Accreditation Report: Waipapa Taumata Rau University of Auckland, Faculty of Medical and Health Sciences

Medical School Accreditation Committee

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Australian Medical Council Limited

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Acknowledgement of Country

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

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. Waipapa Taumata Rau – the University of Auckland main campus is located on the lands of Ngāti Whātua Ōrakei, Mana Whenua o Tāmaki Makaurau. The Programme operates across many sites in Aotearoa, on the lands of several iwi and hapu.

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

Te Waipapa Taumata Rau, the University of Auckland Faculty of Medical and Health Sciences Medical Programme was first accredited by the AMC in 1995. An overview of the Programme's accreditation and monitoring history by the AMC since 1995 is provided below:

Year	Assessment type	Decision
1995	Accreditation	Accreditation granted until 1 January 2006
2005	Reaccreditation	Accreditation granted until 30 June 2011
2010	Accreditation extension submission	Extension of accreditation granted for four and a half years (maximum period) to 31 December 2015
2015	Reaccreditation	Accreditation granted for six years (maximum period) until 31 March 2022
2021	Accreditation extension submission	Extension of accreditation granted for four years (maximum period) to 21 March 2026

Appendix 1 provides an overview of the AMC's accreditation process in Australia.

Accreditation process

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

When undertaking accreditation the AMC refers to the:

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

The goals of the report are to:

- Provide an assessment of the provider and program against the Standards, and the reasons behind the outcomes. This includes highlighting commendations, outlining conditions placed to ensure the

provider and program meet the Standards within a reasonable time, and offering recommendations to support ongoing quality improvement.

- Give a brief overview of the accreditation context, including key program data, previous accreditation activity and provisions for future monitoring and accreditation activity.

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

2025 reaccreditation

An AMC team (the team) conducted a reaccreditation assessment of the University of Auckland, Faculty of Medical and Health Sciences Medical Programme and met with staff (academic and operational), medical students, clinical supervisors and other groups involved in the delivery of the Programme. The team conducted a site visit September 8-12th based at the Grafton Campus, and visited clinical training sites in Auckland, Whangārei, Hamilton, Tauranga and in primary care and rural medicine settings. The team also met with others online, including at Taranaki and Rotorua. The full team member composition can be found in Appendix 2, and the list of meetings held by the team can be found in Appendix 3.

The Programme is excelling in many areas related to the standards, including:

- The governance and operations of the Programme are aligned to the purpose of Faculty and the objective of meeting the health care needs of the communities that it serves, and in advancing equity through its teaching and research activities. Senior University management is actively involved in the Programme and demonstrates a strong institutional commitment to the Programme's success and strategic development.
- There is a strong commitment to advancing health outcomes and equity of Māori and Pasifika communities. This includes prioritising representation in governance with appropriate succession planning; highly regarded policies and processes for recruiting, retaining and supporting Māori and Pasifika students; the internationally recognised work of Te Kupenga Hauora Māori that sits within the Faculty; and the active participation of Māori staff, leaders, and students and Te Kupenga Hauora Māori (TKHM) is engaged in all aspects of Programme development and delivery.
- The breadth and depth of curriculum, including contemporary community needs, that demonstrates a strong commitment to inclusive, relevant and socially responsive medical education.
- The Phase 3 pre-internship program is an exemplar in preparing students for practice through a well-supported transition.

The AMC determined a number of areas of focus for the Programme in the coming years. These generally relate to the following themes:

- External factors such as health system resourcing and legislative changes, and the planned new medical program of the University of Waikato's NZ Graduate School of Medicine. This impacts the updating of agreements with health services for student clinical placements and generates uncertainty in the staff and student body related to a stretched health workforce.
- Communications and information management with the transition of material from a retiring e-learning system (CourseBuilder) to the existing university learning management system (LMS), 'Canvas'.
- Finalising and implementing a community engagement strategy to embed and consolidate the Programme's numerous community touchpoints.
- Training of clinical supervisors on the curriculum and assessment of the Programme, particularly in their ability to assess student application and achievement in Hauora Māori and culturally safe practice.

Some of these areas are represented in the standards that have been determined as substantially met, with a corresponding condition on accreditation. Others are expected to be addressed through periodic (as completed) or bi-annual updates through the AMC's monitoring process.

Decision on accreditation

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

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

At its 16 February 2026 meeting, the AMC's Medical School Accreditation Committee resolved:

i. that the medical program of the University of Auckland, Faculty of Medical and Health Sciences substantially meets the accreditation standards;

ii. that accreditation of the six-year Bachelor of Medicine / Bachelor of Surgery (MBChB) medical program of the University of Auckland, Faculty of Medical and Health Sciences be granted for six years, to 31 March 2032;

iii. that accreditation of the medical 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 Programme 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. Finalise and implement the updated Faculty community engagement strategy to embed and consolidate the programme's numerous community touchpoints into and ensure the community, including community groups experiencing health inequities and Māori communities, have a defined role in: a. Defining the purpose and Medical Programme outcomes b. the design and implementation of the curriculum and associated assessments c. the evaluation of the Programme and its outcomes. (Standard 1.2.1)	2027
2. Provide up-to-date health service agreements for all clinical placement sites to support the education and training of medical students through access to high-quality clinical learning environments. (Standard 1.2.2)	2028
3. Complete the transition of Programme information to Canvas, ensuring appropriate communication to staff, students and placements sites. (Standard 1.4.6)	2027
Standard 2: Curriculum	
4. As part of ensuring a culturally safe teaching environment, facilitate appropriate training for clinical placement supervisors in the Hauora Māori curriculum and monitor for uptake and completion through an effective partnership process. (Standard 2.3.7)	Training to be available by 2027 and monitored for uptake

Condition	To be met by
	and completion by 2028.
Standard 3: Assessment	
5. Identify the resources the Te Kupenga Hauora Māori (TKHM) Programme leads require to strengthen their capacity to design and deliver targeted training for clinical supervisors, specifically in the assessment of competencies within the Hauora Māori Domain. (Standard 3.1.6)	2028
Standard 4: Students	
6. To ensure the accessibility of support services for all Programme students: a. Complete and report on the full implementation of the 3 doors for help approach, including how this is communicated to students; and b. Ensure students have up-to-date, site specific and easily accessible information on the range of supports available to them, and the various processes for accessing these and (i) that this information remains updated and (ii) is regularly communicated to students, particularly when updates to information are made. (Standards 4.2.2 and 5.1.6)	2028
7. Provide evidence the framework for self-disclosure is (i) is a safe and confidential process for voluntary medical student self-disclosure of information and (ii) improves the management of conflicts of interest that may arise as part of the Fitness to Practice process. (Standard 4.2.4)	2027
Standard 5: Learning environment	
8. Evaluate the accessibility of accommodation across student placements and develop and implement a standardised and sustainable approach to facilitate students' access to affordable and appropriate accommodation near clinical placement sites that require students to be away from their usual residence (including when they are required to return to Auckland, if on placement outside of Auckland). (Standards 4.1.3 and 5.1.3)	2028
9. Evaluate the development and implementation of the new professional staff structure, to ensure: a. It provides adequate support for clinical supervisors and clinical placement sites. b. It provides adequate support to students, as part of their clinical placements. c. Meets the overall needs of the Programme and its management**.** (Standard 5.2.2)	2027
10. Implement mechanisms to ensure that there are additional teaching resources on cultural safety and Hauora Māori, designed for use by clinical supervisors working in different settings and with various employment arrangements, to enhance their ability	2028

Condition	To be met by
to assess student application and achievement in these areas. (Standards 2.3.7, 3.1.6 and 5.3.4)	
11. Facilitate regular and compulsory cultural safety training for all students, staff and clinical supervisors. (Standard 5.3.4)	Training to be available by 2027 and monitored for uptake and completion by 2028.
12. Develop and implement a system to monitor clinical supervision capacity across clinical placement sites to ensure: a. Clinical placement supervisors have a comprehensive understanding of their responsibilities and the expectations associated with supervising medical students; and b. Supervision practices are consistent across all sites within the Programme's footprint. (Standard 5.5)	2028
Standard 6: Evaluation and continuous improvement	
13. Develop and implement a process to ensure that relevant external stakeholders have consistent access to evaluation findings and outcomes, and visibility of how their feedback is responded to by the Programme. (Standard 6.3.2)	2027

Commendations

A	Māori health equity is meaningfully embedded throughout the Programme, reflected in the active participation of Māori staff, leaders, and students and Te Kupenga Hauora Māori (TKHM) is engaged in all aspects of Programme development and delivery. (Standards 1.1.4, 2.3.6 and 2.3.7)
B	The effectiveness of many partnerships and the benefits for local communities as well as students is evident across clinical placement sites, including Turuki, Tauranga kaupapa Māori ward, Turanga Health Whakatāne and more. (Standard 1.2.3)
C	The strong dedication of clinical delivery partners (organisations and individuals) across the Programme's footprint, and their consistent support of student education in local healthcare practices and community contexts. Their commitment significantly enriches the clinical learning experience and fosters meaningful connections between students and the communities they serve. (Standards 1.2.2 and 1.2.3)
D	The Programme is strengthened by the detailed and consistent engagement of senior university management, whose active involvement demonstrates a strong institutional commitment to the programme's success and strategic development. (Standard 1.3.2)

E	Māori academic and clinical staff demonstrate purposeful and sustained participation across the Programme's governance structures and management. This active involvement not only enriches Programme leadership but also contributes meaningfully to succession planning and the long-term success of initiatives within the Programme to address the broader health inequities experienced by Māori people. (Standard 1.3.5)
F	The dedication and commitment of the Tumuaki and her immense and visible support across the Programme. (Standard 1.4.4)
G	The extent to which integration and alignment are embedded throughout the Programme, reflecting the collaborative culture and strong, cohesive working relationships among the academic and clinical staff involved. (Standard 2.2.1)
H	The Health Professional Education research focus through the Centre for Medical and Health Sciences Education, which is located in the School of Medicine. (Standard 2.2.4)
I	The ongoing development and updating of clinical scenarios and case studies to reflect contemporary community needs—such as menopause, family violence, and gender-affirming care—is commendable. This progressive approach demonstrates a strong commitment to inclusive, relevant, and socially responsive medical education. (Standard 2.2.7)
J	The work of Te Kupenga Hauora Māori in supporting teachers, clinical supervisors and other staff to integrate Hauora Māori across the Programme delivery. (Standards 2.3.6, 2.3.7 and 3.1.6)
K	The Phase 3 pre-internship program is a pivotal component of the Programme. It prepares graduating doctors with the clinical readiness and professional confidence needed to enter the workforce is part of a well-supported transition into their intern roles. (Standard 2.3.9)
L	The philosophical approach to true programmatic assessment, and the opportunity to use and share the data for remediation, Programme improvement/evaluation, and to inform selection. (Standard 3.1)
M	Te Kupenga Hauora Māori and the Department of General Practice and Primary Health Care on the development of robust assessment of Māori health that aligns with teaching. (Standard 3.1.6)
N	The MAPAS Student Support Advisors apply a deep holistic insight and data to support Māori and Pasifika students to identify and respond empathetically and professionally. This enhances the student experience and contributes to a supportive and safe learning environment. (Standards 3.1.6 and 3.2.2)
O	The MAPAS admissions pathway represents a significant initiative to address longstanding disproportionality in medical education access for Māori and Pasifika. It reflects both the Programme's commitment to Hauora Māori equity and the university's broader purpose of fostering inclusive excellence and social accountability in healthcare. (Standards 4.1.2, 4.1.3, 4.1.4 and 4.1.5)
P	Professional staff at clinical sites provide exceptional support to students, consistently going beyond administrative responsibilities to offer meaningful pastoral care. This commitment significantly

	enhances the student experience and contributes to a supportive and inclusive learning environment. (Standards 4.2.2, 3.2.2 and 5.2.1)
Q	The timeliness between notification of a potential fitness to practice issue and communicating this with students. (Standard 4.3)
R	MAPAS facilities provide a protective and supportive place for both students and staff, and fosters student success and wellbeing. The impact of having a safe space for Māori and Pasifika students was happy and engaged students. The team acknowledges the protective environment that MAPAS House provides to foster student success and wellbeing. (Standard 5.1.1)
S	Site co-ordinators were universally praised as a key point of contact between multiple aspects of Programme delivery, including playing a critical role in fostering relationships with clinical academic staff and non-university affiliated staff. (Standards 5.2.2 and 5.4.1)
T	The role of Clinical Medical Education Fellow (CMEF) – where present – is an invaluable asset to clinical placement sites, aiding in the progression of students and improving both educational and wellbeing support for students. (Standard 5.4)
U	The commitment of clinical supervisors, as well as University academic and professional staff, is highly commended. Their dedication ensures that students' learning experiences remain of the highest quality and are not adversely affected by operational challenges. (Standard 5.4.1)
V	The HOTSPOTS system was valued by both clinical supervisors and students. (Standard 5)
W	The review of the undergraduate medical student general practice, community health and rural medicine curriculum that is being undertaken by the Department of General Practice and Primary Care to ensure a strong primary care focus, facilitating long-term interest in a general practice career (Standards 6.1.1 and 6.1.3)
X	The HOTSPOTS system demonstrates a strong commitment to student wellbeing, with its proactive responsiveness to concerns raised by students. (Standard 6.1.2)
Y	The international connections that Te Kupenga Hauora Māori has, and their collaboration on Indigenous health curriculum and practice. (Standard 6.1.3)

Recommendations for improvement

I	To mitigate ambiguity, clarify and document the roles and responsibilities of Programme leaders, particularly in relation to the Head of Programme and the Head of the School of Medicine. (Standard 1.4.2)
II	The provider works closely with Health Services to promote a culturally safe environment as the expected norm for all students and staff. (Standard 2.3.7)
III	Regarding workplace based assessment, review the frequency of 'not observed' marking used by clinician assessors; and strengthen efforts to achieve greater consistency of both judging the level

	of clinical performance and the quality of feedback provided, which is currently noted to be variable across sites. (Standard 3.3.2)
IV	Provide training to clinical assessors completing eCSR and Hauora Māori assessments to ensure that they are familiar with the Hauora Māori curriculum and Hui process; and are therefore adequately able to both judge student performance and provide appropriate feedback (and avoid frequently marking 'not observed') to avoid undermining the excellent teaching and well considered assessment process. (Standards 3.1.6 and 3.3.2)
V	Continue the efforts by the HoD meeting teams to go through assessment data at discipline and site level. (Standard 3.2.2)
VI	Review the longitudinal assessment system in place for the Rural Medicine Immersion Programme (RMIP) to ensure that assessments are aligned with the delivery of the longitudinal integrated curriculum in the RMIP, as compared to discipline-focused delivery within other health service contexts. (Standard 3.3.3)
VII	Consider expanding the allocation of placements for students with disabilities to increase equity of access for this student cohort. (Standard 4.1.4)
VIII	Consider greater financial/accommodation support for students while on placement at rural sites; as well as those rural students being recalled back to Auckland for specific short-term training experiences. (Standards 4.2.2 and 5.1.3)
X	Consider how information related to student accommodation is regularly updated across all Programme communication platforms. (Standard 5.1.3)
XI	Strengthen a reciprocal recognition system for non-university-affiliated clinical supervisors without honorary appointments, by providing access to resources such as; research infrastructure, professional development opportunities, and relevant education and training to support clinicians in their supervisory role. (Standards 5.3.2, 5.4.1 and 5.5)
XII	Embed community and healthcare consumer perspectives, as part of stakeholder consultations in the review and redesign of the general practice, community health and rural health undergraduate curriculum (Standard 6.1.3)

Monitoring and next steps

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

1. Provide an update on any structural or operational changes to Programme leadership. This may include evaluation of staff roles and responsibilities, or stakeholder perceptions of the leadership structure. (Standard 1.4)
2. Provide an update on any changes to funding or government policy in relation to the Programme, and subsequent impacts on staff, students or community. (Standard 1.4.1)
3. The AMC looks forward to receiving further updates from the Programme regarding better integration of assessment into the RMIP. (Standard 3.3.2)

4. Provide details of any reviews of or changes to the workplace-based assessment in the Programme. (Standard 3.3.2)
5. To ensure that appropriate planning is undertaken in line with the expected increases in student intake, provide detailed annual updates on:
    a. Student enrolments;
    b. Placement site capacity (including the availability of student support team members and accommodation for an increased number of students on placement);
    c. Clinical supervisory capacity across sites;
    d. Workforce shortages (if present) across placement sites;
    e. Any other issues impacting the capacity for students' clinical placements. (Standard 4.1.1)
6. Evaluate, reconsider and report on the presence of the Director of Medical Student Affairs (DMSA) at Board of Examiner (BOE) meetings, and in the decision-making regarding Fitness for Practice Hearings. (Standards 3.2.2 and 4.2.6)
7. Provide the AMC with regular/annual updates on any changes to assessment platforms, including progress on the transition to the Canvas learning management system. (Standard 5.1.4)
8. The findings and recommendations of the General Practice curriculum review when completed, and implementation of the outcomes of the review. (Standard 6.1)

Appreciation

The team is grateful to staff and students of Waipapa Taumata Rau who prepared the accreditation submission and managed the preparations for the assessment. It acknowledges with thanks, 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 as Appendix 3.

Assessment against the Accreditation Standards

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

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

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

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

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

ITEMISED OUTCOME OF ACCREDITATION ASSESSMENT

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

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

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

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

Key:
Met
Substantially Met
Not Met

STANDARD 1: Purpose, context and accountability

1.1	Purpose
1.1.1	The medical education provider has defined its purpose, which includes learning, teaching, research, social and community responsibilities.
1.1.2	The medical education provider contributes to meeting healthcare needs, including the place-based needs of the communities it serves, and advancing health equity through its teaching and research activities.
1.1.3	The medical education provider commits to developing doctors who are competent to practice safely and effectively under supervision as interns in Australia or Aotearoa New Zealand, and who have the foundations for lifelong learning and further training in any branch of medicine.
1.1.4	The medical education provider commits to furthering Aboriginal and/or Torres Strait Islander and Māori people's health equity and participation in the program as staff, leaders and students.

The Waipapa Taumata Rau - University of Auckland's six-year Bachelor of Medicine/Bachelor of Surgery (MBChB) Programme (the Programme) is well established and has a clear and distinctive purpose that is inclusive of learning, teaching, research, social and community responsibilities. The Programme sits within the Faculty of Medical and Health Sciences (the Faculty), and their purposes align strongly. There is clear alignment with the Pou of *Taumata Teitei*, the University's strategic framework.

The Programme has a design that is socially accountable, noting the diverse population of the footprint of the Programme across Auckland and clinical sites in other regions, including Māori and Pasifika, and the inequities faced. The governance and operations of the Programme are aligned to the objective of meeting the health care needs of the communities that it serves and in advancing equity through its teaching and research activities.

Specific community and social responsibilities are recognised through *Taumata Teitei,* including the sustainability of the environment and ecosystems. Graduate outcomes are outlined, with a range of learning experiences and environments to support this including significant use of the wider geographic area of the upper north island. The Programme has a recent focus on rural health, primary care and care for diverse communities.

Health equity, cultural safety and ongoing development of *Hauora Māori* are embedded in the curriculum and the research activities of the Faculty (including *Te Kupenga Hauora Māori – TKHM, now moved onsite)*. This is further evidenced by the embedding of Māori health equity and the level of participation in the Programme as staff, leaders, and students, with Te Kupenga Hauora Māori involved in every aspect of Programme development and delivery. The Tumuaki and her department are commended for their leadership and contributions.

The Programme's strong relationships with Māori communities are a focal point and are sustained through formal partnerships and active engagement with iwi across the region. The University has a significant foundational relationship with Ngāti Whātua Ōrākei. The Faculty's geographic footprint extends into many other tribal areas. Faculty Kaumātua (Elders) sustain relationships with neighbouring iwi. When students are located for training purposes in areas outside of Auckland, they are expected to and supported to engage with tribal networks, usually through the health service network, which will have Māori liaison teams and Kaumātua who will help students engage with local networks and traditions.

There is broad recognition from students, staff, clinicians, and stakeholders of the value that student placements bring across the Programme's extensive geographical footprint on the North Island of Aotearoa. These placements, spanning a diverse range of clinical and community settings in metropolitan, regional and rural areas, provide students with practical, real-world experience that prepares them for professional

practice. Furthermore, they play a critical role in supporting the ongoing pipeline of medical practitioners across Aotearoa.

The work of the Rural Medicine Immersion Programme (RMIP), along with placements in settings such as the Māori health services in Whakatāne and Turuki Health, exemplifies how medical students are meaningfully embedded within communities. These experiences foster culturally responsive practice, deepen students' understanding of local health needs, and strengthen their preparedness to serve diverse populations.

The significant contribution of the Medical Programme to the medical workforce of Aotearoa is clearly demonstrated by the ongoing analyses of the New Zealand Medical Schools Outcomes Database.

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 Programme is a mature and growing Programme with a wide geographic footprint governed in a hub and spoke configuration. It is part of a multiprofessional, research-intensive Faculty, where there is engagement with a wide range of stakeholders and organisations at many levels, including Māori and other community groups who experience health inequities. Some of these relationships extend beyond the Programme and are held with the Faculty or University at large. The MBChB Board of Studies (BOS) is the peak committee for the Programme, and has broad membership including senior Programme leaders, the Tumuaki, Associate Dean Rural, heads of schools, department and domain leads, site leads, students, and a community representative. It is a key point of stakeholder engagement to drive change within the Programme.

The Tumuaki is well engaged with various iwi and groups such as Te ORA (the Māori medical practitioners association), and these relationships allow for feedback into the Programme. Senior Māori staff members have strong connections that the Programme has been able to build upon. There are supportive Mana Whenua (local leaders) to uphold the work being done at each site. Similarly, heads of departments engage with academic leads at clinical sites as well as general practices, and these relationships provide a mechanism for feedback into the Programme, usually through the BOS and its subcommittees. There are two Rural Health Interprofessional Programmes (RHIP) that run in Year 5 for up to 20 students, with iwi and Māori representation on the advisory boards for both - Te Takapau Wānanga in the Hokianga and Whakatāne.

There are many strong, mutually beneficial and effective partnerships across the health and community services that support the education and training of medical students in various health services. Stakeholders spoke fondly of their connections to the Programme and particularly their engagement with students.

These relationships, both formal and informal, contribute to a supportive learning environment and reinforce the Programme's community-centred approach. The team observed the visible and trusting relationships that many communities have with the Programme that extend beyond just placement in clinical settings. For example, students are hosted for rural immersion placements. In Northland, local iwi were key partners in setting up the Year 5 Regional-Rural Programme Pūkawakawa, and continue to be involved in its delivery. Students there have the opportunity to connect with local communities, visit a Marae, participate in waka ama and attend the Waitangi Day events each year.

This relational model, together with the hub and spoke nature of the Programme, have allowed for grassroots and ad-hoc community engagement with the Programme on the design and implementation of the curriculum and evaluation. However, there is currently limited formal engagement of local communities[1] by the Faculty with regards to the curriculum and assessment development and review, and evaluation activities of the Programme. These mechanisms should be formalised, with the planned curriculum review an opportunity to progress these. This will enable stakeholders' engagement in all three areas; purpose and outcomes; design and implementation of the curriculum and assessment system; evaluation of the Programme and its outcomes. The Faculty's strategic plan, which is currently being updated, will incorporate a community engagement strategy aimed at embedding and consolidating the Programme's numerous community touchpoints. This approach is intended to ensure alignment with the revised AMC standards and to strengthen meaningful partnerships with the communities the Programme serves.

In parallel with strengthening community engagement, the Faculty will need to undertake work regarding the formalisation and currency of agreements that underpin clinical education. The Faculty has formal agreements with the eight main Health New Zealand | Te Whatu Ora (the public health system provider in Aotearoa New Zealand) districts, letters of agreement with each general practice involved in student teaching, agreements with health service providers and HNZ | Te Whatu Ora for the delivery of the RMIP and the RHIP. However, there is a lack of consistency in formal agreements, and a number received by the team are significantly out of date. This potentially presents a significant risk to the Programme, particularly considering confirmation that the University of Waikato's NZ Graduate School of Medicine is to proceed and the likely impact on current clinical placements. To ensure clarification of responsibilities between the provider and its partners, it is imperative that all agreements are updated and formalised. It is acknowledged that delays are in part due to the ongoing process of updating the clinical placement agreement for medical students with Health New Zealand | Te Whatu Ora.

The team recognises other partnerships the Faculty has in place to support the Programme, including (i) an agreement with the Medical Council of New Zealand (MCNZ) regarding notification of fitness to practice of graduates; (ii) relationships with organisations such as the Medical Deans of Australia and New Zealand (MDANZ); and (iii) the development of a consensus statement on Informed Consent for Student Involvement in Patient Care, led by the current Faculty Dean.

The Faculty has developed a range of formal and informal partnerships with Māori organisations that are mutually beneficial. Importantly, this includes a formal relationship with Ngāti Whātua Ōrākei — the recognised lead iwi authority of the land on which the university is situated, via a Kōtuitanga; and this partnership is also formally reflected in the university's Taumata Teitei.

Due to the hub and spoke structure of the distributed Programme, relationships with local communities, including iwi, are appropriately devolved through the district sites where clinical campuses are located. The level of formality in agreements with local individuals and organisations varies across sites; however, the

[1] Community groups who are more likely to experience unfair differences in health that result from differing distribution of resources and opportunities within society. In both Australia and Aotearoa New Zealand, there are community groups that the Australian Medical Council (AMC) recognises as experiencing barriers to healthcare access and poorer health outcomes. These may include people (i) with disabilities (ii) from the LGBTQIA+ community (iii) from low socioeconomic backgrounds (iv) from migrant and/or refugee backgrounds and those whose first language is not English (v) in rural communities. Education providers are expected to partner with stakeholders and local communities to identify community groups experiencing health inequities in their context.

team recognises that most clinical placement sites have Māori liaison teams embedded within them. Given the distributed nature of the Programme, localised relationships should not only be maintained but also integrated into broader strategic planning, building consistency and alignment across all clinical sites. Incorporating these distributed communities into the review and development of the Programme, its curriculum, assessments and evaluation is something that the provider should review as part of updating its community engagement strategy.

1.3	**Governance**
1.3.1	The medical education provider has a documented governance structure that supports the participation of organisational units, staff and people delivering the medical program in its engagement and decision-making processes.
1.3.2	The medical education provider's governance structure provides the authority and capacity to plan, implement, review and improve the program, so as to achieve the medical program outcomes and the purpose of the medical education provider.
1.3.3	The medical education provider's governance structure achieves effective academic oversight of the medical program.
1.3.4	Students are supported to participate in the governance and decision making of their program through documented processes that require their representation.
1.3.5	Aboriginal and/or Torres Strait Islander and Māori academic staff and clinical supervisors participate at all levels in the medical education provider's governance structure and in medical program decision-making processes.
1.3.6	The medical education provider applies defined policies and processes to identify and manage interests of staff and others participating in decision-making processes that may conflict with their responsibilities to the medical program.

The Faculty of Medical and Health Sciences is one of six faculties at the University of Auckland – Waipapa Taumata Rau. The Dean of the Faculty reports directly to the Vice Chancellor. The Faculty currently has six Schools: School of Medicine (SOM); School of Medical Sciences (SMS); School of Population Health (SOPH); School of Nursing; School of Pharmacy; and School of Optometry and Vision Science.

The Faculty Dean chairs the Faculty Executive, a key strategic and planning group with the purpose to *foster collaboration, embrace collective decision-making and exhibit visionary leadership*. The Programme is represented at the Faculty Executive by the Deputy Dean, Tumuaki, Heads of Schools, Head of Medical Programme and the Clinical Campus Deans who attend alternate meetings. It is a forum for the Faculty Dean to report on decisions taken at senior university level.

The peak educational committee within the Faculty is the Faculty Education Committee (FEC), chaired by the Associate Dean Teaching & Learning. The Programme is represented by the Head of Medical Programme or proxy and the Phase 1 Director.

The Programme is delivered through the SOM, SMS, SOPH and the Faculty units Te Kupenga Hauora Māori (TKHM) and the Clinical Skills Resource Centre (CSRC), with coordination and oversight by the Medical Programme Directorate (MPD). The Programme model requires collaboration with a network of clinical campuses/sites, public hospitals, general practices and community organisations across the upper North Island.

An organisational diagram of the core units contributing to the Programme (and their relationships to senior leadership) is shown below in Figure 1.

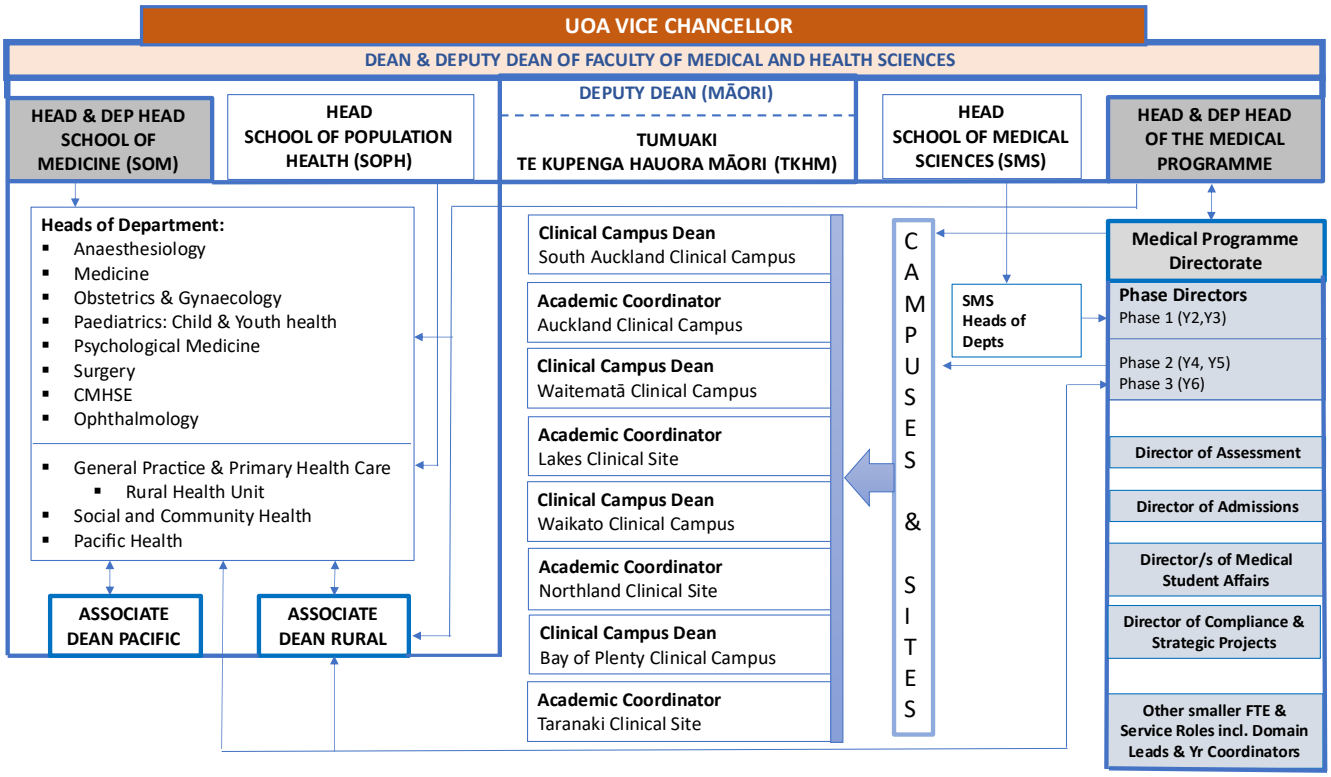

Figure 1. Organisational diagram of the core units contributing to the Medical Programme

The current governance structure, while complex, is effective and understood by staff and provides appropriate academic oversight of the Medical Programme.

The Faculty's governance structure delegates authority for oversight of the Programme to the MBChB BOS. The Head of the Medical Programme (HOP) chairs the BOS, which has the authority to make changes to the Programme curriculum and policies, in line with relevant Faculty and university statutes and regulations. At the heart of the Programme's governance, the BOS plays a crucial role in fostering connections with schools, departments, domains, clinical sites, and students. Its large size enables broad participation and makes the BOS a robust, relational governance model that spans the entire Programme. This stability is reinforced through multiple touchpoints, checks and balances, which are further strengthened by the agile MBChB Strategy Committee and the University's leadership, who are deeply committed to the Programme's success.

There are several formal mechanisms within the Faculty to facilitate student involvement in the governance and strategic direction of the Medical Programme, most notably the Auckland University Medical Students' Association (AUMSA), which serves as the primary body representing the majority of students enrolled in the MBChB Programme. Students are represented on the BOS, including most of its subcommittees, including the Assessment Subcommittee. Student feedback indicates that concerns raised through these forums have, where feasible, led to tangible changes by the Faculty, demonstrating that representation is meaningful and impactful.

Representatives from AUMSA have regular meetings with the HOP and the Phase Directors from the MPD. The team is pleased to see that student participation is incorporated as part of the Faculty's AMC reporting and reaccreditation processes, as this helps embed the intent of the standards amongst the students the Programme is there to benefit.

The team recognises and commends the Faculty (and the broader institution) for how Māori academic staff and clinical supervisors are represented and participate at all levels of governance and Programme decision-making processes. This begins with the Ihonuku Māori | Pro Vice Chancellor Māori, who sits on all boards of the provider (at the institutional level); and within the Faculty, the Tumuaki is a member of all key governance entities of the Programme. The TKHM unit and its senior Māori academics provide significant support to both

the Tumuaki, the Deputy-Dean of the Faculty and to the broader coordination of Hauora Māori teaching and training activities.

1.4	Medical program leadership and management
1.4.1	The medical education provider has the financial resources to sustain its medical program and these resources are directed to achieve the provider's purpose and the medical program's requirements.
1.4.2	There is a dedicated and clearly defined academic head of the medical program who has the authority and responsibility for managing the medical program.
1.4.3	The head of the medical program is supported by a leadership team with dedicated and defined roles who have appropriate authority, resources and expertise.
1.4.4	The medical program leadership team includes senior leadership role/s covering responsibility for Aboriginal and/or Torres Strait Islander and Māori health with defined responsibilities, and appropriate authority, resources and expertise.
1.4.5	The medical education provider assesses the level of qualification offered against any national standards.
1.4.6	The medical education provider ensures that accurate, relevant information about the medical program, its policies and its requirements is available and accessible to the public, applicants, students, staff and clinical supervisors. This includes information necessary to support delivery of the program.

The Programme is led by a designated senior academic, the Head of the Medical Programme (HOP). The HOP sits on the Faculty Executive team, and reports to the Faculty Dean through the Head of the School of Medicine. The HOP leadership role encompasses strategic oversight and engagement with external stakeholders. The HOP is the Director of the Medical Programme Directorate (MPD), which includes holding the MPD budget and line managing MPD academic staff. The MPD is managed within the School of Medicine.

The Head of the School of Medicine provides leadership to the School of Medicine, is responsible for all School undergraduate and postgraduate programmes, and provides line management of Heads of Departments, Campus/site leads and HOP. The HOP sits on the SOM Heads group.

While there is some ambiguity regarding the designated leadership of the Programme, with both the HOP and Head of the School of Medicine being Level 3 Heads, this does not currently appear to impede effective decision-making or the overall functioning of the Programme. However, clear delineation of leadership may further strengthen governance and accountability, now and during future leadership changeovers. The HOP is supported by a Deputy Head (DHOP) whose primary focus is more operational. This structure is also relationally driven, highlighting the importance of succession planning to ensure the continued effective management of the Programme. It will be important for the Programme to report on any changes to the maintenance and development of these relational and structural elements.

The MPD has overall responsibility for oversight and cohesiveness of the Programme, its documentation and integration of new initiatives. In this, the HOP is supported by the Deputy Head, three Phase Directors, Domain leads and the Director of Assessment (position currently under recruitment) as well as several support staff. The reporting lines to the FEC and the Education Quality Office have transparent reporting pathways and accountability mechanisms.

The Programme benefits from dedicated professional staff, whose expertise and passion in their contributions to the delivery of the Programme were clearly observed by the team. As key touchpoints between the provider and clinical placement sites (both students and clinical teachers), their skills in Programme coordination and stakeholder engagement as part of a hub and spoke model, play a vital role in maintaining the quality and integrity of the Programme. The AMC will be interested to monitor the outcomes

of the current professional staff restructure, and how this expertise and collaboration can be maintained, and indeed, enhanced.

There are several external factors affecting the Faculty and the Programme, including a challenging financial environment evident in the budgets for 2025 and 2026; ongoing Health New Zealand | Te Whatu Ora reforms and their national impact on clinical services and Hauora Māori; the proposed new medical program at University of Waikato's NZ Graduate School of Medicine; and ongoing workforce pressures across the health sector. There is clear recognition of the need to manage within existing resources while maintaining the quality and integrity of Programme delivery; however, with the financial constraints and workforce pressures within the health system, and planned increase in student numbers, there are risks to Programme delivery, in particular in the delivery of Phase 2 and 3 of the Programme.

The team noted a range of other potential financial risks including possible reductions in Government EFTS funding to universities for non STEMM courses, a lack of clarity on future support for the dedicated government support for rural Programmes and future requirements for investment in physical infrastructure as the student cohort grows.

The Faculty is actively navigating these constraints through prudent financial oversight and strategic prioritisation. The team was impressed with the collegial way budget discussions between different parts of the Programme appear to take place. There is a recognition of a greater purpose and supportive approach to putting money where it is needed that is focused, collaborative and collegial. The AMC will be interested to review the impact of these factors on the Programme in future through its monitoring process.

The Faculty provides all policies, Programme details and requirements to staff, students, clinical supervisors and the general public via a number of platforms. The public website provides relevant information for those interested in the Programme, including those considering applying. Programme staff, students and clinicians have the MBChB Portal and Canvas – the provider's learning management system (LMS). The team noted that Programme content (policies, procedures, guidebooks and other resources) was being transitioned to the new LMS Canvas, and some students reported confusion as to where Programme information could be located.

It is acknowledged that replacing online communication platforms can be a lengthy project, and the provider will need to ensure that (i) all Programme information for staff, student and clinical placement site staff is transferred to Canvas, including all associated links and that (ii) all staff, students and clinical placement site staff have received appropriate communication on these updates and (iii) appropriate information/guides on how to utilise and navigate the information on Canvas are provided.

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 graduate outcomes for the Programme are clearly outlined and are mapped to the University's graduate outcomes and the revised AMC Standards' graduate outcomes. The structure of the Programme has been broadly similar since it was instituted in 2013 and the team notes that a Programme-wide comprehensive curriculum review is imminent. There is already strong evidence of consideration of the needs of Māori, Pasifika and other vulnerable groups in the curriculum, and the team encourages the planned enhanced consumer engagement in the design and implementation of this review (see Standard 1.2.1).

Overall, students have equitable access to teaching and learning experiences across the Programme, enabling them to achieve the required learning outcomes. The consistency of educational delivery is supported by a comprehensive suite of online resources available to both students and teaching staff. These resources are aligned with the intended learning outcomes and complement both face-to-face teaching and clinical experiences.

While the overall quality of clinical education is considered comparable across sites, some students based at regional locations reported concerns about receiving fewer structured tutorials during their clinical placements compared to their peers in Auckland. This variation is not uncommon in medical education, where smaller or regional clinical sites often offer more immersive, hands-on experiences, while larger urban hospitals may provide more formalised teaching sessions. The Programme appears to balance these differences by ensuring that all students are supported to achieve the same learning outcomes, regardless of site.

In Phase 1, all students are based at the Grafton campus, which provides a uniform academic environment, ensuring that foundational teaching is delivered consistently. This centralised delivery model helps to establish a shared academic experience, develop community and reassure students about the equivalence of their early learning.

As students progress into Phases 2 and 3, they are offered clinical placements across a wide geographical footprint, including metropolitan, regional and remote settings. These placements expose students to a diverse range of clinical environments, patient populations and supervision styles, which are broadly comparable in quality and collectively ensure that graduates are well prepared to perform competently in their roles as interns.

The team observed that academic, professional and clinical placement staff demonstrated a strong commitment to supporting students in attaining the prescribed learning outcomes and a clear awareness of the curriculum framework and associated educational resources.

2.2	Curriculum design
2.2.1	There is purposeful curriculum design based on a coherent set of educational principles and the nature of clinical practice.
2.2.2	Aboriginal and/or Torres Strait Islander and Māori health content is integrated throughout the curriculum, including clinical aspects related to Aboriginal and/or Torres Strait Islander and Māori health across all disciplines of medicine.
2.2.3	The Aboriginal and/or Torres Strait Islander and Māori health curriculum has an evidence-based design in a strengths-based framework and is led and authored by Aboriginal and/or Torres Strait Islander and Māori health experts.
2.2.4	The medical education provider is active in research and scholarship, including in medical education and Aboriginal and/or Torres Strait Islander and Māori health learning and teaching, and this research and scholarship informs learning, teaching and assessment.
2.2.5	There is alignment between the medical program outcomes, learning and teaching methods and assessments.
2.2.6	The curriculum enables students to apply and integrate knowledge, skills and professional behaviours to ensure a safe transition to subsequent stages of training.
2.2.7	The curriculum enables students to evaluate and take responsibility for their own learning, and prepares them for lifelong learning.
2.2.8	The curriculum design and duration enable graduates to demonstrate achievement of all medical program outcomes and AMC graduate outcome statements.
2.2.9	The curriculum outlines the specific learning outcomes expected of students at each stage of the medical program, and these are effectively communicated to staff and students.
2.2.10	There are opportunities for students to pursue studies of choice that promote breadth and variety of experience.

The Programme is underpinned by a thoughtfully constructed curriculum framework that is both vertically and horizontally integrated. The team commends the extent to which integration and alignment are embedded throughout the Programme, reflecting the collaborative culture and strong, cohesive working relationships among the academic and clinical staff involved.

Beginning with a common first year, the curriculum spirals through five key domains – (i) Clinical and Communication Skills (ii) Applied Science for Medicine (iii) Personal and Professional Skills (iv) Hauora Māori and (v) Population Health - providing a coherent and cumulative learning experience across three phases: Phase 1 (Years 2 and 3), Phase 2 (Years 4 and 5) and Phase 3 (Year 6) delivered through department leads at each site. This structure supports the development of a strong foundation for lifelong learning and professional competence.

The curriculum enables students to develop their knowledge, skills and behaviours throughout the Programme, preparing them for progression into the medical workforce and their post-graduate training. There is clear and deliberate alignment between learning outcomes, teaching and learning methods, and assessment practices. The Phase and Domain Committees provide effective governance, ensuring that new curriculum content is appropriately integrated and aligned with the Programme's overarching educational objectives.

The team observed evidence of Programme responsiveness in updating curricular content to align with community needs. The development and updating of clinical scenarios, in line with and representative of community needs, including the recent addition of menopause, family violence and gender-affirming care, is

progressive. As is the bank of 192 considered, tagged and mapped case studies which are drawn from teaching across the Faculty and reviewed and maintained by the Clinical Scenarios Moderation Subcommittee of the BOS.

The team considers the Hauora Māori curriculum to be a world-leading example of the development of a Māori health curriculum by Māori academic and clinical staff, which has been embedded throughout the broader Programme. The Hauora Māori curriculum design is evidence-based and delivered through a strengths-based framework that promotes critical self-reflection. It provides leadership and guidance to the health sector both within Aotearoa and internationally, contributing to the advancement of culturally responsive medical education. Nine separate Hauora Māori teaching or assessment activities are integrated into the teaching undertaken in other domains. It is noted that three areas of improvement and development have been identified in the teaching Programme (i) revitalised Te Ara (graduate profile in Hauora Māori for undergraduate Programmes) (ii) cultural safety review and (iii) consideration of the needs of Māori students within Māori health teaching. The AMC looks forward to receiving updates on this review as it progresses.

There is a strong commitment to research across a broad range of disciplines, including biomedical science, clinical medicine, public health, and medical education. This is evidenced by a high level of research capability and a substantial body of peer-reviewed publications and evidence-based outputs. Of note is the Faculty's internationally recognised leadership in Māori health professional education, which is world-leading in its scope and impact. The Faculty also hosts one National Centre of Research Excellence, four University Research Centres, and seven Faculty Research Centres, and almost one third of the university's top 500 researchers are within the Faculty.

Students in the Programme begin developing core clinical skills in structured environments, including simulated settings with peers and trained actors. This foundational training is integrated with concurrent modules and is designed to ensure students demonstrate competency before progressing to real patient interactions. Throughout the Programme, students engage in diverse clinical experiences under the guidance of qualified clinicians. In the final year, learning adopts an apprenticeship model, with students embedded in clinical teams and contributing to patient care under supervision. This graded responsibility supports the transition to postgraduate training and fosters confidence in clinical decision-making, as well as the development of professional identity.

Clinical pharmacology education is vertically integrated across phases of the Programme, combining formal modules with synchronous and asynchronous learning activities. Students are introduced early to a curated list of essential medicines, linked to clinical scenarios, to support safe prescribing practices. Progress testing from Years 2 to 6 reinforces the application of knowledge to clinical practice. Longitudinal assessment in areas such as Personal and Professional Skills and Hauora Māori encourages reflective learning and supports the development of professional competencies aligned with best practice.

The Programme has been updated to incorporate the revised AMC graduate outcome statements and includes learning and teaching related to learning outcomes in (i) patient safety; (ii) health advocacy; (iii) infection control; (iv) interprofessional practice; (v) health literacy considerations; (iv) informed consent; (vii) avoidance of bias; (viii) health and communication technologies; and (ix) peer feedback.

Learning outcomes for each year of study are made digitally accessible to both students and staff. These outcomes are organised by module, domain, and discipline, and can be located online. Currently, these are accessed in two key locations: the searchable Learning Outcomes database on the MBChB Portal, and the annual Guidebooks available via the MBChB Portal and Canvas. The University's in-house platform, CourseBuilder, had until July 2025 held much of the Programme's online learning resources. The Programme is in the process of transitioning all content to Canvas as the main source of course information. Both the Guidebooks and the Learning Outcomes database are reviewed and updated annually to ensure that students have access to the most current and relevant learning outcomes aligned with their year of study.

Students have opportunities to pursue studies of choice with regard to both courses and location of studies. An intercalated BMedSc(Hons) degree can be undertaken during a deferred year between Years 3 and 6 of the Programme. There is a selective placement in Year 5 which can be utilised by students to pursue an area of their particular interest, or as a directed selective for remediation purposes. Rural Medicine Immersion

Programme students can opt for a rural selective within the student's region where they can gain experience in a variety of settings, including rural hospital placement, rural emergency medicine (utilising Hato Hone St John and retrieval helicopter services), or rural primary care placements (in the current RMIP teaching practices).

The team notes that the planned curriculum review is expected to build on and develop current curricular strengths and to provide an opportunity for a more proactive approach. It was evident from the meetings with the domain groups that consideration has already been given to curriculum enhancements. For example, in the Personal and Professional Skills Domain the team was advised of plans to add a sixth theme, Leadership and Followership to the Domain and how this theme could be integrated with material across other domains.

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 education provider utilises a diverse array of learning and teaching methods that are specifically designed to suit the context and objectives of the Programme and are stage appropriate for students. This includes: asynchronous and synchronous online learning; large and small group face to face learning, simulation; laboratory learning sessions; group project work; the development of a reflective portfolio and clinical attachments in all phases of the Programme.

These methods are selected to effectively support the development of the required knowledge, skills, and

professional behaviours in students. By employing a combination of approaches (such as interactive lectures, case-based learning, simulation, clinical placements, and digital tools) the provider fosters an engaging and supportive educational environment that aligns with contemporary best practice in medical education.

Patients are acknowledged as teachers and this philosophy is embedded throughout the Programme. As part of Phase 1, while students are learning new skills, patients are involved in various activities including clinical lectures, clinical skills learning sessions (with simulated patients) and online learning materials. Students also gain experience in the Hui process and the Whakanoa ceremony through the Hauora Māori Domain.

University-employed and affiliated staff demonstrate a strong commitment to student success. There is clear evidence that staff are aligned in their efforts to support students in achieving the intended learning outcomes and are informed about the curriculum resources available to them. Students benefit from structured interprofessional learning (IPL) experiences throughout the Programme. These opportunities begin in the common first year and Phase 1 and continue into the clinical years, where students frequently engage in multidisciplinary team environments. Specific initiatives built into the Programme include (i) a Year 2 Hauora Māori intensive; (ii) the 'Nursing Experience' and a Quality and Patient Safety Workshop in Year 3; (iii) the Population Health Intensive in Year 5; and (iv) a joint nursing/medical student advanced cardiac support life support simulation training in Year 6. This IPL experience was further evidenced to the team via student feedback received at a number of clinical placement sites. This exposure supports the development of collaborative practice skills and is to be commended. The Faculty has noted the need to consider how it will deliver certain activities, such as targeted workshops, as student numbers grow. The AMC looks forward to updates on this, as these activities are undertaken and reviewed in the future.

Students' clinical skills are developed via a graduated approach. Experience with patients commences in Year 2, increases in Year 3 as students gain exposure to clinical environments, and culminates with 90 weeks of supervised clinical placements across Years 4 to 6. Students have several opportunities to learn in clinical skills sessions where trained actors play the role of patients and provide feedback on communication skills and bedside manner.

Overall, students have access to equitable teaching and learning experiences across the Programme's distributed sites. The diverse range of clinical and supervisory settings is generally of comparable quality and supports graduate readiness for internship (see Section 3.3 for further commentary).

As noted by the Faculty and attested to by students and the team, learning and teaching in Hauora Māori is a major strength of the Programme. This is evident from the beginning, when all first-year students are required to undertake and pass the Waipapa Taumata Rau Course (developed with TKHM), in order to be eligible for selection into the MBChB. Hauora Māori teaching and assessment encompasses the recognition of the health inequities experienced by Māori, a thorough understanding of the systemic factors that contribute to and sustain these inequities, and the role students, as future health professionals within the health system, can play in addressing and eliminating them. This work is further strengthened by the recently developed Pacific Health curriculum, which has now been incorporated across Years 2 to 6 of the Programme. The team acknowledges that TKHM is undertaking significant work in supporting teachers, clinical supervisors, and other staff to integrate Hauora Māori across the Programme delivery.

Students learn about other community groups experiencing health inequity throughout the Programme, including the Professional and Clinical Skills (PCS) Domain, Population Health Intensive and the Medical Humanities Programme. The Pasifika Health curriculum has been increased in recent years and now has at least one touchpoint in each year of the Programme, including a highly regarded day in Year 5 that includes learning about migration and the impacts of colonisation. The Programme has expanded teaching on gender and LGBTQIA+ health in response to student feedback. There is a reproduction and development module in Phase 1, as well as core learning on LGBTQIA+ health in the PCS Domain. In Year 3 Medical Humanities, students can elect the 'Queering Health' option, and the Programme is investigating the possibility of making this available to all students. How learning and teaching of the inequities facing a range of equity groups can be further increased across the Programme should be considered as part of the upcoming curriculum review.

Through the establishment of TKHM, the embedding of Hauora Māori, the provider's strategic vision and links with the community, it is clear that the Faculty and the provider more broadly are committed to

culturally safe teaching and learning for students and staff across all educational and clinical settings. Achieving cultural safety across the entire footprint of the Programme - particularly within health services and clinical environments – has been observed to be challenging. Staff and students report occasional instances in clinical environments where teaching and learning were not seen as culturally safe. Noting this, the team heard that concerns, when identified, are addressed promptly and constructively. However, not all clinical placement supervisors have completed training in the Hauora Māori curriculum and cultural safety, which can be reflected in the lack of willingness to participate in the clinical assessment of students on the HM curriculum.

Cultural Safety is one of five foundational elements in the Personal and Professional Skills (PPS) Domain, and TKHM actively promotes its integration throughout the curriculum and clinical training. The provider should consider how Faculty and TKHM can be better supported to address training gaps, particularly for clinical staff involved in assessments, in the context of growing student cohorts and ongoing pressures within the clinical workforce. (Please see Sections 3 and 5 for further discussion.)

Students undertake an extensive range of face-to-face experiential learning experiences throughout the Medical Programme. The Programme offers students flexibility in both course selection and study location. In Phases 2 and 3, students may choose their cohort location for Years 4, 5, and 6, including placements at regional and rural sites, as well as opportunities to focus on research. During Phase 1, as part of a Medical Humanities course, students can choose from up to 17 topic options, while during Phase 2, students can undertake a selective placement to pursue their professional interests. Phase 3 provides students with the opportunity to undertake an 8-week elective of their choice.

The team noted that Year 6, informally known as the Trainee Internship year, is a strength of the Programme, providing students with valuable real-world experience, enhancing their clinical capability, professional skills, and ensuring readiness for entry into the medical workforce. This year includes increasing exposure to what will be regular work practices as a graduate doctor / PGY1, such as working one ‘long day’ per week, weekend shifts, patient admissions and ward calls.

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 Programme has developed a comprehensive, pedagogically and philosophically sound system of assessment. This is based on a documented set of Assessment Purposes and Principles, inclusive of transparency; alignment; equity and fairness; acknowledging the development of students over the duration of the programme; utilising a variety of assessment methods; and continuously reviewed for quality improvement.

Oversight of the system of assessment is performed through multiple levels of committees, each with a different purpose. These include:

- the Assessment Subcommittee (ASC), which provides expertise into assessment strategy; implementation; compliance and standards assurance; evaluation and improvement; and progress test management. The ASC approves changes based on input from Phase Curriculum groups and stakeholder consultation.
- the Board of Studies (BOS) ensures alignment with the curriculum and ratifies policy and assessment structural changes.
- the Board of Examiners (BOE), one for each Phase, confirms and ratifies results of students.
- Students are included at the BOS meetings.

The Director of Assessment is responsible for strategic and operational leadership of assessment, inclusive of input regarding the “tools/methods” and content of assessment from the various Heads of Department and Phase Leads. The Director of Assessment will document the system of assessment and assessment procedures in the Assessment Manual, due for completion in late 2025. However, the team note that the Director of Assessment position is currently vacant, and that the Programme is currently shortlisting candidates for this position. The efforts to maintain high quality documentation are encouraged and represent best practice, and the AMC looks forward to reviewing a copy of this manual in further submissions from the Programme.

In the Programme’s submission, measures to maintain assessment validity; reliability; fairness, flexibility and equity; and flexible delivery are well-described and follow the University’s policies and procedures. The

availability of a psychometrician to support comprehensive assessment data analysis using established methodology is highly beneficial to the Programme. The assessment data is utilised to:

- Detect and support students requiring further remediation.
- Inform evaluation and iterative quality improvement of the programme.

A series of Progress Tests runs throughout the Programme providing feedback on student performance to Faculty academic staff and clinical supervisors. The Progress Tests provide students with the opportunity to review their progress toward achieving Medical Programme outcomes over the duration of the programme. Students have commented that they would like more granular individual data on their performance to be made available to guide their private study in addressing learning gaps identified by progress testing.

The Programme utilises a wide variety of methods in addition to progress testing to assess knowledge, skills, clinical performance, professional behaviours and reflective practice. These include Objective Structured Clinical Examinations (OSCE) and Workplace Based Assessments (WBA). Whilst each assessment point represents a low-stakes data collection opportunity, at times, a relatively low number of assessment points may compromise the validity/reliability of the data collected from each method per se (e.g. *n* of OSCE stations). The Departments have control over the assessment type that they have selected for their discipline, in conjunction with the Director of Assessment. Although this may reduce the broad sampling/assessment validity and reliability of each assessment method, the data obtained is collated across assessment methods and meaningfully interpreted by the BOE panel members to provide a comprehensive picture of each student's performance against each of the 5 curriculum domains, utilising a rubric to guide decision-making.

Staff from the Māori and Pasifika Admissions Scheme (MAPAS) and staff involved in student selection attend BOE, which in turn informs selection policies and support processes for MAPAS students. This philosophical approach to true programmatic assessment, and the opportunity to use and share the data for remediation, Programme improvement/evaluation, and to inform selection, is to be commended. The team notes the presence of the Director of Medical Student Affairs (DMSA) on the BOE, which is further considered later in this Standard.

Professional behaviours are monitored and assessed via Electronic Clinical Supervisor Reports (eCSRs), including professionalism and Hauora Māori criteria; as well as WBA which includes logbooks and checklists during clinical attachments and assessments. The eCSRs are discussed in more detail below, including concerns about assessor selection, training and standardisation.

The system follows the provider's policies and procedures. Standard-setting efforts utilise current evidence-based best practice, and the Programme participates in external benchmarking and quality improvement (e.g. ACCLAiM OSCE collaboration). There is evidence of regular review of the assessment system's quality. The Progress Test is pre- and post-moderated; with appropriate consideration of the level of performance/knowledge of year level and determination of pass/fail thresholds – particularly at Year 6.

Academic progress decisions are made at BOE meetings conducted for each academic phase. The Programme uses a 'programmatic approach' to inform decisions by the BOE synthesising data from multiple low-stakes and longitudinal assessments; integrated across domains, phases and clinical settings.

The Programme has designed an assessment blueprint and learning outcome database, which depicts constructive alignment between learning outcomes and assessment. These are also mapped against the Graduate Learning Outcomes and the AMC Graduate Outcome Statements. The assessment blueprint is shared with students and staff via the MBChB Portal. These efforts are highly commendable, though the team noted these were not always utilised to full effect by all students.

The design of the Hauora Māori Domain and the embedding of the Domain across assessment types is excellent. It was evident across sites that value was placed on the Hauora Māori learning outcomes, particularly among students. However, the level of engagement and expertise of assessors across clinical sites was variable, and this was noted by both students and staff. This was an area that was clearly concerning to students, with some students reporting clinical supervisors' default to recording 'not observed' for the Hauora Māori Domain, for example, in the eCSR/CSR, with students stating that assessment can be quite varied according to "who you hand the form to". The Programme has identified this as an area that requires

improvement. The variability of clinical supervisor engagement in assessing Hauora Māori was an example of the hidden curriculum undermining the excellent Hauora Māori teaching and learning in the Hui Process. The use of 'not observed' against Hauora Māori on eCSR's may inadvertently suggest that Hauora Māori is less important than other aspects of learning. The high number of international medical graduates among clinical teaching staff make it imperative that formal Hauora Māori training is required for all staff.

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.

There are multiple opportunities for students to seek, discuss and be provided with feedback. Students were provided with specific teaching (and assessment) on seeking, receiving and using feedback in the Learning and Teaching PPS Theme. Examples of specific opportunities for feedback provided to students include, but are not limited to:

- The Progress Test Dashboard, which provides individual and cohort-level performance data, blueprint domain feedback, item-level learning points, and direct links to curriculum content.
- Written and practical assessment feedback in Years 2 and 3, which may include group feedback sessions to discuss common errors and strengths.
- Clinical Supervisors Reports (CSR) and Mini-Clinical Evaluation Exercise's (Mini-CEX), with face-to-face feedback being encouraged following each workplace based assessment.
- Long Case assessments in Year 6 have immediate face-to-face feedback provided at completion, focusing on clinical reasoning, communication, and patient management skills.
- For students who fail an Objective Structured Clinical Examination (OSCE) station, targeted written or verbal feedback is provided.
- The Professional and Personal Skills (PPS) Domain has explicit learning activities on giving and receiving feedback to improve students' feedback literacy.

The Programme has shared a number of reviews and improvements to assessment activities that are being undertaken, which the AMC looks forward to hearing more about in subsequent monitoring submissions (refer to Standard 3.1 Assessment Design for students requesting greater access to individualised feedback on their Progress Test results). Feedback, including timeliness and consistency, was reported as variable across multiple sites. Evidence of considerable delays in receiving feedback (in the order of months) at multiple sites and year levels was noted by students.

The reporting process for students who were not performing at the expected level was well-described and carefully considered. There were opportunities for this identification to occur as part of in-course and attachment assessments, as well as mid-year and end-of-year assessments (e.g. Progress Testing). Attendance, engagement and professionalism are monitored. Assessment data for each student are comprehensively reviewed at BOE meetings twice per year. Once identified, multiple avenues for academic support and remediation can be provided to students. The data obtained from each assessment method are utilised to best effect, e.g. Students with unsatisfactory Progress Test results are invited to meet with CMEFs 1:1. MAPAS support plans are offered to MAPAS students identified as not performing at the expected level.

The student support process, particularly the availability of both Faculty and School level support staff, provided a safe and supportive environment; however, the team would have liked to have seen a clearer separation between the roles of DMSA staff involved in BOE and Fitness to Practise hearings and those

engaged in academic or professionalism-related decision-making.

While the Faculty has noted that DMSA staff can act as advocates for students at BOE meetings without 'being involved in assessment'. It should be considered whether accommodations/adjustments to assessment tasks should be provided in consultation with DMSAs ahead of assessment occurring; and that the assessment outcomes should thereafter be considered by the BOE free from any potential influence from the DMSAs to ensure that progression decisions are impartial and objective. The Student Support Advisor role, particularly within MAPAS, have an excellent understanding of student issues. The Clinical Medical Education Fellow (CMEF) role, where present, is viewed as very helpful by the students. The team considers that having greater access to CMEFs, (not currently available at all clinical placement sites) could take the pressure off a stretched clinical workforce.

There are processes for cohort assessment outcome data to be shared with convenors, curriculum leads, and clinical site leads. The efforts by the HoD to meet with teams at clinical placement sites and review assessment data at the discipline and site levels are encouraging and should be maintained. Feedback and evaluation are also collected and shared with academic leads, and inform assessment reviews.

The team observed evidence at clinical sites of the identification of individual students who require additional support. However, clinical supervisors at some sites also raised concern that they were not made aware by the central Programme team of students who required extra support (in a feed-forward approach). It was identified that at clinical sites outside of Auckland, professional staff were an important conduit for student support information.

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 Director of Assessment leads the regular, systematic review of assessment, inclusive of the appropriate committees/departments/course leads. This review is responsive to the assessment data collected, as well as qualitative evaluation and feedback processes incoming to the Director of Assessment, and is shared with assessment leads as appropriate. This process also reviews assessment and progression outcomes across the various associated sites for equivalence.

The Programme's hub and spoke model promotes consistency of assessment across sites. In addition to the formal processes, the communication observed between the HoD and the clinical supervisors was exemplary. However, students have raised concerns about consistent expectations for assessments across sites. For example, at some clinical sites, the students commented on differences in assessment practices in relation to the mini-CEXs. Students raised that there was variability between sites, and between teams and supervisors at the same sites, due to difficulty accessing supervisors who could sign off on their evaluations. Due to the highly 'stretched' nature of some services, students felt they could not demonstrate competence and have it evaluated by the clinical supervisor they had been attached to/worked closely with. The provider is aware of these issues, and the team recognises that the clinical staffing shortages across the Aotearoa New Zealand health system may be impacting the clinical load of supervisors at clinical placement sites, particularly regional sites and some remote general practices. The provider will need to ensure that these concerns are appropriately addressed and subject to ongoing monitoring, to maintain consistency in both the student experience and learning outcomes.

Of particular note, the students and the academic team have noted that a review is needed as to how the Programme's discipline-based clinical assessment structure integrates with assessment in the longitudinal

RMIP attachments. The Programme leads are aware of this issue, and the AMC looks forward to reviewing updates on the proposed resolution in subsequent reports.

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.

Entry into the Programme occurs through a common Year 1 in the Faculty's Biomedical Science or Health Science bachelor programmes, or postgraduate students can enter directly into Year 2. There is a wide range of entry pathways and selection processes that support the selection of a diverse student cohort with an impressive proportion of Māori, Pasifika and rural students.

Student numbers are determined by Aotearoa New Zealand's government funding caps. Since 2024, there has been a progressive increase (n= 60) in the domestic cap of medical students to 317. With international and returning students, the 2026 Year 2 class may reach 365 students with an anticipated 350 graduates. Domestic full fee-paying students are not permitted under existing Aotearoa New Zealand legislation. The increase to 350 first-year students will increase the overall size of the Programme as larger cohorts progress.

This increase in students is to be considered alongside the current and likely future pressures on placement capacity, within health services. This potential reduction in capacity is due to forecasted increasing workforce shortages, particularly within general practice, primary care, and rural or regional settings. This is compounded by additional uncertainty regarding the commencement of the University of Waikato's recently announced primary medical program. The provider has, however, demonstrated a strong willingness to engage in these discussions and acknowledges the resulting constraints on future student number growth. Placement capacity should consider the facilities available, as well as the supervisory capacity. Continued, detailed reporting on these matters through AMC monitoring, including specific data on student numbers, placement site capacity, and clinical supervision, remains essential to ensure the provider continues to meet the accreditation standards, as well as informing the Programme's strategic decision-making to ensure adequate clinical training capacity.

The Programme has three selective entry pathways on top of the general entry pathway: Māori and Pasifika admissions scheme (MAPAS), Regional Rural admissions scheme (RRAS) and University Targeted Access Schemes (UTAS), which include students with disability, refugee or low socioeconomic backgrounds. Each year, the Faculty seeks University approval for the upper limit of students in each of these categories. In 2026, for a cohort of 317 domestic students, the breakdown is proposed to be: 108 General pathway students; 127 MAPAS students; 73 RRAS students and 9 UTAS students - 2 Disability, 1 Refugee and 6 low socioeconomic backgrounds. The Programme intends to keep these proportional breakdowns with increased student numbers.

The team heard of high demand for these pathways, exceeding the available places. For example, the disability entry pathway attracts 20 students with only two places available. The Faculty has been able to

support many of these students entering the Programme via other pathways where possible; however, consideration should be given to this balance to promote inclusivity.

MAPAS targets align with the projected proportion of Māori and Pasifika populations in the North Island of Aotearoa New Zealand, specifically in the key age demographic of 18-35. The MAPAS pathway is influential in addressing the longstanding low disproportionality of Māori and Pasifika students and working towards health equity. These diverse entry pathways are followed through with meaningful and individualised student academic and wellbeing supports across all learning sites and phases, and there is a positive student wellbeing culture supporting self-disclosure and access to additional supports.

The Programme begins supporting Māori and Pasifika students well before their admission, in line with the Faculty Vision 20:20 project, which aims to increase Māori and Pasifika student intake to reflect population proportions. There are three parts to Vision 20:20; the MAPAS pathway, the Whakapiki Aki Project and Hikitia Te Ora, all operating through a culturally safe, Kaupapa Māori framework. The Whakapiki Aki Project actively engages with rangatahi (Māori youth) at secondary schools to promote health as a career. The Faculty also offers Hikitia Te Ora, a certificate in health sciences as a foundational or transitional Programme for Māori and Pasifika students who would benefit from further academic literacy or exposure to science prior to entering the Programme. This has been exceptionally successful with 110 of Hikita Te Ora students graduating from the Medical Programme between 2015 and 2023.

The Whakapiki Aki Programme has been mirrored by the Pasifika Wayfinders Programme, which is led by the Faculty Associate Dean Pacific. TKHM staff form meaningful relationships with prospective students from an early stage, including hosting them at the Grafton campus for MAPAS general interviews in December each year. This relationship-building is important to ensure students can access their supports and that staff are aware of where additional support may be needed from the beginning.

More generally, students, particularly those from low socio-economic backgrounds, have reported that clinical placements often impose an additional financial burden. This burden arises from having to pay multiple rent or accommodation costs, relying on a car for transport to and from placement sites, and facing difficulties accessing emergency relief funding. Students also report a financial and logistical burden when being recalled from rural placement to return to Auckland for further training.

Information about the selection policies and admissions processes is publicly available on the university website. Since 2015 the Programme has used the Multiple Mini Interview (MMI) for admissions and it has been conducted online since 2020. The Central Admissions team are responsible for admissions, and the MMI's currently have seven plus one stations.

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.

There is a strong commitment to student wellbeing and inclusion, particularly with the addition of the longitudinal, innovative wellbeing curriculum, *SAFE-DRS.* Students and Faculty would benefit from the development and implementation of an accompanying wellbeing strategy that establishes a framework that brings together the numerous student support facets into one overarching framework. Services such as counselling, health and learning support to address students' financial, social, cultural, spiritual, personal, physical and mental health needs are available, including Employee Assistance Program (EAP) services at each clinical placement site, and Faculty access to two tranches of emergency financial relief for students. This was evidenced through several student reports, where individual needs were addressed at both the local placement and institutional level. The provider should ensure that all students are fully aware of the supports available to them, including those on clinical placements can access localised supports, as well as those offered through the Faculty and the wider university. The support provided by the professional staff members at the clinical placement sites in particular, has been praised by many students (please see Standard 5.1 for further discussion).

Student wellbeing and inclusion are embedded from the beginning of the Programme, with specific support for students from diverse backgrounds, including Māori and Pasifika students, those with disabilities, LGBTQIA+ students and carers. Student support begins from Year 2, where students are all on site in Grafton. Student support teams are proactive in hosting wellbeing events, and students have access to standing weekly events that are also accessed by students in other degrees. Students develop a sense of community during these years before they leave for their clinical sites for Phases 2 and 3.

Local site staff and student year representatives are pillars of support for all students, who maintain a strong and mutually supportive relationship with each other. Students at clinical sites have access to an Employee Assistance Program and have access to a variety of local supports, some site dependent such as CMEFs. Students are encouraged to access local support, such as finding a local GP and are also able to access online resources such as counselling.

The Wellbeing Curriculum, including the Phase 1 Year 2 SAFE-DRS programme, reinforces wellbeing strategies that include a curriculum component exploring the 'Doctor as patient and colleague'. This continues into the Phase 2 and 3 years where self-care in relation to Personal and Professional Skills is assessed on clinical placements via the eCSR. The team, however, notes the limitation of this assessment, where many students report that supervisors, particularly those who may not be familiar with the student, mark this as 'not assessed'.

A wide range of support services is available to students, including targeted initiatives for Māori students, such as MAPAS House and orientation activities. Learning support is particularly strong at sites where Clinical Medical Education Fellows are present. Mental health resources are accessible through online counselling services and EAP access. Students with disabilities are supported through access to the Disabled Students

Support Space at the Grafton campus, and an initial consultation/meeting with the DMSA during their first year in the Programme, facilitating early connection to the support services they may need.

As previously highlighted, there is significant concern among the student body regarding the rising cost of living and the limited availability of support services (see Standard 4.1). Access to these supports is inconsistent; for example, some cohorts have access to low-cost accommodation, while others do not. In Whangarei, the Year 5 Pūkawakawa student cohort has been given access to on-site accommodation until 2025, and with the new Year 4 cohort beginning in 2026 in Northland, this will be offered to them instead. Students in some Regional-Rural Programmes in Waikato, Lakes and Whakatāne have access to funded accommodation. There is an accommodation and fuel allowance provided to students who need to travel to a placement away from their usual residence – $25 (NZD) per night and a fuel allowance allocated based on kilometres travelled.

Students who identify themselves as having a disability to the Faculty at commencement, are linked with support very early, both centrally and with the DMSA. In reference to the University and Faculty guidance on reasonable accommodations, this process identifies reasonable adjustments, which are implemented by the Programme. It is recognised that many types of adjustments are available, beyond assessment only, with examples such as attendance hours, extensions to assessment deadlines and graded returns provided by the student support team.

Students may have learning needs that arise during the programme. These may be identified and mitigated in a number of ways including by academic staff. Clinical Medical Education Fellows (CMEF), where present at clinical placement sites, may play an important role in addressing these concerns. For example, where students might require additional support on a clinical placement and the placement supervisors are stretched, the CMEFs can provide additional clinical skills learning opportunities. For others, there is a declaration at Year 2, then annually from there. This is consistent with the MCNZ process. Students are encouraged to submit a declaration each year, and any reasonable adjustments or plans required are developed in collaboration with the DMSA. The volume of declarations is acknowledged and ensuring that there is adequate staff FTE (full-time equivalent) allocated to this task is integral to the ongoing success of this process. At the time of graduation, students with identified needs are encouraged to engage with their DCTs at their prevocational training sites but are not obligated to. The University has a Memorandum of Understanding with the Medical Council of New Zealand regarding this process.

The Faculty has a zero-tolerance policy for discrimination; however, the Programme acknowledges the significant challenges experienced by Māori medical students, who report disproportionately high rates of direct and observed racism, bullying and harassment. As noted under Standards 4.2 and 5.1, the team recognises that Māori and Pasifika students are appreciative of the MAPAS safe space, the HOTSPOTs system, and the team notes the rollout of bystander training for Year 4 students. The team notes that the Faculty is currently investigating the best evidence to inform anti-racism training and interventions in the various settings in which this abuse occurs. The AMC anticipates receiving an update on this work, along with any possible additional initiatives the Faculty may be considering.

A key reporting mechanism to support student safety, including cultural safety, of learning environments is HOTSPOTS, a national award-winning system used in Years 4 to 6 of the Programme. HOTSPOTS identifies potential areas of concern (not individual people) through six-monthly student surveys. Students feel these are generally safe and anonymous, and the results are shared with Chief Medical Officers, academic site leads and HODs. Where ‘hot’ areas of concern arise – e.g., a trend of increasing identification of certain rotations as unsafe – Programme leaders undertake relevant actions which may include further investigation or removal of students from that rotation. Chief Medical Officers, clinicians, staff and students all spoke positively about the program, and the team were advised of a number of instances where HOTSPOTS data/feedback had resulted in positive change.

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 fitness to practice processes are well aligned with those of the MCNZ, and the relatively high number of disclosures reflects the trust and safety students have in the process. The provider's prompt consideration of concerns and responses to students are also noted as strengths. Student cases are assessed, and the students themselves are supported by the appropriate team, including MAPAS support if required, in a timely manner. If remediation is required, students are usually advised within 48-72 hours, or up to one week and are provided with a plan and follow-up. Students are also able to appeal to the Dean.

Students have, however, expressed a need for greater clarity and transparency regarding the processes that follow a self-disclosure, particularly in relation to decisions affecting their continuation in the medical programme. There is potential for issues with confidentiality and conflicts of interest at the intersection of student support, the fitness-to-practice process, and student progression – particularly from the inclusion of student support staff (such as DMSA) within fitness to practice hearings and their presence for assessment decision-making at the BOE meetings. Students need to be assured of a safe, confidential process for voluntary medical student self-disclosure of information that facilitates additional support within the programme.

Despite many efforts of the Programme to improve stigma around fitness to practice, the Faculty acknowledge the potential for fear around such notifications, particularly 'non-critical' incidences, even with the low numbers of these that are lodged. The team recognises the good work that has been done, such as the Year 4 Health and Wellbeing Day, education from Year 2 that the Medical Council of New Zealand has a Health Committee, and a small group educational activity regarding the impact alcohol and drugs can have on doctors.

As noted in Section 4.2, the HOTSPOTS system is again highly valued by students, Faculty, and the clinical placement sites for its function as a mechanism for anonymous and responsive reporting of concerns about professional behaviour.

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.

Students are required to have membership with the Medical Protection Society or equivalent alternative provider (Medicus, NZMII) from their first semester in the Programme for professional indemnity insurance. All providers offer free membership for students and appropriately indemnify students for all educational activities.

When overseas travel is undertaken, the University offers free comprehensive international travel insurance to all outbound students doing their Selective and Elective who have their travel registered and approved via the university's Traveller Relationship Management platform.

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 Programme's distributed model requires teaching and learning spaces at multiple sites. The education sites at all Programme phases are well set up for staff and students, with internet connectivity, computer facilities (both University and health service), meal preparation and meeting spaces. Students have specific areas where they can connect and interact with each other, as well as accessible libraries and learning resources. Staff and students share many common spaces. Consideration will need to be given to how the capacity of these facilities will be impacted by future increases in student numbers, particularly at the Grafton site, which was noted to already be at capacity. Sites are encouraged to continue to ensure they are able to cater to the diverse needs of their staff and student population, such as through provision of multifaith prayer areas, breastfeeding friendly spaces and other needs as may be identified in the future

MAPAS House on the main campus is utilised by MAPAS students and is commended as a safe space, fostering student success and wellbeing. Māori and Pasifika students knew how to access MAPAS support and reported feeling safe in the "university only" areas of clinical teaching sites. The team witnessed multiple cohorts of MAPAS students accessing MAPAS House during the visit.

The team notes that at present, the physical presence and visible signage of MAPAS is not replicated across all sites for safety reasons, with reports of cultural insensitivity and other microaggressions against students when on some clinical placements. LQBTQIA+ students and staff similarly reported feeling safe when in "university only" spaces and supported by the provider's wellbeing initiatives and supports. The HOTSPOTS system is working to address student concerns in a systematic manner and is greatly appreciated by clinical partners.

Financial pressures related to clinical placements are a common concern raised by students. Access to accommodation near clinical placements has been identified as a particular challenge (and in some cases unaffordable) for Phase 2 students. This differs from those students participating in the RMIP, where accommodation is subsidised or provided by a partnering organisation and/or charity.

Students with disabilities or caring responsibilities face additional challenges in balancing full-time study with part-time employment, further increasing financial pressures. While travel and accommodation allowances are valued by students, there is scope to improve their accessibility and responsiveness to individual needs.

Students acknowledge the extensive use of technology by the provider in supporting learning, assessment and Programme outreach. There is access to a broad range of online resources, primarily accessed through the MBChB Portal, including lectures, online modules, clinical scenarios and other tools. Students and clinical supervisors report some frustration with the ability to easily navigate across platforms and find information. Effective integration of these platforms remains key to enhancing their effectiveness.

The education sites visited were well set up for students, with computer facilities (both University and hospital) and meeting spaces. There were specific areas for students to interact and connect. All sites visited had accessible libraries and meeting spaces. There were, however, concerns raised by both staff and students related to the capacity of current facilities regarding increasing student numbers. Facilities are currently fit for purpose for the current cohort of students. However, space at the Grafton site is becoming increasingly limited.

Students raised concerns regarding the ballot system used for certain placements, particularly the impact of not being allocated to a preferred location when a specific rationale for the preference had been identified. While these concerns did not appear to affect the quality of learning once on site, the associated financial burden remained a challenge. Students, especially those in Phase 2, shared personal experiences of difficulty in securing accommodation. It is noted, however, that students participating in the RMIP have their financial and accommodation needs met through Programme support.

Access to affordable accommodation remains a significant challenge for many students, particularly when required to travel back to Auckland from placement sites, where they are expected to arrange their own accommodation. This issue is notably mitigated for students participating in the Rural Medical Immersion Programme, where accommodation is either subsidised or provided through partnering organisations.

The team noted that there appears to be a distinction in support between students undertaking year-long placements and those attending shorter placements or mandatory activities at the Grafton campus.

Students reported a lack of consistency across digital platforms, creating challenges in navigation and access to essential information across the Learning Management System (LMS) and student portal. With the current transition to Canvas occurring, the Programme team are aware of this and are actively working to update any broken links to resources, and to ensure navigation and essential information are accessible to students. It should be ensured that the LMS content, particularly content that relates to assessments and placements, is (i) version controlled and dated and (ii) students are made aware of updates to programme content on the LMS when they are made. It is understood that once the transition is complete, access to information should be simplified, and that this will effectively support the Programme's learning, teaching, assessment and research.

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.

Faculty staff (both academic and professional) are clearly proud of the Programme and demonstrate a strong commitment to training and supporting the future medical workforce of Aotearoa. There are sufficient academic staff employed to plan, implement and revise all aspects of the programme. Many staff, particularly in leadership positions, have a smaller FTE than might be expected. At present, this is seen as an asset, as they are often involved in other aspects of the Programme or clinical practice. However, both staff numbers and FTE will need to be continuously monitored and reviewed in line with the current external operating environment, curriculum review and the future growth in student numbers.

At clinical placement sites where Education Fellows are present, their role is an asset. They support learning & teaching and assessment processes for students, while also alleviating some of the workload pressures on an already stretched clinical workforce. The team recommend that the provider review how this role can be incorporated across all sites/clinical regions, particularly as student numbers increase.

Requests for new academic or professional staff FTE are reviewed through Heads of Department, campus or unit leads, and the MBChB Strategy Committee to ensure transparency across the Faculty and alignment with Programme delivery requirements. Final approval is granted by the Faculty Dean. The Programme has experienced low turnover among permanent academic staff, contributing to workforce stability. Succession planning is embedded within a 12-month cycle and integrated into staffing and budget planning processes to support continuity and strategic workforce development.

While general academic staffing levels are adequate, there is a lack of dedicated resourcing to support TKHM staff in the effective implementation and ongoing development of the Hauora Māori curriculum, and in its assessment. Specifically, there is an identified need for personnel to deliver teaching and to train clinical and professional staff in the provision and assessment of culturally safe healthcare.

Communication across the various components involved in implementing clinical education across the Programme's geographically diverse footprint is reported to be highly effective. This is supported by structured Heads of Department meetings and strong collaborative relationships between academic and professional site coordinators.

The Programme currently has an appropriate profile of professional staff, split across broad functional groups of general administration, teaching administration, student engagement, student support and technical services (teaching).

There is a clear appreciation within the Faculty and across most clinical placement sites for professional staff and site coordinators, who undertake the day-to-day operations of the Programme's clinical placements. The professional staff are the localised point of contact for all questions related to the Programme from clinical supervisors, honorary staff and students. This localised and distributed expertise and accessibility is fundamental to the success of the Programme, the wellbeing of students and contributes to the wellbeing of clinical supervisors. As student numbers grow and the professional staffing profile is reviewed, this distributed professional expertise and level of accessibility and support for students and clinical staff should stay aligned and sufficiently resourced, to ensure that Programme delivery is not negatively impacted. The team understands careful consideration has gone into reviewing the balance of numbers, functional categories and seniority of professional staff across the Faculty to better support core activities, and also

notes the high value of corporate knowledge held by these staff and their importance to stakeholder relationships and Programme delivery.

The frequent use of trained actors and consumers in Phases 1 and 2 of the Programme provides authenticity in practising clinical scenarios and is a commendable example for other providers. Actors are trained to act as patients and also to provide feedback to students.

5.3	Staff appointment, promotion and development
5.3.1	The medical education provider's appointment and promotion policies for academic staff address a balance of capacity for teaching, research and service functions. The appointment and promotion policies include a culturally safe system for measuring success of Aboriginal and/or Torres Strait Islander and Māori staff.
5.3.2	The medical education provider appraises and develops staff, including clinical title holders and staff who hold a joint appointment with another body.
5.3.3	The medical education provider provides Aboriginal and/or Torres Strait Islander and Māori staff with appropriate professional development opportunities and support. Aboriginal and/or Torres Strait Islander and Māori staff have formal opportunities to work together in teams and participate in mentoring programs across the medical program and higher education institution.
5.3.4	The medical education provider ensures that staff, clinical supervisors and students have training in cultural safety and participate in regular professional development activities to support ongoing learning in this area.

The provider's appointment and promotion policies for academic staff will need to continue to maintain a balance of capacity for teaching, research and service functions. For Māori staff, these policies should incorporate mechanisms to ensure that cultural workload demands are appropriately recognised and managed.

Some clinical supervisors report their own wellbeing being compromised at present, due to a strained health system that is also undergoing restructuring. This is the case for both clinical supervisors whose roles are partly funded by the university and those with honorary university appointments. In both cases, teaching and training time is often reported as being compromised due to the pressures of service delivery. For clinical supervisors awarded honorary senior lecturer titles, the provider must ensure clear communication regarding the scope, expectations, and any entitlements of the role, as feedback from clinical placement sites has indicated inconsistencies in understanding (see Section 5.4 for further commentary).

Cultural safety training is currently not mandatory; however, the Faculty recognises the need to strengthen this area. While a range of optional modules are available, and some content is incorporated into the Hauora Māori curriculum for students, further emphasis is required. Additionally, both the Medical Council of New Zealand and specialist medical colleges have articulated clear expectations regarding cultural safety training. At a minimum, clinical supervisors should have a sound understanding of the Hauora Māori components of the Programme and be appropriately upskilled to assess these competencies effectively in clinical practice.

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.

Feedback from placement sites demonstrates some concern among some clinical supervisors regarding the supervisory workload and how this will increase over the coming years, as student numbers increase. The provider is encouraged to ensure expectations are clearly outlined with both organisations (clinical placement sites), academic and clinical staff delivering the supervision, professional staff and students.

Students' experiences at various clinical placements to support their learning of working in diverse communities are excellent. The clinical placement at Kaupapa Māori organisation Turuki Health, where students participate in community-led initiatives that incorporate Te Ao Māori models of wellbeing, and experience clinical examinations in Te Reo, Samoan and many other languages, is commended. There are similar opportunities to explore diverse community health needs via the RMIP, Middlemore, Rotorua, Whangamatā and Whangārei placements.

There remains ongoing uncertainty regarding the establishment of the proposed NZ Graduate School of Medicine program at the University of Waikato and the potential implications this may have on the future capacity of clinical placement sites. It will be important to keep the AMC informed of these developments, particularly in relation to how the Faculty is engaging with Te Whatu Ora – Health New Zealand and other medical program providers to collaboratively manage the situation and develop sustainable solutions.

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.

There is a system of clinical supervision in place that reflects the dispersed nature of clinical placements. However, students report variability in the supervision they receive across sites, and that this can impact their learning and experience of assessment. This variability cannot be decoupled from current clinical staff shortages being experienced across the health system. These shortages are most evident outside of Auckland. The team noted concern expressed by some placement site clinical supervisors regarding the sustainability of a structure based on "goodwill" in a health system under significant clinical pressure. A number of senior medical officers (SMOs), resident medical officers (RMOs), and locum staff are actively involved in clinical supervision; however, many are not formally appointed as university supervisors and, as a result, have not received training or briefing on the programme's expectations.

Further work is required to ensure that both students and clinical placement sites have consistent and reliable access to up-to-date guidebooks and online resources. Feedback from students and clinical supervisors indicates that the current distribution of materials across multiple platforms and locations creates confusion and inefficiencies. The Faculty has largely completed the transition to a unified digital platform (Canvas), which is intended to enhance accessibility of Programme information and promote consistency in learning materials across all clinical sites. As outlined under Standards 1.4, 2.2 and 5.1, the AMC looks forward to receiving updates through annual monitoring on the full implementation of this

transition, including assurance that all Programme stakeholders have consistent and accurate access to information regarding the Programme and its requirements.

Access to training for clinical supervisors is available, but knowledge of these resources is variable, and for some clinical supervisors, this was viewed as a contributing factor to their own stress and well-being. HOTSPOTS has again been identified as a valuable tool by both staff and students to monitor the quality of clinical supervision and clinical sites. Other tools for monitoring clinical supervision are not systematic and could be improved and made more comprehensive.

As noted in Section 5.3.2, many clinical supervisors are awarded the title of Honorary Senior Lecturer, which provides access to certain university resources, such as library services and academic subscriptions. However, awareness of these entitlements varies across clinical sites and is often influenced by the Programme's visibility and engagement at each location. Although there is a minimum expectation of 1 hour per week (0.025 FTE), at some sites, there is an expectation that recipients of the honorary title contribute approximately 0.1 FTE to teaching, which many find difficult to accommodate. Whilst at other sites, the team noted that Programme leaders have made themselves available to support assessments, such as OSCE marking. Where there was involvement from Programme leadership, it was highly regarded and discussed as an example of the Programme's connections with the sites.

Strengthening collaboration between the Programme and the clinical sites will help ensure that appropriate time is allocated for teaching responsibilities. Given the increasing pressures on clinical services, this remains an important area to monitor. The current reliance on the goodwill of clinical staff is becoming unsustainable in an already stretched health system, with some supervisors expressing concerns about the impact on their own wellbeing. As discussed in Standard 1.2.2, there is a need for many formal agreements related to student placements and supervision to be updated. These include the responsibilities of hospital and community practitioners who contribute to delivering the Medical Programme and the responsibilities of the medical education provider to these practitioners. While this does occur functionally, and there is relative clarity from clinical leadership and supervisors about their responsibilities, the updated agreements will ensure this remains the case. As mentioned elsewhere in this report, increasing the availability of CMEFs will reduce the pressure on clinical supervisors.

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 provider has a clear commitment to continuous quality improvement, and the team heard many examples of changes made to the Programme in response to both formal evaluation activities and informal feedback (including by students). The Programme adheres to both University and Programme-specific evaluation policies and strategies. The formal oversight of evaluation of the Programme is done through the Evaluation Sub Committee (ESC) of the Board of Studies (BOS). The ESC is responsible for gaining approval from the BOS for a systematic annual plan for the evaluation and monitoring of the Programme, implementing the plan, monitoring the implementation, synthesising feedback from monitoring and reporting this to the BOS.

The ESC has recently reviewed the Programme's evaluation strategy for the first time since 2015. The new 2025 Principles of Evaluation are based on the Kirkpatrick model. The ESC's newly developed 2026-2030 evaluation plan aligns with this and the AMC standards.

The Medical Programme Directorate (MPD) is responsible for setting annual evaluation plans for the Programme, while Schools and Departments also coordinate and conduct their own evaluation activities. The MPD annual evaluations include: student evaluation surveys for all phases, with Phase 2 and 3 including the clinical environment experience; HOTSPOTS; clinical attachment, site and domain surveys; special projects unrelated to departmental teaching or curriculum, such as new initiatives.

Schools and departments have evaluation systems for monitoring their respective curriculum components and evaluating new components or initiatives. Most departments conduct these annually or biannually, with some attachments evaluating after each teaching cycle or block. These evaluations have a curriculum focus and broadly cover content delivery, assessment methods, students' engagement and specific departmental tools. The Programme is working to streamline the dissemination of annual evaluations and the collation and reporting of data.

The team noted that the Department of General Practice and Primary Health Care is currently undertaking a comprehensive review of the Faculty undergraduate curriculum in general practice, community health, and rural health. This review aims to strengthen the curriculum and more effectively support student interest in general practice as a career pathway. The provider is encouraged to continue exploring opportunities for incorporating community and healthcare consumer perspectives into stakeholder consultations to help ensure that the revised curriculum aligns with community needs and expectations. The AMC looks forward to receiving the findings and recommendations from this review upon its completion in 2026.

The provider collects comprehensive data on medical student cohorts and systematically uses them for evaluation. The Programme also systematically and formally seeks feedback from students and staff. The dissemination of student feedback through the Programme's governance is represented below in Figure 2.

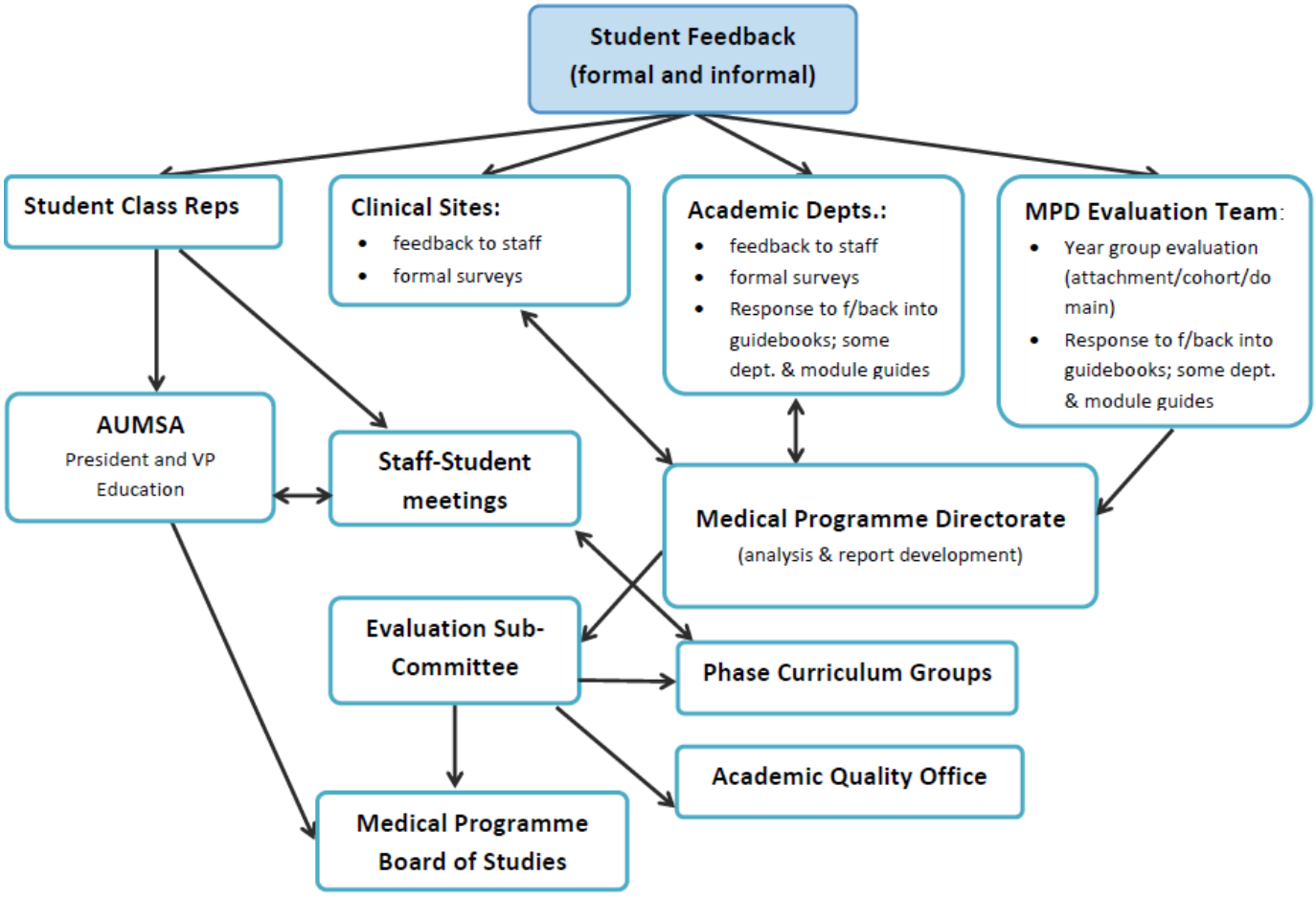

Figure 2: Dissemination of student feedback through the Programme's governance

Outside of the Programme, feedback is collected from prevocational training sites through their Directors of Clinical Training (DCTs), who meet regularly with the Phase 3 Director. The HOP and Phase 3 Director also attend the annual DCT training day and shares feedback with the BOS and MPD on graduates of the Programme who are in their PGY1 or PGY2 year of training. The ESC has recently updated their terms of reference and now has a requirement to seek feedback from prevocational training providers and to include a member on the ESC who could provide insight on graduate performance in the postgraduate years.

Programme leaders – HOP, Department leads, Phase leads, academic staff - meet with clinical site leadership and health services on a regular basis to discuss the Programme. These are generally more informal but were highly valued by the chief medical officers (CMO's) at sites the team visited. The Programme has successfully implemented the HOTSPOTS system, which since 2019 has been used to monitor student experiences of bullying, discrimination, harassment and inclusion on clinical attachments. Reports from HOTSPOTS are shared with department heads, CMO's, and academic leaders on site. This information received is highly valued by clinical Programme partners, and the team heard of a few instances where changes were made to rotations or student contact with clinicians immediately based on HOTSPOTS reporting.

The provider engages in extensive collaboration with other institutions and medical education bodies to support the evaluation and continuous improvement of its own programme. It also actively shares its practices and insights to contribute to sector-wide learning and development. Te Kupenga Hauora Māori showcases at an international level, the Programme's many connections and collaborations on Indigenous health curriculum and practice. The provider takes part in the Medical Schools Outcome Database (MSOD).

There are strategic collaborations with the University of Otago medical program, including a joint statement on informed consent and a student code of conduct. The two medical program leaders also meet annually to share direction and develop advocacy.

The Programme is active in Medical Deans Australia and New Zealand and its sub-committees: Medical Education Collaboration Committee (MECC) and Workforce and Training Committee. They are also part of the following organisations that support their continuous improvement of the Programme based on national and international developments and best practice in medicine and medical education: Medical Education Leads Australia New Zealand (MELANZ), Australian & New Zealand Association for Health Professional Educators (ANZAHPE), Australasian Collaboration for Clinical Assessment in Medicine (ACCLAiM), Australasian Medical Schools Assessment Collaboration (AMSAC) and the Universitas21 Medical Education Group.

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 Programme analyses the performance of student cohorts through progress testing three times per year. The same test is completed by all years of the Programme, and questions are related to clinical scenarios and the global learning outcomes. Outcome analysis of these is reported to the Assessment Subcommittee. The Programme holds longitudinal Progress Test data from 2013 onwards and can be sorted by demographic: year cohorts, entry pathways, and gender. Continuous analysis and comparison of data support the Programme in managing changes in anticipated cohort performance. It is anticipated to be used to identify trends in students' knowledge development and help assess the comparability of learning across different clinical sites.

Comprehensive longitudinal data is also collected linking selection criteria, achievement outcomes and required student support. Student achievement and progression data is shared regularly with relevant committees responsible for student selection, curriculum review and development and student support, with some specific data shared with the FEC and other Faculty committees. The BOE receives student summative results and progress test outcomes.

Similarly, data are collected and analysed across the Programme's different sites, with appropriate analysis and assessment done to ensure similar overall student and graduate outcomes. These are reviewed at the end-of-year Heads of Department meetings and in other fora, such as the BOS. As the RMIP is implemented, the AMC looks forward to hearing about its evaluation and outcomes.

Much of the data on student performance and its assessment relative to student characteristics are gathered through membership on the BOE, which is broad-based, and its members also sit on selection and curriculum committees. However, there is less formal feedback and sharing of the data back to the selection and curriculum committees.

The Faculty monitors the performance and achievement of Māori and Pasifika students at the FEC. Māori education expertise is utilised in evaluating Programme outcomes for Māori and Pasifika students, with the

Tumuaki and other Māori education experts working alongside the Associate Dean Equity on this work. Comprehensive data is collected for MAPAS entry students and is used to inform student support and progression.

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 BOS receives a comprehensive range of information on evaluation, continuous improvement, and review processes through various subcommittees or staff. For example, the Phase Directors report to the Phase Curriculum Groups, and a summary is sent to the BOS. Student representatives sit on the BOS and most of its subcommittees, which supports sharing the data with students and those delivering the Programme. An annual summary report on the HOTSPOTS system is made available to all students and staff via the MBChB portal.

The Medical Student Outcomes Data initiative represents a collaborative effort between the Programme and Health New Zealand | Te Whatu Ora, the country's largest health service provider. However, aside from this initiative, evaluation outcomes are not routinely disseminated to broader stakeholder groups. The Programme has acknowledged this as an area requiring improvement, particularly in strengthening engagement and data-sharing mechanisms with prevocational training providers.

The Faculty is strongly encouraged to explore strategies to enhance transparency and collaboration with external stakeholders regarding the evaluation and reporting of Programme outcomes. Whilst feedback is sought from prevocational training providers, mechanisms for providing feedback to these providers should be considered as part of closing the communication loop. It is recommended that the Faculty consider developing structured channels for sharing evaluation findings that are relevant to clinical supervisors, hospital education teams, and other partners involved in the continuum of medical education. Furthermore, there is recognition that timely, targeted feedback can improve alignment between medical school outcomes and the expectations of the health workforce. Establishing regular reporting cycles, supported by digital platforms and stakeholder briefings, is an option to consider to ensure that evaluation data informs curriculum development, placement quality, and any targeted clinical placement site training initiatives. These efforts would strengthen the Programme's accountability and responsiveness to the evolving needs of the healthcare sector.

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: Glossary of Acronyms, Abbreviations and Terms

Term	Definition
AMC	Australian Medical Council
ASC	Assessment Subcommittee (of the Board of Studies)
AUMSA	Auckland University Medical Students' Association
BMedSc	Bachelor of Medical Science
BOE	Board of Examiners
BOS	Board of Studies
CMEF	Clinical Medical Education Fellow
CMO	Chief Medical Officer
CSRC	Clinical Skills Resource Centre
DCT	Director of Clinical Training
DHOP	Deputy Head of the Medical Programme
DMSA	Director of Medical Student Affairs
EAP	Employee Assistance Program
eCSR	Electronic Clinical Supervisor Report
ESC	Evaluation Subcommittee (of the Board of Studies)
FEC	Faculty Education Committee
FTE	Full Time Equivalent
HOD	Head of Department
HOP	Head of the Medical Programme
IPL	Interprofessional Learning
LMS	Learning Management System
MAPAS	Māori and Pasifika Admissions Scheme
MBChB	Bachelor of Medicine/Bachelor of Surgery
MCNZ	Medical Council of New Zealand
MDANZ	Medical Deans of Australia and New Zealand
MMI	Multiple Mini Interview
MPD	Medical Programme Directorate
OSCE	Objective Structured Clinical Examinations
PCS	Professional and Clinical Skills Domain
PPS	Personal and Professional Skills Domain
RHIP	Rural Health Interprofessional Programme
RMIP	Rural Medicine Immersion Programme
RMO	Resident Medical Officers

Term	Definition
RRAS	Regional Rural Admissions Scheme
SMO	Senior Medical Officers
SMS	School of Medical Sciences
SOM	School of Medicine
SOPH	School of Population Health
The Faculty, FMHS	The Faculty of Medical and Health Sciences
The Programme	The Bachelor of Medicine/Bachelor of Surgery (MBChB)
Te ORA	Māori Medical Practitioners association
TKHM	Te Kupenga Hauora Māori
UTAS	University Targeted Access Scheme
WBA	Workplace Based Assessment

Appendix 3: Membership of the 2025 AMC Assessment Team

Name	Role
Emerita Professor Kirsty Foster OAM (Chair), BSc, MBChB, FRCGP, DRCOG, MEd, PhD	Emerita Professor, Faculty of Medicine, University of Queensland
Dr Curtis Walker (Deputy Chair), BSc, BVSc, MBChB, FRACP (Nephrology), FRACP (General and Acute Medicine)	Physician/Nephrologist, Health New Zealand | Te Whatu Ora, MidCentral
Ms Melody Ahfock, BSc	President, Australian Medical Students' Association Doctor of Medicine Student, University of Queensland.
Associate Professor Karen D'Souza, MBBS	Course Director, Doctor of Medicine Program, Deakin University, School of Medicine, Faculty of Health
Mr Michael Edmonds	General Manager, Te Toi Ora Ki Whaingaroa
Emeritus Professor Nicholas Glasgow, BHB, MBChB, GradDipFamMed, GradCertEdStudies, MD, MD (Hon), FRNZCGP, FRACGP, FAChPM	Emeritus Professor, School of Medicine and Psychology, Australian National University Chair, Canberra Regional Medical Education Council
Associate Professor Tania Huria, BA, BN, PostGradDip (Public Health), MPH, PhD.	Director Hauora Māori & Equity, Sexual Wellbeing Aotearoa and Dean Ako (Teaching and Learning), University of Otago
Professor Ruth Kearon, BMBS (Hons), MHealthMgmt, FRACGP, FRACMA, GAICD	Head of the Tasmanian School of Medicine, University of Tasmania
Sophie Burke	Manager, Medical School Assessments, Australian Medical Council
Belinda Gibb	Director, Indigenous Policy and Programs, Australian Medical Council
Melissa Johnson	Cultural Strategic Facilitator, Indigenous Policy and Programs, Australian Medical Council
Esther Jurkowicz	Program Lead, Accreditation Assessments, Australian Medical Council
Fatima Mehmedbegovic	Policy and Programs Officer, Medical Schools Accreditation, Australian Medical Council

Appendix 4: Summary of the 2025 AMC Assessment Team's Accreditation Program

Meetings	Roles engaged with
8 September 2025 ***Waipapa Taumata Rau, the University of Auckland Grafton campus***	
Mihi Whakatau - Welcome	Cultural Team Dean, Faculty of Medical and Health Sciences (FMHS) Deputy Dean FMHS Tumuaki, FMHS; Head, Te Kupenga Hauora Māori (TKHM) Head, School of Medicine Deputy Head, School of Medicine Head, School of Medical Science Head, School of Population Health Head of Medical Programme (HOP) Rural Health Unit Director TKHM, Hauora Māori Domain Year 6 Lead Director of FMHS Finance - Acting Director of FMHS Operations Faculty Associate Dean (Learning & Teaching) Deputy Head of Medical Programme Programme Delivery Manager – Medical Programme Directorate Associate Professor, School of Medicine; Previous HOP AUMSA President AUMSA VPE MPD; PPS Domain Coordinator Kaiarataki Pro Vice-Chancellor (Māori)
Faculty governance	Dean FMHS Deputy Dean FMHS Tumuaki FMHS, Head TKHM Head, School of Medicine Deputy Head, School of Medicine Head, School of Medical Science Head, School of Population Health Head of Medical Programme Rural Health Unit Director Director of FMHS Finance - Acting Director of FMHS Operations Faculty Associate Dean (Learning & Teaching)
Medical Programme Governance	Head of Medical Programme Deputy Head of Medical Programme Head, School of Medicine Head, School of Medical Science Head of Department, Medicine

Meetings	Roles engaged with
	Head of Department, Obstetrics & Gynaecology Head of Department, Psychiatric Medicine Head of Department, Surgery Head of Department, Molecular Medicine Head of Department, Medical Imaging Head of Department, Nutrition Head of Department, GP Head of Pacific Health Tumuaki FMHS, Head TKHM Academic Coordinator, Auckland Clinical Campus Dean, Waitematā Clinical Campus Dean, Bay of Plenty Academic Coordinator, Lakes Academic Coordinator, Northland Academic Coordinator, Taranaki Rural Health Unit Director Directors of Medical Students Affairs Phase 1 Director Phase 2 Director Phase 3 Director Director of Admissions Chair Pastoral Care Subcommittee Chair Evaluation Subcommittee; Centre for Medical and Health Sciences Education (CMHSE) Chair BMedSc (Hons) BOS PCS1 coordinator; PPS coordinator TKHM, Hauora Māori Domain Lead Associate Professor, School of Medicine; Previous HoP
Heads of Departments	Head of Department, Psychiatric Medicine Head of Department, Surgery Deputy Head of Department, Ophthalmology Head of Department, Molecular Medicine Head of Department, Medicine Head of Department, Medical Imaging Head of Department, Nutrition Head of Department, General Practice & Primary Health Care Head of Pacific Health Centre for Medical and Health Sciences Education (CMHSE) Head of Department, Molecular Medicine and Pathology Head of Department, Obstetrics, Gynaecology and Reproductive Sciences
Māori academic staff	Deputy Dean FMHS

Meetings	Roles engaged with
	Tumuaki FMHS, Head TKHM TKHM, Hauora Māori Domain Lead TKHM, Hauora Māori Domain Year 6 Lead Professor of Surgery, SOM and TKHM Senior Lecturer in Health Professional Education, CMHSE Senior Lecturers in Paediatrics, SOM and TKHM Associate Professor, Office of the Tumuaki Associate Professor, TKHM
General Practice, Community Health and Rural Medicine (GPCHaRM)	Head, School of Population Health Head of Department, General Practice and Primary Health Care General Practice - Year 2 Lead General Practice - Year 4 Lead General Practice - Year 5 Lead General Practice - Year 6 Lead Urgent Care Rural Health Unit Director
Medical Programme Directorate Senior Leadership	Head of Medical Programme Deputy Head of Medical Programme Phase 1 Director Phase 2 Director Phase 3 Director
FMHS Professional Staff	Programme Delivery Manager, Medical Programme Directorate Group Services Managers, School of Medicine FMHS Technical Services Manager- Teaching Group Services Manager, Te Kupenga Hauora Māori Academic Progress Coordinator, Medical Programme Directorate Practicum Placement Coordinator, Medical Programme Directorate Group Services Manager, School of Medical Sciences Group services team manager, School of Medical Sciences Rural and BOP Clinical Campus
Teaching and Learning	FMHS Associate Dean (Learning & Teaching) Professional Teaching Fellow, Lead, PCS2, UIPC, Palliative Care TKHM, Hauora Māori Domain Lead Associate Professor, School of Medicine Centre for Medical and Health Sciences Education (CMHSE) Chair Evaluation subcommittee; CMHSE Senior Lecturer in Health Professional Education, CMHSE Professional Teaching Fellow - Clinical Skills
FMHS and Medical Programme Student Support	FMHS Student Support & Engagement Manager FMHS Student Support Advisor-Rural FMHS Student Experience Advisor

Meetings	Roles engaged with
	FMHS Student Support Advisors FMHS Associate Dean Equity and Diversity Head of Medical Programme Directors of Medical Students Affairs Lead Clinical Medical Education Fellow (CMEF) Student Support Advisors-Te Kupenga Hauora Māori Chair, Pastoral Care Committee; FMHS, Fitness to Practice Academic Lead Academic Coordinator-Auckland Phase 2 Director
MAPAS Student Support	Student Support Advisors, Te Kupenga Hauora Māori Student Support Advisor, Vision 2020 Group Services Manager, Te Kupenga Hauora Māori Tumuaki FMHS, Head TKHM Kaitiaki, Whakapiki Ake Director Hikitia Te Ora (Certificate in Health Sciences)
Students	President, AUMSA Vice-President Education, AUMSA Equity representative, AUMSA Mangai Māori representative, AUMSA Pasifika representative, AUMSA Rainbow representative, AUMSA Students with Dependents representative, AUMSA Education representative, AUMSA Year 2 representatives, AUMSA Year 3 representatives, AUMSA Year 4 representatives, AUMSA Year 5 representatives, AUMSA Year 6 representatives, AUMSA Year 2 students Year 3 students
9 September 2025 ***Waipapa Taumata Rau, the University of Auckland Grafton campus***	
Phase 1 Curriculum Group	Phase 1 Director Year 2 Academic coordinator Year 3 Academic coordinator Head of Department, Medical Imaging Head of School of Medical Science Principles of Medicine Coordinator Cardiovascular System Coordinator Respiratory System Coordinator

Meetings	Roles engaged with
	Head of Department, Molecular Medicine Genitourinary System Coordinator Doctor, Pharmacology TKHM, Hauora Māori Domain Lead Chair BMedSc (Hons) BOS Obstetrics and Gynaecology Reproduction, Development and Ageing Coordinator Regulation of Body Function Coordinator Clinical Methods coordinator Human Early Life Development Coordinator PCS1 Coordinator PCS2 (Phase 1); Ethics Lead Year 5
Phase 2 Curriculum Group	Phase 2 Director GPCHaRM (Year 4) Staff Doctor, Specialty Surgery Deputy Head of Medical Programme Doctor, Clinical Pathology Drug and Alcohol Assessment General Practice - Year 5 Lead GPOPS Staff Doctor, General Surgery Rural Health Unit Director Doctor, Specialty Medicine Doctor, Geriatrics TKHM, Hauora Māori Domain Year 6 Lead Doctor, Obstetrics and Gynaecology Doctor, Paediatrics Doctor, Population Health Intensive Doctor, Psychiatry
Phase 3 Curriculum Group	Phase 3 Director General Practice, Year 6 Lead Doctor, Emergency Medicine HoD-Medical Imaging Associate Professor, General Medicine Honorary Associate Professor, General Surgery TKHM, Hauora Māori Domain Year 6 Lead Doctor, Obstetrics and Gynaecology Doctor, Paediatrics Academic Coordinator - Northland PCS1 coordinator; PPS coordinator Academic Coordinator - Taranaki

Meetings	Roles engaged with
Admissions	Tumuaki FMHS, Head TKHM FMHS Associate Dean (Academic) Director of Admissions Rural Health Unit Director Deputy Head of Medical Programme Head - School of Population Health Head - School of Medicine Head - School of Medical Science Head of Pacific Health
Pastoral Care	Chair – Pastoral Care Committee; FMHS –Fitness to Practice Academic Lead Directors of Medical Students Affairs FMHS Student Support and Engagement Manager Phase 1 Director Year 2 Academic Coordinator Doctor, Paediatrics Associate Professor, School of Medicine; Previous HoP Psychometrician Head of Medical Programme FMHS Student Support Advisor
Evaluation and continuous improvement	Chair Evaluation subcommittee; CMHSE MPD; PPS Domain Coordinator Head of Medical Programme Phase 1 Director Phase 3 Director Psychometrician, Centre for Medical and Health Sciences Education (CMHSE) Senior Lecturer in Health Professional Education, CMHSE Programme Delivery Manager - MPD General Practice - Year 6 Lead
Assessment	Psychometrician Phase 1 Director Phase 2 Director Phase 3 Director Head of Medical Programme School of Medicine; Previous HoP TKHM, Hauora Māori Coordinator Year 6 Chair Clinical Scenarios subcommittee Clinical Skills Assessment General Surgery MPD; PPS Domain Coordinator

Meetings	Roles engaged with
	Lead Clinical Medical Education Fellow (CMEF) Academic Coordinator-Auckland
Rural Medicine	Rural Health Unit Director Business Manager – Rural Health Unit Assessment Lead, RMIP Rural Health Interprofessional Programme (RHIP), Whakatāne, Community Representative Academic Coordinator, RMIP Hāwera & Academic lead RMIP Te Takapau Wananga (TTW), Hokianga, Community Representative Year 5 RMIP student, Te Kuiti Professional Teaching Fellow - Rural Medicine
Board of Examiners (BOE)	Tumuaki FMHS, Head TKHM Deputy Head of Medical Programme Academic Progress Coordinator Psychometrician Head of Medical Programme General Practice - Year 5 Lead Phase 1 Director Phase 2 Director Phase 3 Director Psychological Medicine HoD-Medicine HoD-Surgery Doctors, Obstetrics and Gynaecology
Auckland City Hospital	
Hospital Executive	Chief Medical Officer Chief Health Professions Officer
Academic leads, Teaching and Professional Staff	Professor, Medicine Professor, Surgery Orthopaedic Surgeon Doctors, Paediatrics Doctor, Obstetrics and Gynaecology - Year 5 Lead Group Services Manager-School of Medicine
Clinical academics and Clinical supervisors	Doctors, Medicine Doctor, Obstetrics and Gynaecology Doctor, Anaesthesiology Doctor, Surgery
Students	Year 6 Student / Site Representative Year 4 Students
North Shore Hospital	

Meetings	Roles engaged with
Hospital Executive	Chief Medical Officer Immediate Past Chief Medical Officer
Academic leads, Teaching and Professional Staff	Clinical Campus Dean - Waitematā A/Professor, Surgery Doctor, Geriatric Medicine Professor, Surgery Doctors, Medicine Doctor, Surgery A/Professor, Psychiatry Doctor, Professional Teaching Fellow Site Team Leader
Clinical academics and Clinical supervisors	Doctor, Obstetrics and Gynaecology Doctor, Surgery Doctors, Medicine Doctors, Paediatrics Doctors, Psychiatry Doctor, METU Doctor, Psychiatry and Pacific Health
Students	Year 4 Students Year 5 Students Year 6 Student / Site Representative Year 6 Students
Middlemore Hospital	
Hospital Executive	Acting Chief Medical Officer Immediate past Chief Medical Officer
Academic leads, Teaching and Professional Staff	Doctor, Medicine / Deputy Head of Medical Programme Doctor, Emergency Medicine Doctors, Obstetrics and Gynaecology Doctor, Medicine Doctor, Paediatrics A/Professor, Paediatrics Doctor, Surgery A/Professor, Orthopaedic Surgery Doctor, Geriatric Medicine Group Services Manager - South Auckland Clinical Campus
Clinical academics and Clinical supervisors	Doctor, Paediatrics Doctor, Palliative Care Hon A/Professor, Dermatology Doctors, Medicine Doctor, Prevocational Educational Supervisor (PES)

Meetings	Roles engaged with
	Doctor, Obstetrics and Gynaecology
Students	Year 6 Student / Site Representative Year 6 Students Year 5 Students Year 4 Students
10 September 2025 ***Tauranga Hospital***	
Hospital Executive	Group Director Operations Acting Chief Medical Officer Ex-Chief Medical Officer / HoD General Medicine Clinical Campus Dean – Bay of Plenty Business Leader – Bay of Plenty Clinical Campus
Academic leads, Teaching and Professional Staff	Medicine / Year 6 Coordinator Medicine/ Year 4 Coordinator Doctor, Medicine Doctor, Paediatrics Doctor, Psychiatry Doctor, Surgery Site Coordinators
Clinical academics and Clinical supervisors	Director of Clinical Training Doctor, Paediatrics Doctor, Anaesthesiology
Students	Year 4 Students Year 5 Students / Site Representatives Year 6 Students
Waikato Hospital	
Hospital Executive	Chief Medical Officer
Academic leads, Teaching and Professional Staff	Clinical Campus Dean - Waikato Doctors, Medicine Doctor, Geriatric Medicine Doctor, Obstetrics and Gynaecology Doctor, Surgery - Orthopaedics Doctor, Paediatrics / TKHM Doctor, Psychiatry Doctor, Paediatrics Doctor, Radiology Professor, Anaesthesiology Doctor, Surgery Manager - Waikato Clinical Campus Site Coordinator - Waikato Clinical Campus

Meetings	Roles engaged with
Clinical academics and Clinical supervisors	Doctor, Psychiatry Doctors, Medicine Head of Department, Medicine Doctor, Surgery - Cardiothoracic
Students	Year 4 Students Year 5 Students Year 6 Students Year 6 Student / Site Representative
Whangarei Hospital	
Hospital Executive	Group Director Operations Chief Medical Officer Pou Takawaenga (Māori Directorate)
Academic leads, Teaching and Professional Staff Clinical academics and Clinical supervisors	Academic Coordinator - Northland Doctor, Psychiatry Doctor, Surgery Doctors, Medicine Doctor, Paediatrics Doctor, Psychiatry Doctor, Palliative Care Doctor, Emergency Medicine Doctor, Obstetrics and Gynaecology Site Team Leader
Students	Year 6 Students Year 5 Students
Whangamatā Medical Centre, Rural Medicine Immersion Programme	
Director, Rural Health Unit Academic Coordinator, RMIP Thames Practice Manager/Director Business Manager, RMIP General Practitioners RMIP students	
Turuki Health Centre, Mangere	
Pou Manukura Clinical Directors Student Placement Lead Directors of Nursing	
Shore Care Urgent Care	
Medical Director & Student Supervision Urgent Care Fellow & Student Supervision	

Meetings	Roles engaged with
Practice Manager Professional Teaching Fellow - UoA	
11 September 2025 ***Waipapa Taumata Rau, the University of Auckland Grafton campus***	
Population Health Domain	HoD-General Practice & Primary Health Care Professor, General Practice and Primary Health Care; Population Health Domain Lead Professor, Population Health Intensive Professional Teaching Fellow, School of Population Health Professor Emeritus, Quality and Safety Faculty Sustainability Lead Course Director Population Health 111
Hauora Māori Domain	TKHM, Hauora Māori Domain Lead TKHM, Hauora Māori Coordinator Year 6 Tumuaki FMHS, Head TKHM
Personal & Professional Skills Domain	PCS1 coordinator; PPS coordinator MPD; PPS Domain Coordinator PCS1 Coordinator Professional Teaching Fellow, Lead - PCS2, UIPC, Palliative Care PCS2 (Phase 1), Ethics Lead Year 5 Director of Medical Students Affairs School of Medicine; Previous HoP TKHM, Hauora Māori Coordinator Year 6 Senior Lecturer in Paediatrics, SOM and TKHM
Vice Chancellor	University of Auckland Vice Chancellor Deputy Vice Chancellor Operations and Registrar Deputy Vice Chancellor Education
Health New Zealand – Te Whatu Ora	Chief Medical Officer Director - workforce planning and development Chief Advisor Education (Medical)
Fitness to Practice	Tumuaki FMHS, Head TKHM Chair – Pastoral Care Committee; FMHS –Fitness to Practice Academic Lead Deputy Chair FTP Committee Head of Medical Programme Director of Medical Students Affairs Deputy Head of Medical Programme Phase 3 Director HoD-Psychiatric Medicine School of Medicine; Previous HoP

Meetings	Roles engaged with
Medical Programme Senior Leadership	Dean FMHS Deputy Dean FMHS Tumuaki FMHS, Head TKHM Head - School of Medicine Deputy Head - School of Medicine Head - School of Medical Science Head of Medical Programme Deputy Head of Medical Programme Director of Faculty Operations

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