identification of strategies to support retention of First Peoples staff members, as well as approaches to succession planning, is encouraged to meet Standard 5.2.3.

Currently, the School of Medicine and Dentistry relies heavily on central offering of services in the First Peoples space from the First Peoples Health Unit (FPHU). This resource is under immense pressure with current unfilled positions of two full-time staff and a reduction in funding for programs. The School is at risk of a reduction in services from this unit due to resourcing pressures, impacting access to expert knowledge and making the partnership and offerings unsustainable. In striving to achieve Standard 5.4.2, the School is encouraged to incorporate Aboriginal and/or Torres Strait Islander representation within the leadership structure of the School to reduce the need for outreaching, reliance on services external to Griffith, and to secure sustainability of offerings.

Interactions with GUMURRII

The GUMURRII Unit provides an exemplary, culturally safe space and support for Aboriginal and/or Torres Strait Islander students. The students spend time in the unit for both peer support and tutoring. First Nations students reported a deep connection to the unit and its staff, which persisted even after they had left the main campus for rotations in clinical sites such as Tweed Heads. The Dean and the Phase 1 lead communicate regularly with GUMURRII staff and visit the unit, improving the flow of information and support available for First Nations students. Both the Dean and Phase 1 Lead are commended for attending GUMURRII activities, personally welcoming Aboriginal and/or Torres Strait Islander students, and allowing for the opportunity to form relationships with the students and staff at GUMURRII.

Engagement of patients and community in formal teaching

The Griffith Health faculty has an extremely large patient simulation program. A Human Patient Simulation Coordinator is employed at the Health Group level and casts, trains and supports all simulated patients that are used in all health programs, including the MD program, across the Gold Coast, Nathan, Mt Gravatt and Logan campuses. Likewise, funding of simulated patients sits with the Health Group level. An administrative officer assists with the MD program at the Sunshine Coast site. All simulated patients used in the MD program are employed at the School level. At the Gold Coast campus, over 150 actors/community members are trained simulated patients. On the Sunshine Coast, there are approximately 65 community members registered as potential simulated patients, with about 30 of those people used regularly for these onsite activities. The large current pool of simulated patients accessible to the MD program is diverse in terms of gender, culture, age and disability. In particular, there are simulated patients who are from Aboriginal and/or Torres Strait Islander and immigrant backgrounds, and who are native speakers of languages from a variety of countries.

Staff indemnity

Griffith has appropriate indemnification of staff to meet its legal obligations, including public and products liability, professional indemnity and other relevant forms of insurance.

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.

Griffith has a documented policy and procedure that provides eligible academic employees with an opportunity to apply for promotion and receive recognition for outstanding achievement (it does not apply to clinical title holders; casual academic teaching and/or research employees; or adjunct, visiting and honorary appointees of Griffith University). The Promotion of Academic Employees Policy does not mention Aboriginal and/or Torres Strait Islander peoples, nor cultural safety. The Promotion of Academic Employees Procedure does not provide adequate adjustments to accommodate Aboriginal and/or Torres Strait Islander cultural competencies, nor cultural safety. This should be considered as a key area of improvement.

The team notes the Academic Staff Probation and Confirmation Procedures are currently being reviewed to eliminate inconsistencies with the Academic Staff Enterprise Agreement, whereby the enterprise agreement will prevail.

Formal development programs

There are no formal educational development programs provided for Griffith staff, including for clinical title holders. The recently commissioned external review proposed conducting periodic reviews of each academic title holder's contributions to the School and providing them with constructive feedback. In addition, it was recommended that appointments be time-bound, with renewals based on the strengths of the title holder's contributions, to better engage clinical title holders and enhance their association with the School.

Aboriginal and/or Torres Strait Islander staff in the program, although employed in balanced academic roles, have a teaching-intensive work profile, not allowing time for any research. The team did not observe evidence of opportunities to attend professional development activities such as those facilitated by the Australian Indigenous Doctors' Association (AIDA), Leaders in Indigenous Medical Education (LIME) or Pacific Region Indigenous Doctors Congress (PRIDoC). The School should update the AMC on these opportunities through monitoring activities.

The team noted, as did the external report, that there is a lack of clarity in some roles and responsibilities, particularly in the terms of reference for some major role-based educational appointments. The lack of adequate standard operating procedures could impair governing educational processes. There could be negative impacts, particularly when new faculty or staff members commence, or people perform duties when key staff members are on leave. In these cases, inefficiencies and misunderstandings could occur.

Cultural safety training and impacts

Cultural safety training is offered by Griffith to staff (voluntary completion) and students (mandatory completion). The team heard from the Director, FPHU, about their authentic and inspiring efforts and outcomes in providing awareness, building understanding, encouraging collaborations and nurturing connections, which are all highly commendable. This is being achieved by a very small team, and the School should ensure there is consideration of resourcing to continue to enable this excellent work.

The above-mentioned cultural safety training that is available is differing and complementary, from either a national perspective or place-based, specific to the locations of the University. The effort to source and deliver this high-quality cultural safety training is commendable.

As mentioned above, at the time of the accreditation visit, cultural safety training is mandated as compulsory for students; however, it is not currently compulsory for staff. This cultural training offering includes the opportunity to complete two workshops with the focus of embedding Aboriginal and Torres Strait Islander aspects in curriculum, as well as cultural safety. This training also includes a national course and one developed by the FPHU.

The team acknowledges that many clinical supervisors are required by their employer (including Queensland Health, NSW Health and related entities) to complete cultural safety training from their employer or other sources, although it was unclear how Griffith monitors completion rates. In relation to Griffith staff, Standard 5.3.4 states that the medical education provider should ensure that staff and clinical supervisors should have training in cultural safety and participate in regular professional development activities to support ongoing learning in this area. The team understands that Griffith supports a change to make cultural safety training compulsory for all staff. A condition has been added to support and ensure this positive change.

In the external review of the Griffith medical school program, including its curriculum (detailed under Standard 6.1), the report noted unprofessional behaviours by a few faculty members were observed. Although it was acknowledged that these issues had been recognised by the School, follow-up action was described as either slow or absent. Any lack of timely intervention could adversely affect high-functioning teams and/or individuals who are committed to maintaining professional standards. As specific details were omitted in the external review, the team was unable to identify any specific cultural safety issues. However, active management and monitoring by the School will be required to ensure a safe environment for staff and students.

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.

Griffith works with a range of health services and other partners to ensure that the clinical learning environments provide high-quality, diverse clinical experiences for Griffith medical students.

Clinical learning environment

During Phase 1, communication skills, physical examination and procedural skills are taught using both simulated patients and simulation facilities. Community placements also occur in Phase 1 as well as longitudinal general practice placements, which provide valuable learning experiences that are appreciated greatly by students.

In the first block of Phase 2, Transition to Clinical Practice, students are immersed in community organisations in pairs or small groups to provide a variety of opportunities for them to experience the involvement of multidisciplinary teams in patient care.

Full-time clinical placements occur in Phase 3 across Gold Coast, Sunshine Coast, Logan, Tweed or rural sites. Students are immersed in General Medicine, General Surgery, Child Health, Women's Health, Mental Health, Aged Care and Cancer Care. In the teach-out program, terms are seven weeks, reducing to six weeks in the revised MD. Rural students have longitudinal integrated placements as part of the Rural Longlook program, which places students at eight different rural sites. This program offers students a longitudinal, integrated curriculum with guided learning and support that is comprehensive and practical. Students report high levels of satisfaction with this experience.

Rural clinical experience

The Rural Longlook program is via contract with the RMEA. The provision of both a medical educator and nurse educator at each site is impressive and provides high-quality teaching and learning opportunities. The students come together once monthly for a hub day where high priority is given to ensuring the MD curriculum is covered, using case-based discussion, simulation, procedural skills and other relevant skills such as prescribing.

The RMEA also works with clinical facilities that are part of the rural clinical program to ensure there is sufficient capacity for Griffith medical students alongside students from other medical schools also undertaking rural placements of varying length and experience.

Delivering clinical experience to Aboriginal and/or Torres Strait Islander peoples

Currently, there are some opportunities for students to have clinical experience in providing health care to Aboriginal and/or Torres Strait Islander peoples. This occurs at certain sites (e.g. Tweed Heads) and in rural rotations, but is opportunistic in nature, with this information and awareness being noted as new to university staff. Students are enthusiastically seeking further opportunities in the clinical setting to experience healthcare delivery to Aboriginal and/or Torres Strait Islander peoples.

Collaboration with clinical placement sites

Griffith works collaboratively with co-located health profession education providers, such as Bond University and the University of Queensland (UQ), to ensure adequate clinical facilities and teaching capacity for MD students. The Joint Medical Schools Placement Committee (JMSPC) is an example of such a collaboration. This committee meets regularly to discuss Griffith and Bond University student numbers and placements in the Gold Coast HHS, and to address issues that may arise with respect to the delivery of participating medical programs.

The Tweed Joint Clinical Placements Committee is another example of such collaboration. This committee includes representatives from Griffith and Bond University and meets yearly to discuss student placements at Tweed Valley Hospital, the use of resources, planning and coordination of teaching sessions, and the coordination of assessment.

The QEII, UQ and Griffith University Combined Medical Student Placement Committee also meets to discuss the clinical teaching at QEII relevant to the two universities. There are regularly students from UQ and Bond University who rotate through Logan Hospital, and the Medical Education Unit there communicates with Griffith to determine if there are any conflicts. The RMEA also works with clinical facilities that are part of the rural clinical program to ensure there is sufficient capacity for Griffith medical students alongside students from other medical schools also undertaking rural placements of varying length and experience.

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 team observed there is an effective system of clinical supervision throughout the medical program, ensuring safe involvement of students in clinical practice. During Phase 1 GPLP placements, students are supervised by their assigned general practitioner, who reports through to the GPLP placements officer, the wider GPLP academic team, and GP Lead. Supervising practitioners are provided with a handbook and training sessions to prepare them to supervise students.

During immersive clinical blocks in later years, students are supervised onsite by teams of registered medical practitioners in the specialty area in which they have been placed (e.g. Women's Health). These teams include consultants, registrars, junior doctors and interns. When attending patients, students are typically accompanied by a consultant, registrar or junior medical officer. Students are supervised in all clinical engagements with patients as part of each medical team to ensure they are safely involved in the provision of care to patients. They are also supported by a broader leadership structure at each site, including a Clinical Sub Dean and Clinical Discipline Leads.

The Medical Student Placement Managers are central to the organisation and support of students on placements. They also act as a bridge between the Clinical Sub Dean, Phase Leads, Discipline Leads, students and the health service. Students reported high satisfaction and appreciation of the Medical Student Placement Managers.

The Clinical Sub Deans represent the School within the hospital environment and provide an important intermediary function between the hospital and Griffith. They are responsible for learning and teaching activities within the hospital, through consultation with the Course Convenors/Phase Leads and Clinical Leads.

Clinical supervision in rural placements

In the Rural Longlook program, students are immersed in their site's clinical environment and are supported by a medical and clinical educator (often a nurse) at each site. RMEA has a student coordinator and facilities manager who oversees placements and accommodation. Students are supervised by onsite junior doctors, registrars, rural generalists and general practitioners. The medical educator is a fractional role (often a rural generalist) who works with clinical teachers/supervisors and students to identify curriculum needs and training opportunities. Similarly, students attending rural general practice clinics as part of their Year 4 General Practice clinical block are supervised by their assigned general practitioner, who liaises with the Rural General Practice Block Student Coordinator.

Supervision guides and support

Students and general practitioners are provided with a joint handbook for each course that is run in GPLP and for the Year 4 General Practice block. This is complemented by an online presentation and question-and-answer session via Microsoft Teams prior to the commencement of Clinical Practice 2 and 3. There are also two online Faculty Development modules for general practitioners that have been developed and are updated annually. In addition to training, ongoing support to general practitioners is provided by a clear point of contact for enquiries at each campus with both the professional and academic staff.

All supervisors for students on clinical placements in Years 3 and 4 have access to the Clinical Supervisors Guide that is updated annually and includes key contacts, the clinical years' structure, student attendance, assessment requirements, assessment forms and standards/rubrics, a link to the LMS course sites, the skill/ability level at which students should be functioning, the clinical competencies of students on entry, the role of students on clinical placements, and the required input/supervision from supervisors. Ongoing support to clinical supervisors is provided by Clinical Sub Deans, who can liaise with the Course Convenor(s) and Program Director as required.

Clinical supervisors within the rural program are supported onsite by the medical/nurse educators who oversee each student's curriculum needs and training opportunities. Supervisors and educators are directly supported by the RMEA Clinical Leads and coordinators and meet regularly to discuss any matters that arise with respect to placements and the supervision of students.

Monitoring supervisor performance

There are a variety of mechanisms to monitor the performance of the clinical supervisors. Any issues with respect to clinical supervisors can be addressed first onsite by the Clinical Sub Deans with the Course Convenor. Students provide feedback to the School on their placements and the nature of their clinical supervision, including through the Student Experience of Course/Student Experience of Teaching surveys, and through their GUMS representative. In the rural program, the performance of clinical supervisors is monitored by the medical educator (a rural generalist) and clinical educator (a nurse) who oversee the student's placement. Any issue identified is managed by the Clinical Sub Dean or Discipline Lead.

Allocated teaching time

Griffith has service-level funding arrangements with clinical sites to supply quarantined teaching time in each of the major disciplines—Medicine, Surgery, Child Health, Women's Health, Mental Health, Aged Care, Cancer Care, Anaesthetics, Orthopaedics, Emergency Medicine and Intensive Care—in addition to funding for the Clinical Sub Dean. Depending on the specialty, funded time typically varies between 0.1 FTE (four hours per week) to 0.2 FTE (eight hours per week). This funding arrangement of Discipline Leads ensures there is a champion in each of the core disciplines who coordinates clinicians within the discipline and is the point of contact for the Sub Dean, Phase Lead and Program Convenor.

There is also an expectation that medical staff will teach students as part of their day-to-day duties. This can be pre-planned (e.g. meetings, outpatients, ward rounds) or opportunistic (e.g. bedside teaching). With the assistance of onsite clinical coordinators, teaching is organised in a way that does not interfere with the quality of care provided to patients by clinicians.

Relevant to the GPLP and Year 4 General Practice clinical block, eligible practices can be paid $200 per session or half day as part of the Teaching Practice Incentive Payment from Medicare.

Definition of responsibilities

There is an expectation of all staff, both academic and professional, that they will model appropriate professional behaviour, and understand and assist in the development of the professional identity of the students in the acquisition of the knowledge, skills and attitudes expected of Griffith medical students and graduates. Griffith also supports practitioners to identify, report and manage confidentially any lapses in professional behaviour, as per policy and procedure.

For Years 3 and 4, the Clinical Supervisor Guide provides practitioners with information on their responsibilities toward students and the School, including information on the level at which students should be functioning, the clinical competencies of students on entry, the role of students on placements, and the required input/supervision from clinical supervisors with respect to a variety of skills. Course Convenors are further responsible for setting the requirements in each course, in collaboration with Phase Leads, course staff, Clinical Sub Deans and clinical site coordinators.

With respect to academic title holders, these are affiliated members of Griffith and are expected to carry out research and/or teaching as appropriate. Their responsibilities can include participation in student teaching, supervision and assessment, and participating in research including collaborative research projects with Griffith students.

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 Program and Course Review Procedure sets out the annual review of courses as well as an in-depth review of programs every seven years. The annual reviews include evaluations and reporting on the strengths, challenges and opportunities of the course (including student outcomes/progression, student feedback, internal assurance, identification of potential assessment integrity issues, and external benchmarking activities) and identifies opportunities for improvement.

The day-to-day operational aspects of the medical program are monitored by Course Convenors and Phase Leads, and the program's leadership team through the weekly MD Management Meeting. Various student and staff meetings, and meetings between Course Convenors and their teachers/facilitators, take place regularly across all levels of the program, contributing to ongoing evaluation of learning and teaching.

As part of the School's approach to risk management, the team was advised that an Information Communication Technology disaster recovery–planning scenario is implemented annually, which is commendable.

External review for continuous improvement

The team were impressed by the School's continuous improvement initiative to undertake an external review to benchmark the MD curriculum and assessment against international standards and to identify areas for further improvement. The willingness of the School to share the full report with the AMC is an exemplar in transparency and commitment to continuous improvement. The work to implement recommendations from the external report so quickly is commendable.

The external report commented on program impact evaluation and noted that the new MD program incorporates elements of quality control and quality management processes, but concluded that it urgently needs a comprehensive, systematic approach based on best practices to evaluate both short- and long-term outcomes. This is required to ensure detection of enhancements to the quality of training in advance of assessing the long-term impact of curricular changes. The report proposed that this comprehensive evaluation process be urgently implemented, collaborating with key stakeholders, including health services leadership at both state and federal levels. The conclusions in this external review align with a number of the team's findings in this report, as noted specifically in Standard 5.

The team understands the School has commenced the process to formally appoint the external reviewer as an Adjunct Professor of Medical Education, with a mandate to ensure implementation of recommendations outlined in the external report.

The recommendations and suggestions include the following areas:

Areas for further improvement

- program impact evaluation
- alignment of student assessment to the new MD program
- identifying early the underperformers and developing relevant guidelines/protocols (SOPS)
- professional communication skills and interprofessional learning
- faculty and professional staff concerns.

People development

- faculty development framework and role-based appointments
- detection and mitigation of skills and expertise gaps
- alignment with incentives, promotions and accountability
- promoting scholarship of teaching and learning
- establishing a unit/centre for health professions education.

Areas to consider for further enhancements

- branding of the revised MD program
- First Peoples' health in the new MD program
- leveraging on recent advanced technology
- curriculum audit
- first mover opportunities to enhance Griffith brand and interdisciplinary approach to solve healthcare problems.

The School should continue to update the AMC on the implementation of the areas for further improvement and development, as outlined.

Evaluation activities

The team notes the evaluation activities and implementation of revised weightings that have been well received by students. Specifically (as noted in Standard 4), WBAs (e.g. Mini-CEX, OSCAR, ITA) were not previously weighted. In Phase 2 Year 3, WBAs will constitute a maximum of 30 per cent of the grade, with these assessments being 'must submit' and 'must pass'. Students must pass the Phase 2 clinical blocks to progress to Phase 3 Year 4. From 2025, weighting of WBAs will be introduced in Year 4 (the final year of the current program), which will assist in the transition of this year to the new Phase 3 in 2026. The weighting of end-of-year multiple-choice question exams and OSCE assessments has been reduced (e.g. the Year 3 OSCE is weighted at 25 per cent), recognising the importance of a system of assessment that spans the whole program. These changes have been well received by students.

As discussed in previous standards, the assessment and evaluation functions are combined and managed by the Assessment and Evaluation Lead, and this should be reconsidered in terms of the sustainability of the combined workload that is consolidated into the responsibility of this role. The School would benefit from documented processes that ensure that any actual or perceived conflicts of interest are managed, potentially by incorporating segregation of duties.

Student feedback

The Medical Education Unit was able to collect anonymous Student Experience of Teaching survey data at the end of each trimester at GCUH. This data was provided to the program to inform ongoing improvements to assessment practices, ensuring that the balance and distribution of assessments align with student needs and expectations.

A new committee, the MD Student Staff Consultative Group, was established in 2023 to facilitate communication with students, address their concerns and involve them in co-designing aspects of the curriculum. This is in addition to student representation at the Medical Program Committee and School Committee.

Collaboration with other education providers

In the accreditation submission, the School provided several examples of collaboration with national and international medical schools across a variety of activities. Among these collaborations are the Royal Australian College of General Practitioners (RACGP) Academic Post Program (with Monash and Bond universities), Clinical Skills (including CLEIMS) and reflective journalling (with Kaohsiung Medical University, Taiwan), as well as involvement in MDANZ. The external review discussed above was conducted by a senior staff member of the National University of Singapore.

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 School promotes the Medical Schools Outcomes Database survey to each graduating cohort with high participation rates by Griffith students. The School last evaluated Griffith cohort performance via the outcomes of the AMC–MBA Preparedness for Internship Survey in 2019. According to the latter survey, Griffith graduates felt prepared for internship to a degree broadly consistent with the national average.

The accreditation submission outlines examination of student performance in a number of different ways. The School is evaluating the progress of the new MD program implementation and whether Phase 1 is meeting outcomes. The teach-out Years 2 and 3 for 2023–2024 performance of student cohorts are also being evaluated. Performance data are shared with Course Convenors and Phase 1 leads, including Assessment Leads. The Program Director and Head of School are involved in reviewing selection policies and making recommendations to the School Committee. The team noted that the systematic sharing of this data with the committees responsible for student selection, curriculum and student support could benefit from procedures that provide improved clarity.

The School is expected to continue to apply evaluation mechanisms in the implementation of the new MD program and in monitoring reports, provide updates on specific areas of improvement or change as a result of its analysis.

Outcome evaluation for student cohorts from equity groups

The Griffith University Elders and First Peoples Knowledge Holders Advisory Board (Elders Group) provides strategic advice and guidance to the Vice Chancellor on establishing and maintaining effective and ongoing engagement and consultative mechanisms with First Peoples communities and partners, as well as advice on priorities, strategies and initiatives for First Peoples teaching and learning, research and engagement. Although the Elders Group's powers are limited to providing advice, rather than decision making, the involvement of Aboriginal and/or Torres Strait Islander peoples in evaluation activities is positive.

The First Peoples Pathway to Medicine introduced in 2023 has had a positive impact on the selection and admission process for Aboriginal and/or Torres Strait Islander peoples. Removing the GAMSAT requirement for

all First Peoples applicants has assisted to increase First Peoples enrolments in the current Year 1 cohort, in contrast to the current Year 2, 3 and 4 cohorts. Combined with the scholarship opportunities and subsequent support available to this cohort, the initiative seems successful. However, there are limited ATAR adjustments available for Aboriginal and/or Torres Strait Islander peoples using the Bachelor of Medical Science pathway. The team recommends that the School reconsiders this and provides more meaningful adjustments.

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 School has a range of committees, groups and operational teams in the governance structure that play a part in the ongoing evaluation, improvement and review of various aspects of the education program. The successful instrumental implementation to date throughout the vast majority of Phases 1 and 2 of the new MD program are clear.

Evaluation results are made available to stakeholders with an interest in graduate outcomes. Prevocational stakeholders have representation within MD program committees, which gives opportunities to consider evaluation results. School representatives participate in JMSPC meetings to discuss placements in the Gold Coast HHS which provides sources of feedback and monitoring.

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	Background
Professor Jane Bleasel (Chair)	Head of School and Dean of Medicine, Joint Medical Program, School of Medicine and Public Health, University of Newcastle
Professor Suzanne Pitama (Deputy Chair)	Dean and Head of Campus, School of Medicine and Health Sciences, University of Otago, Christchurch
Fergus Leicester	Chief Financial Officer, Intuit Technology
Associate Professor Nicole Mercer	Associate Head of School, Indigenous Strategy, School of Medicine, Faculty of Health, Deakin University
Dr Shyamsundar Muthuramalingam	Manager, Consumer Engagement and Health Promotion, South Australian Prison Health Services, Central Adelaide Local Health Network
Haseeb Riaz	Medical Student, University of Western Australia
Professor Dianne Stephens OAM	Dean, School of Medicine, Charles Darwin University
Associate Professor Alexandra Webb	Associate Director Education (Medicine), School of Medicine and Psychology, College of Health and Medicine, Australian National University
Juliana Simon	Head of Accreditation Assessments, Australian Medical Council
Sophie Burke	Manager, Medical School Assessments, Australian Medical Council
Esther Jurkowicz	Program Support Officer, Medical School Assessments, Australian Medical Council

Appendix 3: Meetings by the 2024 AMC Assessment Team

Meetings	Roles engaged with
Monday 9 September 2024 ***Griffith University, School of Medicine and Dentistry***	
Acknowledgment of Country and Welcome	Director – First Peoples Unit Dean Medicine and Program Director Doctor of Medicine Head of School Deputy Head Learning and Teaching. Deputy Head Research School Manager Program Support Officer
School of Medicine and Dentistry Executive	Dean Medicine and Program Director Doctor of Medicine Head of School Deputy Head Learning and Teaching. Deputy Head Research School Manager Paramedicine Program Lead Public Health Program Lead
Aboriginal and/or Torres Strait Islander Strategy – School Perspective	Director, First Peoples Health Unit. Senior Manager, GUMURRI Student Success Unit. Senior Lecturer, DVC (Indigenous, Diversity and Inclusion). Dean Medicine and Program Director Doctor of Medicine. Head of School. Phase 1 Lead, Gold Coast and Interim IPL Lead
Academic Leaders - Curriculum	Phase 1 Lead, Gold Coast and Interim IPL Lead Phase 2 Lead, Gold Coast Phase 3 Lead, Gold Coast Communication Skills Lead and Internationalisation Lead Clinical Skills Lead and OSCE Lead - MD Program Pathology Lead Anatomy Lead Associate Professor in Primary Care and Academic Lead in General Practice Lead for Reflective Practice Phase 1 Lead, Sunshine Coast Senior Lecturer and Academic Lead in General Practice. Associate Phase 3 Lead

Meetings	Roles engaged with
Aboriginal and/or Torres Strait Islander Staff	Senior Manager, GUMURRI Student Success Unit Director, First Peoples Health Unit Senior Lecturer, DVC (Indigenous, Diversity and Inclusion) Lecturers in First Peoples Health
Meeting with Bond University (Virtual)	Dean Head of MD Associate Professor General Manager, Education Services and Partnerships
Griffith Past and Future	Dean Medicine and Program Director Doctor of Medicine Prof. of Obstetrics & Gyn., former Dean of Medicine
Assessment Strategy	Dean Medicine and Program Director Doctor of Medicine Assessment and Evaluation Lead; MD Research Projects Lead OSCE Assessment Lead and Coordinator - MD Program Deputy Head Learning & Teaching Phase 1 Lead, Gold Coast and Interim IPL Lead Phase 2 Lead, Gold Coast Phase 3 Lead, Gold Coast Internationalisation Lead, and Communication Skills Phase 1 Lead, Sunshine Coast
Assessment in Practice	Assessment and Evaluation Lead; MD Research Projects Lead OSCE Assessment Lead and Coordinator - MD Program Phase 1 Lead, Gold Coast and Interim IPL Lead Phase 2 Lead, Gold Coast Phase 3 Lead, Gold Coast Internationalisation Lead, and Communication Skills Lead for Reflective Practice and course convener Course Convener Phase 1 Lead, Sunshine Coast Dr Gayatri Marwah, Lecturer, course convener Senior Project Manager, Learning and Teaching (Exam Soft implementation)
Information Technology	Manager, Learning and Teaching (Design), Health Group level Learning and Teaching Consultant (Design) Lead Platform Engineer, Student Management Solutions. Platform Engineer, Learning and Teaching Solutions.

Meetings	Roles engaged with
	Senior Strategic Leader (BI & Analytics) Phase 1 Lead, Gold Coast Executive Officer
Aboriginal and/or Torres Strait Islander Students	Year 1 and 3 Students
Professional Staff Governance and structure Resourcing	School Manager Executive Officer Program Support Officer, Medicine Program Support Officer, Accreditation Academic Support Officer Academic Support Officer Administration Officer (Exams) Placements/Work Integrated Learning (WIL) Team Leader Executive Officer Sunshine Coast Administration Officer Clinical Coordinators
Debrief with Dean	Dean Medicine and Program Director Doctor of Medicine
Tuesday 10 September ***Griffith University, School of Medicine and Dentistry***	
Vice Chancellor and President	Vice Chancellor
President of Academic Board	Provost
Griffith Health Executive	Pro Vice Chancellor (PVC) (Griffith Health) Dean Research Dean (Learning & Teaching)
Teaching and Learning Overview	Dean Medicine and Program Director Doctor of Medicine Deputy Head (Learning and Teaching) Phase 1 Lead, Gold Coast and Interim IPL Lead Phase 2 Lead, Gold Coast Phase 3 Lead, Gold Coast Pathology Lead Anatomy Lead Program Advisor Phase 1 Lead, Sunshine Coast
Student Support	Phase 1 Lead, Gold Coast and Interim IPL Lead Phase 2 Lead, Gold Coast Phase 3 Lead, Gold Coast

Meetings	Roles engaged with
	Placements/Work Integrated Learning (WIL) Team Leader Program Advisor and Sunshine Coast Support Services Phase 1 Lead, Sunshine Coast (UNSC Support Services Lead for Reflective Practice and Course Convener
Admissions and Selection	Dean Medicine and Program Director Doctor of Medicine. Domestic Admissions Coordinator Senior Manager, Domestic Admissions Internationalisation Lead, and Communication Skills Director, International (Griffith Health) Coordinator International Admissions Deputy Director, Griffith International
Student Services	Deputy Manager (Domestic Admissions) Manager, Exams and Progression Student Connect Representative Manager, Placements Support Hub Manager, Student Disability and Accessibility, Student Success Director, Student Health, Counselling and Wellbeing Discipline Librarian, Researcher Services (Nominee) Senior Manager, GUMURRI Student Success Unit
Student Experience Student society representatives Students from a variety of year levels	President, Griffith University Medical Society Vice President, Griffith University Medical Society Griffith University Medical Society Members First Peoples Students International Students
Interprofessional Learning	Interprofessional Learning Lead for the Health Group Phase 1 Lead and Interim Interprofessional Lead Phase 3 Lead and CLEIMS Deputy Head Learning and Teaching Program Advisor
Research learning & Community Partners	Assessment and Evaluation Lead; MD Research Projects Lead Senior Lecturer, Public Health Senior Lecturer, Clinical Medicine Sunshine Coast Deputy Head Research Manager Medical Student Placement Program, Medical Education Unit

Meetings	Roles engaged with
	Manager Medical Student Placement Program, Medical Education Unit
Aboriginal and/or Torres Strait Islander community stakeholders	Director – First Peoples Unit Project Coordinator, Pro Vice Chancellor (Health) GCUH First Nations Health Equity Team Members
Meeting with Prevocational training authority	Manager, PMAQ
Debrief with Dean	Dean Medicine and Program Director Doctor of Medicine
Mermaid Central Medical Clinic	
General Practitioner Clinic Site Visit	General Practitioners
General Practice Clinical Unit	Associate Professor in Primary Care and Academic Lead in General Practice Placements/Work Integrated Learning Team Leader Acting Senior Projects Officer (Clinical Placements), Gold Coast Private Health Network
Wednesday 11 September 2024 ***Gold Coast University Hospital***	
Hospital Executives	Deputy Executive Director, Medical Services & Clinical Governance Co-directors for Clinical Education, GCUH
Clinical School Leadership	Dean Medicine and Program Director Doctor of Medicine Medicine Clinical Lead Phase 2 Lead, Gold Coast Co-directors for Clinical Education, GCUH
Clinical School Placement	Team Leader, Placements/Work Integrated Learning Placements/Work Integrated Learning, Year 3 & 4 Placement Officer Phase 2 Lead, Gold Coast
Clinical placement supervision and placement strategy	Medicine Clinical Lead Clinical Sub-Dean Phase 2 Lead, Gold Coast Manager Medical Student Placement Program, Medical Education Unit Manager Medical Student Placement Program, Medical Education Unit
Students currently on placement	Year 3 and 4 Students

Meetings	Roles engaged with
Academic staff and clinical titleholders	Medical Director of Neurology Clinical Lead Acute Surgical Unit, Clinical Director GSGCUV Director of Internal Medicine Training Program/ DPE Medicine Clinical Lead Mental Health Clinical Lead Clinical Lead Emergency Department
Junior Medical Staff	Junior Medical Staff Medicine Clinical Lead
Tour of facilities	Medicine Clinical Lead Co-directors for Clinical Education, GCUH Manager Medical Student Placement Program, Medical Education Unit
Virtual meeting with Rural Program Clinical site	Chief Executive Officer Rural Medical Education Australia Medical Student Coordinator & Facilities Manager Clinical Sub-Dean Year 4 Rural Clinical Lead Year 3 Rural Clinical Lead Research Representative Director, Training at Rural Medical Education - Toowoomba
Debrief with Dean	Dean Medicine and Program Director Doctor of Medicine
Sunshine Coast Health Institute (SCHI) and Sunshine Coast University Hospital	
Tour of facilities	Executive Director SCHI Simulation Centre Manager Clinical Sub Dean Executive Support Officer
Hospital Executives	Clinical Sub Dean Chief Executive Chief Operating Officer Executive Director MS Medical Superintendent (Gympie)
Clinical School Leadership	Clinical Sub Dean, Sunshine Coast University Hospital MD Program Advisor Senior Lecturer, Clinical Medicine Sunshine Coast Phase 1 Lead GP and Senior Lecturer in Primary Care

Meetings	Roles engaged with
	Senior Lecturer in Medical Science – Anatomy & Pathology Course Convenor Clinical Practise
Students currently on placement	Students
Academic staff and clinical titleholders	SMO Obstetrics and Gynaecology SMO Paediatrics SMO Intensive Care Rural Generalist SMO and Executive Director Medical Service, Gympie
Junior Medical Staff	Junior Medical Staff
Clinical placement supervision, placement support on site and professional staff	Clinical Sub Dean, Sunshine Coast University Hospital Program Advisor Clinical Coordinator, Sunshine Coast Executive Support Officer Phase 2 Lead, Gold Coast
Tweed Valley Hospital	
Hospital Executives	Director Medical Services, Tweed Byron Murwillumbah Deputy Director Medical Services, Tweed Byron Murwillumbah
Clinical School Leadership	Clinical Sub Dean, Tweed Valley Hospital Phase 3 Lead, Gold Coast. Associate Phase 3 Lead
Clinical placement supervision and placement strategy	Tweed Valley Hospital Phase 3 Lead, Gold Coast Associate Phase 3 Lead Medical Student Coordinators, Tweed Valley Hospital
Students currently on placement	Year 3 and 4 Students
Academic staff and clinical titleholders	Clinical Sub Dean/Intensivist Clinical Lead Emergency VMO General Surgeon-Upper GI/Supervisor/ATH JMO PGY2/ATH Surgical Registrar/Supervisor/ATH
Junior Medical Staff	Junior Medical Staff
Tour of facilities	Clinical Subdean, Tweed Heads Hospital Phase 3 Lead, Gold Coast

Meetings	Roles engaged with
	Medical Student Coordinator, Tweed Valley Hospital Medical Student Coordinator, Tweed Valley Hospital
Virtual meeting with Logan Hospital	Phase 3 Lead, Gold Coast Placements/Work Integrated Learning (WIL) Team Leader. Clinical Lead Aged Care & Clinical Sub Dean - Logan Hospital Clinical Lead for Cancer Care Clinical Lead for Paediatrics Clinical Lead for General Medicine Clinical Lead for ICU/Critical Care
Thursday 12 September 2024 ***Griffith University, School of Medicine and Dentistry***	
Alumni	Alumni
Meeting with University of Queensland	Dean, University of Queensland Medical School
Debrief with Dean	Dean Medicine and Program Director Doctor of Medicine
Friday 13 September 2024 ***Griffith University, School of Medicine and Dentistry***	
Meeting with Dean and School leadership	Head of School. Dean Medicine and Program Director Doctor of Medicine. Deputy Head Learning and Teaching. School Manager

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