Accreditation Report: Bond University, Faculty of Health Sciences and Medicine

Medical School Accreditation Committee

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Contents

Acknowledgement of Country ii

Executive Summary 1

Assessment against the Accreditation Standards 10

STANDARD 1: Purpose, context and accountability 12

- **1.1 Purpose** 12
- **1.2 Partnerships with communities and engagement with stakeholders** 14
- **1.3 Governance** 16
- **1.4 Medical program leadership and management** 19

STANDARD 2: Curriculum 21

- **2.1 Medical program outcomes and structure** 21
- **2.2 Curriculum design** 22
- **2.3 Learning and teaching** 26

STANDARD 3: Assessment 30

- **3.1 Assessment design** 30
- **3.2 Assessment feedback** 33
- **3.3 Assessment quality** 34

STANDARD 4: Students 36

- **4.1 Student cohorts and selection policies** 36
- **4.2 Student wellbeing** 39
- **4.3 Professionalism and fitness to practice** 40
- **4.4 Student indemnification and insurance** 41

STANDARD 5: Learning environment 42

- **5.1 Facilities** 42
- **5.2 Staff resources** 43
- **5.3 Staff appointment, promotion and development** 44
- **5.4 Clinical learning environment** 46
- **5.5 Clinical supervision** 46

STANDARD 6: Evaluation and continuous improvement 48

- **6.1 Continuous review, evaluation and improvement** 48
- **6.2 Outcome evaluation** 50
- **6.3 Feedback and reporting** 51

Appendices 52

- **Appendix 1: Accreditation in Australia and Aotearoa New Zealand** 52
- **Appendix 2: Glossary of Acronyms, Abbreviations and Terms** 53
- **Appendix 3: Membership of the 2025 AMC Assessment Team** 55
- **Appendix 3: Summary of the 2025 AMC Assessment Team's Accreditation Program** 56

Table of Figures

Figure 1: HSM Faculty Governance 16

Figure 2: Roles and responsibilities of governance entities 17

Figure 3: Medicine Strategy Group 18

Figure 4: Placements for Years 1 to 3 28

Figure 5: Six pillars for comprehensive program evaluation 48

Figure 6: Quality program assurance process and quality indicators 49

Acknowledgement of Country

The Australian Medical Council (AMC) acknowledges the Aboriginal and/or Torres Strait Islander peoples as the original Australians, and the Māori as the original people of Aotearoa New Zealand.

We acknowledge and pay our respects to the Traditional Custodians of all the lands on which we live and work, and their ongoing connection to the land, water and sky. The Australian Medical Council offices are on the land of the Ngunnawal and Ngambri Peoples. The Bond University, Faculty of Health Sciences and Medicine's main campus is located on the lands of the Kombumerri peoples. The Program operates across many lands across Queensland and New South Wales.

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

Executive Summary

Accreditation history

The Bond University, Faculty of Health Sciences and Medicine was first accredited by the AMC in 2004. An overview of the Program's accreditation and monitoring history by the AMC since 2024 is provided below:

Year & Assessment type	Decision
Bachelor of Medicine / Bachelor of Surgery (MBBS)	
2004: Accreditation	Accreditation granted until 31 December 2011
2006 – 2009: Follow-up assessments	2006: 2004 accreditation decision confirmed 2007: 2004 accreditation decision confirmed 2008: Accreditation period reduced to 31 December 2009 2009: Reinstated accreditation until 31 December 2011
2011: Accreditation extension submission	Extension of accreditation granted for four years (maximum period) until 31 December 2015
2015: Material change	Planned transition from MBBS to MD not considered a material change and assessed in conjunction with 2015 reaccreditation assessment
Bachelor of Medical Studies/Doctor of Medicine (BMedSt/MD)	
2015: Reaccreditation	Accreditation granted for six years (maximum period) until 31 March 2022
2021: Material change	Plans to offer a second cohort intake in September considered a material change Accreditation confirmed until 31 March 2022
2021: Accreditation extension submission	Extension of accreditation granted for four years (maximum period) until 31 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.

An AMC team (the team) conducted a reaccreditation assessment of the Bond University, Faculty of Health Sciences and Medicine's, and met with staff (academic and operational), medical students, clinical supervisors and other groups involved in the delivery of the Program. The team visited clinical training sites in Brisbane, Gold Coast and Tweed Valley. The full team member composition can be found in Appendix 2.

When undertaking accreditations the AMC refers to the:

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

The goals of the report are to:

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

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

Decision on accreditation

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

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

The AMC's Medical School Accreditation Committee at their 16 February 2026 meeting resolved that:

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

ii. that accreditation of the five-year Bachelor of Medical Studies/Doctor of Medicine (BMedSt/MD) medical program (delivered over four years and eight months) of the Bond University, Faculty of Health Sciences and Medicine be granted for six years, to 31 March 2032;

iii. that accreditation of the program is subject to meeting the conditions contained in the accreditation report, and to meeting the monitoring requirements of the AMC, which may include a monitoring visit during this period.

Conditions on accreditation

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

Condition	To be met by
Standard 1: Purpose, context and accountability	
1. Develop and implement a comprehensive framework of engagement with the community groups served by the medical program. The framework should: a. Identify community groups or organisations that are experiencing health inequities and Aboriginal and Torres Strait Islander peoples within their influence. b. Facilitate representation by community representatives, groups or organisations in governance and decision-making processes (e.g. First Nations Health Committee, etc). c. Define methods for contributing systematically to the design, evaluation, and continuous improvement of the medical program. d. Systematically review the value of community placements to ensure sustainability beyond relationality. (Standard 1.2.1 and 6.1)	2027
2. Consult with the students and their representatives to evaluate and identify mutually beneficial partnerships and effective participation and visibility in the governance and decision-making of their medical program. (Standard 1.3.4)	2027
3. In collaboration with Aboriginal and Torres Strait Islander peoples and partners, provide evidence of appropriate Aboriginal and/or Torres Strait Islander representation at all levels of governance and medical program operations through: a. Ensuring there is identified First Nations leadership at senior governance positions at the University level (medical education provider). (Standard 1.3.1) b. Investment in recruitment to academic positions in the First Peoples Health team, that is scalable and sustainable, to expand capability and capacity to deliver the goals of the University, Faculty and medical program, including involvement in decision-making processes. (Standard 1.3.5, 1.4.4 and 5.2.3) c. Increasing Aboriginal and Torres Strait Islander representation among academic staff, clinical supervisors and professional staff across all levels of the program. (Standard 1.4.4 and 5.2.3)	2027
Standard 2: Curriculum	
4. Finalise and implement the First Nations Health Curriculum Framework and the Curriculum, demonstrating: a. A sustainable plan and timeline for implementing and integrating the First Nations Health curriculum in the Bachelor of Medical Studies/Doctor of Medicine programs. b. Medical program outcomes for graduates addressing the place-based cultural and spiritual needs of equity groups, particularly Aboriginal and/or Torres Strait Islander Peoples and communities. c. Aboriginal and/or Torres Strait Islander health content is vertically and horizontally integrated throughout the curriculum, including clinical aspects related to	Finalise by 2027, implement by 2028

Aboriginal and/or Torres Strait Islander health across all program disciplines and how non-Indigenous program staff are accountable in this process. d. The Aboriginal and/or Torres Strait Islander health curriculum has an evidence-based design based on a strengths-based framework, led and authored by Aboriginal and/or Torres Strait Islander health experts. e. Support for Aboriginal and/or Torres Strait Islander staff to undertake and engage with learning and teaching research and scholarship, to inform learning, teaching and assessment. f. Engagement with Aboriginal and/or Torres Strait Islander staff and community members to develop a research agenda that will support and enhance Aboriginal and/or Torres Strait Islander health teaching, learning, and assessment. (Standard 2.1, 2.2.2, 2.2.3, 2.2.4)	
5. Develop and implement culturally safe learning and teaching policies and practices informed by Aboriginal and/or Torres Strait Islander knowledge systems and medicines. This should include appropriate resourcing across learning environments to support student development in culturally safe practice. (Standard 2.3.7)	Develop by end 2026, implement and resource by end 2027
6. Develop and implement within the medical program enhanced opportunities for students to: a. Have formal and clinically focused learning experiences, including interprofessional practice, which are logically sequenced, meaningful, practical and assessable. (Standard 2.3.3,2.3.4 and 3.2.1) b. To learn and address the differing needs of community groups experiencing health inequities, including Aboriginal and Torres Strait Islander communities. (Standard 2.3.6) c. To gain experiential learning in regional, rural and remote healthcare settings in Australia. (Standard 2.3.8 and 5.4.1)	Develop by 2027, implement 2028
7. Develop and implement a pre-internship program aligned with graduate outcomes, with a defined plan and timeline for integration in the Doctor of Medicine program. The program should: a. Collaborate with students and clinical supervisors in the design and implementation of the pre-internship program. b. Evaluate the quality of placements (clinical and community) as appropriate and adequate preparation for internship and meeting the AMC graduate outcomes. (Standard 2.3.9)	Develop during or by the end of 2026, and implemented by the end of 2027
Standard 3: Assessment	
8. As part of the implementation of the First Nations Health Framework and Curriculum, a. Provide evidence of the assessment of Aboriginal and/or Torres Strait Islander health and culturally safe practice across the Program, mapped to Program outcomes, and outline actions to address gaps identified in core clinical competency mapping. b. Demonstrate that the assessment of culturally safe practice is consistently integrated across disciplines and practice settings and is underpinned by a strengths-based approach.	2027

c. Incorporate regular evaluation of the implemented curriculum to support further development. (Standard 3.1.6)	
9. Implement a formal process for delivering timely, individualised OSCE feedback to students, and progress planned digital enhancements to this process. (Standard 3.2.1)	2026
Standard 4: Students	
10. In consultation with Aboriginal and Torres Strait Islander peoples and communities, develop and implement sustainable, well-resourced strategies for the recruitment, retention, and graduation of Aboriginal and/or Torres Strait Islander students. These strategies should ensure: a. Discrete cohort targets and program-led recruitment. b. Improvements to financial support for Aboriginal and Torres Strait Islander students. c. Appropriate financial and staff resources allocated to expand outreach, recruitment, and retention, including for the Nyombil Centre. d. Assured access to cultural leave to reduce burden on students. (Standard 4.1.2, 4.1.3 and 4.2.5)	Develop 2026, implement 2027
11. Develop and implement strategies to systematically enhance recruitment, retention, and graduation rates of students from equity groups and rural backgrounds, with specific targets. (Standard 4.1.2 and 4.1.3)	Develop by end 2026, implement by end 2027
12. Develop and implement confidential, accessible, and culturally safe support services for Aboriginal and/or Torres Strait Islander students, with sufficient staff and resources allocated. An ongoing communication plan to inform students of the support options should accompany implementation. (Standard 4.2.2 and 4.2.7)	Develop 2026, implement 2027
Standard 5: Learning environment	
13. Develop and implement a defined and sustainable strategy for recruiting and retaining Aboriginal and/or Torres Strait Islander staff with appropriate plans for succession planning. Staffing capacity should align with the expected outcomes of the implementation of the First Nations Health Curriculum Framework and Curriculum, recruitment and cultural safety initiatives. (Standard 5.2.3)	Develop 2026, implement 2027
14. To ensure the Program achieves its outcomes, review and strengthen existing approaches, identifying and recruiting patients and community members for active engagement in learning and teaching activities. Implemented processes should be inclusive, well-resourced, and genuinely reflect the breadth of communities served by the Program. (Standard 5.2.5)	2027
15. Develop and implement a culturally safe system for measuring the success of Aboriginal and/or Torres Strait Islander staff, ensuring that indicators of achievement reflect culturally appropriate measures and are embedded within the appointment, promotion, and performance review processes. (Standard 5.3.1)	Develop 2026, implement 2027
16. Strengthen and incorporate ongoing cultural safety training for all staff, clinical supervisors, and students, ensuring participation is mandatory and compliance is monitored as part of embedded professional development. (Standard 5.3.4)	2027

17. As part of the First Nations Health Curriculum Framework and Curriculum, develop and implement structured, culturally safe opportunities for students to deliver health care to Aboriginal and/or Torres Strait Islander peoples and communities. (Standard 5.4.2)	Develop 2027, implement 2028
Standard 6: Evaluation and continuous improvement	
18. Provide evidence that feedback from students, staff, prevocational training providers, health services and communities is systematically utilised to inform program improvement. (Standard 6.1.2)	2027
19. Provide evidence that program outcomes for cohorts of students from equity groups, including Aboriginal and/or Torres Strait Islander students, are formally and consistently evaluated, and shared through governance channels. Evaluation of Aboriginal and/or Torres Strait Islander cohorts must be informed by Aboriginal and/or Torres Strait Islander education experts. (Standard 6.2.4 and 6.3.1)	2027
20. Provide evidence that there are formal procedures for sharing evaluation results with stakeholders interested in graduate outcomes and consider their views in continuous evaluation and improvement of the program. Stakeholder groups identified should include pre-vocational training providers and co-located schools. (Standard 6.1.2 and 6.3.1)	2027

Commendations

A	The Bond University, Faculty of Health Sciences and Medicine program's purpose is clearly articulated, aiming to prepare students to be leaders and contributors to the health workforce. (Standard 1.1.1)
B	The medical program explicitly targets the specific needs of local communities and has established strong, sustainable partnerships with general practices and community placement providers to enhance training opportunities. (Standard 1.1.2 and 1.2.2)
C	The valuable partnership with the Elder in Residence provides cultural guidance for program development, while the Institute for Urban Indigenous Health (IUIH) offers students practical experience in Aboriginal Community-Controlled Health Organisations. (Standard 1.2.3)
D	The governance structure of the University and Faculty, including roles and responsibilities, are clearly outlined and documented, with oversight from both academic and professional perspectives for the medical program. (Standard 1.3.1, 1.3.2)
E	The Dean of Medicine, along with the academic leadership team and professional staff, have clearly defined roles and are dedicated to delivering a high-quality, impactful medical program. (Standard 1.4.2 and 1.4.3)
F	The First Nations Health team is highly capable and well-prepared to meet the requirements for integrating and implementing the First Nations Health Curriculum. (Standard 1.4.4)
G	The Program has a clear purpose with structured learning outcomes aligned with AMC graduate outcomes, featuring a spiralled and thoughtful curriculum design that provides a wide and deep range of integrated and innovative learning opportunities for students transitioning into supervised practice. Key areas of innovation are:

	• Inclusion of community placements and volunteer initiatives, development of communication, critical thinking skills and civic discourse as part of the core curriculum. • Incorporation of Clinical Placement Coaches in learning environments offering peer-to-peer support for students. • The design of a case-based learning model and Bond Virtual Healthcare sessions to support students in integrating knowledge, skills, and professional behaviours in a structured environment. • The capstone project allows students to engage with and contribute to resource-limited healthcare settings in a local, interstate, or international environment. • Introduction of the Continuing Professional Development Portfolio (CPD), complementing the capstone project, to develop student learning autonomy.
H	The Core Clinical Conditions and Competencies Matrix (4CM) establishes a framework for essential clinical conditions and competency levels for graduating medical students.
I	The work and support of the First Nations Health team and Elder in Residence on advancing the First Nations Health Curriculum, cultural safety and First Nations health and equity initiatives.
J	The involvement of students and leadership in the LGBTIQA+ Curriculum Review and research into Planetary Health as developing commitment to health equity.
K	The program has a comprehensive and well-structured assessment framework aligned with medical program outcomes and curriculum and delivered to a high standard. (Standard 3.1)
L	There is exemplary dedication to purpose-driven, quality assessment methods, led by highly skilled Assessment Leads. (Standard 3.1)
M	The introduction of the CPD Portfolio in the BMed fosters professionalism, student independence, and accountability. (Standard 3.1.1, 3.1.2 3.1.4, 3.1.5)
N	Innovative use of technology (ExamSoft and the Osler ePortfolio) and Clinical Placement Coaches support student progression and improve feedback provided to students in real time. (Standard 3.1.1 & 3.1.4).
O	A clear governance structure ensures strong oversight, along with regular review and enhancement of assessment practices. Paired with benchmarking activities, this guarantees comparability of standards with other medical programs. (Standard 3.3.1)
P	The BondAbility program plays a vital role in supporting students with disabilities, both prior to admission and throughout the course of their studies. (Standard 4.1.4)
Q	Academic and professional staff are committed to student wellbeing and to providing a safe and supportive environment for students, with a range of strategies developed to support student wellbeing and inclusion. (Standard 4.2.1)
R	There is significant investment in high-quality, state-of-the-art facilities, including the Bond University Clinical Education and Research Centre (BUCERC) expansion and the Bond Institute of Health & Sport (BIHS) North building, which provide an outstanding learning environment for students. (Standards 5.1.1 and 5.1.2)

S	Commitment and value are demonstrated by professional staff, particularly the student placement coordinators, who are highly regarded by both students and colleagues for the high-quality support and assistance they provide on-site. (Standard 5.2.1)
T	Bond-funded educational roles at clinical sites, such as Sub-Deans and Clinical Placement Coaches, provide local leadership and strengthen supervision and student support, complemented by the Clinical Advisory Board, which fosters effective governance and communication. (Standard 5.4.1, 5,5,1 and 5.5.2)
U	The implementation of a comprehensive evaluation protocol based on a six-pillar model, incorporating insights from a scoping review of program evaluation practices across medical schools.

Recommendations for improvement

I	Given the imminent expansion of the medical program, identify strategies to: • Ensure governance structures remain effective and responsive to changing needs, including reducing single-point decision risk. • Enhance communication of governance decisions to all stakeholders • Improve feedback processes and two-way communication with partners that support student education and training locally to ensure mutually beneficial collaborations • Embed evaluation in expansion plans and ensure stakeholders are consulted on program changes with direct impact to them. (Standard 1.2.2)
II	Integrate planetary health content across all years of the curriculum. (Standard 2.2.4 and 2.2.10)
III	Evaluate the Clinical Placement Coach Program to determine its effectiveness and areas for improvement, ensuring experiences of comparable quality. (Standard 2.1.2)
IV	Integration of First Nations research methodologies to further strengthen research scope and capabilities. (Standard 2.2.4)
V	Implement a system that consistently shares student cohort performance data collected by clinical sites with the Program and relevant supervisors to drive curriculum improvement. (Standard 3.2.3)
VI	To accommodate increasing student numbers, assess whether: a. Clinical placements and teaching time in all disciplines will meet the needs of growing student cohorts, especially in high-demand areas. b. The balance of hospital opportunities as preparation for internship, including in rural and remote areas, is effective. c. The workload of clinical placement staff and supervisors is sustainable. (Standard 5.1, 5.2 and 5.4.1)
VII	Identify communication gaps with clinical supervisors to enhance information sharing, strengthen feedback loops, and ensure consistent supervision quality across all placement sites. (Standard 5.5.1 & 5.5.2).
VIII	Review and refine current processes for gathering feedback from students to enhance engagement, ensuring they are assured that their feedback is actively used to improve the program. (Standard 6.1.2)

IX	Provide evidence of student performance (particularly performance at clinical sites) being evaluated in relation to student characteristics and of this evaluation being effectively fed to relevant committees. (Standard 6.2.3)

Monitoring and next steps

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

1. The implementation of the timetabling project, and any evaluation done to ascertain if project goals have been achieved, especially around improvements to students' learning and well-being. (Standard 2)
2. The impact of the Child and Young Person Simulated Participant program introduced in 2025. (Standard 2)
3. Implementation of the CPD portfolio, including how it supports student learning and professional development, with clear evaluation measures, outcomes, and subsequent improvements. (Standard 3.1.1, 3.1.2 and 3.2.1).
4. Findings and analysis of the planned scholarly investigation into the transition from scored to competency grading in the pre-clinical years (3.1.1).
5. Introduction of the Bond CORE subjects in Years 1 and 2 and their assessment as potential opportunities for interprofessional learning and assessment. (3.1.4)
6. The planned expansion to 20 procedural skills by graduation over the next five years to ensure both feasibility and educational value. (3.1.4)
7. The progress of full integration of OSCE marking to Examsoft, and any feedback from students on the feedback process. (3.2.1)
8. Performance data from Limited Open Book Progress Tests to ensure written examinations retain validity and reliability while enabling greater flexibility in student placements. (Standard 3.3.1)
9. Uptake and consistent application of online supervisor training modules across all clinical sites, including plans for sustained engagement. (Standard 3.3.1)
10. Provide an update on collaboration with education providers of primary medical programs to ensure equitable distribution of placement opportunities within the capacity of clinical placement positions in Queensland and New South Wales. (Standard 5.4.1)
11. Provide an update on ways the Program supports students to address practical concerns (i.e. travel and accommodation), with the increase in student placement opportunities. (Standard 5.1.3)

Appreciation

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

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

Assessment against the Accreditation Standards

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

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

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

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

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

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

ITEMISED OUTCOME OF ACCREDITATION ASSESSMENT

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

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

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

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

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

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

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.

Bond University's Faculty of Health Sciences & Medicine (the Faculty) clearly defines its purpose as a primary medical education program to equip its students to be leaders and contributors to the health workforce. The Faculty aligns itself with the University's Strategic Plan (2023-2027), the institution-wide Innovate Reconciliation Action Plan, and has developed a Research Plan (2023-2027) to foster a research ecosystem in collaboration with industry partners.

The medical program, an undergraduate entry program comprising the Bachelor of Medical Studies and the Doctor of Medicine, sits within the Faculty of Health Sciences and Medicine. In line with preparing graduates to address local challenges, the Program has committed to increasing recruitment of students from Queensland and Northern New South Wales. The Program aims to cultivate a comprehensive understanding of the healthcare needs of the Australian population through a life cycle approach to curriculum design and delivery.

The Bachelor of Medical Studies has a case-based curriculum, with early hands-on clinical experience and research-driven learning. The curriculum is structured around four domains: clinical practice, professionalism and leadership, health and society, and science and scholarship.

The Bond Medical Program is a five-year undergraduate-entry program, that students can complete in four years and eight months. The first three years (or two years and eight months) of the Bachelor of Medical Studies lead into the transition to the MD, where foundational knowledge is connected to practical experience. The final two years of the MD are based on clinical placements across diverse healthcare settings and simulated learning environments. The Program uses a number of innovative learning and assessment methods:

- Starting in 2025, the CPD portfolio has been integrated into the first three years to promote lifelong learning. This will involve an assessed portfolio through which students' competencies will be monitored using the Osler dashboard, which also tracks compliance with the course requirements. The team noted the usefulness of this resource in recording and providing data on student progress.
- Students reported the Bond Virtual Healthcare program as a useful, safe, and low stakes learning environment.
- As part of the requirement for an MD, students engage in research during the Program. Research collaborations can offer students opportunities to access data and work in multidisciplinary groups to understand how to translate findings into meaningful healthcare improvements.
- Another development related to medical education and research is the Tweed Valley Hospital Training Hub, which Bond University partially funded.
- To broaden the student experience, the Simulated Participant Program has expanded, connecting students with community members from a more diverse range of backgrounds. Sequential clinical

placements are provided across a range of hospital, general practice, and community settings, with a capstone clinical experience being available.

- The capstone rotation offers immersive elective placements for students overseas, including the wider Pacific region, giving them healthcare learning and working experiences in resource-limited environments. Several research institutes and a primary care practice-based research network are involved. A Professor of Community Clinical Education has been appointed to advance the goals surrounding healthcare equity.
- The Clinical Placement Coaches Program supports workplace-based learning by offering feedback and informal teaching during clinical placements. This program is regarded as a valuable innovation, is well supported by staff with assigned roles and resources and well aligned with the expectations of the program and students to meet program outcomes.

Additionally, from 2020 onwards, students undertake community placements (within the MD) with local organisations to enhance their exposure to community healthcare across various settings. Community placements have developed over time, and students are increasingly becoming part of the team at placement sites. However, the team has received mixed reports on the value of these placements. It will be essential for the Program to continually monitor the outcomes of these placements and support the providers in building capacity to offer learning experiences aligned with the graduate outcomes. The team recognises an infrastructure is in place to support this, along with the community groups' willingness to host placements. It will be crucial to formalise and embed placement requirements and support mechanisms to reduce reliance on informal relationships with key personnel at sites.

Feedback from clinical placement sites indicated a high percentage of the program's graduates return to work as interns in the region, and health services are largely positive about the capabilities of graduates.

This report explores in detail the design of the Program's curriculum and assessment under Standard 2.2 and Standard 3.1, respectively.

The University has stated a commitment to advancing Aboriginal and Torres Strait Islander health equity. A range of initiatives support this commitment, including the Reconciliation Action Plan, the establishment of a First Nations Health team, the appointment of First Nations Health academics, and engagement with Aboriginal and/or Torres Strait Islander community groups. The Faculty is committed to closing the gap in medical education and health for Aboriginal and/or Torres Strait Islander peoples.

The establishment of the First Nations Health Team has developed a model to provide leadership and accelerate plans to develop and integrate the First Nations Health curriculum and other initiatives. Plans are underway to expand the First Nations Health team, noting that the team will play a key role in learning and teaching, curriculum development, and continuous improvement of the Program.

The Program reported that First Nations health education is integrated throughout the Program to support students' learning about providing culturally safe care. The team noted these plans and the need for resourcing and timelines to ensure this is implemented over the next year (2026).

The team acknowledges the dedication and goodwill of the University, Faculty and Program staff in promoting equity for Aboriginal and/or Torres Strait Islander peoples. The team encourages reflection across various areas to determine if current mechanisms enable the University, Faculty, and Program to meet their aims for First Nations Health, including accountability for the safety of Aboriginal and/or Torres Strait Islander staff, students, and communities it works with. These areas include:

- The absence of a designated senior academic leader, such as a Pro-Vice Chancellor or Deputy Vice-Chancellor Indigenous (PVCI or DVCI), to promote Aboriginal and/or Torres Strait Islander education and research, guide strategies for enhancing Aboriginal and/or Torres Strait Islander health, and foster relationships with communities and organisations. This position would also support reducing barriers and conflict for Aboriginal and/or Torres Strait Islander staff working across the university. (Standard 1.3.5 and 1.4.4)

- The current pathway for Aboriginal and/or Torres Strait Islander students into the Program, with a scholarship available for Aboriginal and/or Torres Strait Islander students is noted. The team strongly recommends these initiatives secure additional resourcing and planning to enhance effectiveness to achieve their intent. (see Standards 4.1.2 and 4.1.3)
- Students were unaware of confidential reporting mechanisms or safe avenues to report incidents of culturally unsafe/racist behaviours experienced or witnessed in learning environments. (see Standard 4.2.7)
- The University has established partnerships to support cultural awareness and community engagement, and staff are required to complete the University's cultural awareness training program. There did not, however, appear to be evidence of further development in this area. (see Standard 5.4.3)

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 team noted the Faculty and Program's commitment to engaging with community groups within the Program through various student learning experiences and place-based centres. It is noted that the Simulated Participant Program was co-designed with simulated patients to ensure authentic learning experiences to prepare students for clinical work. The Faculty's Expert Patient Engagement Working Group, with medical program and Aboriginal and/or Torres Strait Islander staff representation, aims to enhance the involvement of individuals with lived experiences. This Working Group could play a valuable role in curriculum development and evaluation if well-structured and monitored for effectiveness.

The Program connects with partners through the Gold Coast Primary Health Network and has placement agreements with major teaching sites in the Gold Coast and Northern New South Wales, including both private and public hospitals. The proactive effort to engage with General Practice (GP) settings is seen as a crucial step in developing and maintaining effective partnerships that support the education and training of Bond medical students. Funding arrangements vary across different partnerships, offering necessary flexibility.

The Program's leadership collaborates with other universities with medical programs on the Gold Coast in a joint committee on areas of mutual interest (e.g., placements), with evidence of consultation with the state government and prevocational health organisations. The Program collaborates with Prevocational Medical Accreditation Queensland and is involved in ongoing discussions through the Medical Schools Liaison

Committee. At a jurisdictional level, there is a regular meeting with Queensland Health, where all education providers attend. This provides a platform for strategic discussions on placements, curriculum and internship placements. As there are projections for increasing student numbers in the region over coming years, it will be important to ensure efficiency and collegiality in these collaborative meetings.

The Program has a range of partnerships with health services and coordinating organisations. The Northern New South Wales Academic Health Alliance is a positive part of the governance and provides a place to discuss placements etc. NSW Health Education and Training Institute (HETI) is not as integrated with the Bond medical program as it is with the medical programs in New South Wales. It was noted that requests such as accommodating mid-year intern positions can be problematic as they have to be managed on an ad hoc basis, rather than a streamlined national process. At a jurisdictional level, there is a regular meeting with Queensland Health, where all education providers attend.

The Faculty has a strong connection with a Traditional Custodian of the Gold Coast region, who also serves as Elder in residence. There is evidence of an effective partnership with him and of his inclusion in the Faculty's work. The formal partnership with the Institute for Urban Indigenous Health (IUIH), with a Medical Program funded dedicated position to coordinate student placements in community health clinics, supports the Program's goals for community engagement. Bond University has established partnerships to support cultural awareness and community engagement, and staff are required to complete the University's cultural awareness training program (a micro-credential online course and On-Country cultural immersion).

The team met with Aboriginal and/or Torres Strait Islander staff and the Bond University Elder-in-Residence, and affirmed that he is integral to the University's connection with the community, providing specific cultural guidance to staff and students. There is evidence of significant expertise and commitment among the First Nations staff, and the Faculty is encouraged to ensure there is adequate support for their role in stakeholder and community engagement.

The various initiatives and the establishment of the First Nations Health Committee provide an opportunity for stakeholder involvement in the evaluation of the Program. While this is a positive initiative and the Committee is chaired by a staff member who identifies as Aboriginal and/or Torres Strait Islander, a general lack of robust Aboriginal and/or Torres Strait Islander representation was noted. The Program should look into ensuring appropriate representation by Aboriginal and/or Torres Strait Islander peoples on this committee, with related supports provided. are appropriately represented and supported to be on this committee.

A community of practice is being established with regional universities to support the development of mutually beneficial partnerships with Aboriginal and/or Torres Strait Islander people and organisations. The aim is to foster collaboration, share resources, and strengthen partnerships. The formal agreement with the Institute for UIH is valuable for the Program, advancing the Program's goals for meaningful community engagement.

Beyond these activities, the team has observed limited evidence of the Program actively engaging community groups and organisations within its scope in defining, designing, implementing, and evaluating the Program and its outcomes. The commitment to Aboriginal and/or Torres Strait Islander health is noteworthy; however, the Program needs to also consider other communities that experience health inequities and extend its reach to include community and/or patient experiences beyond those involved in the Expert Patient Engagement Working Group. Several partnerships have been developed for community placements, e.g., providing students with experience in education of students with disabilities and aged care. These relationships appear to be strong, and the organisations feel supported and are treated the same as clinical placements in terms of financial reward. The Program could explore ways to offer opportunities for these organisations to contribute to curriculum development and use broader advertising to attract a diverse range of partners.

Feedback from community partners about engagement with the program is positive, evidencing that partnerships are effective and mutually beneficial. More could be done to improve evaluation practices with the communities served by the Program, as there is limited evidence of strong engagement in the program development or continuous improvement activities. (see Standard 6.1.2)

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.

Bond University was established in 1987 as a not-for-profit entity wholly owned by Bond University Limited, a public company limited by guarantee. Elected University Councillors serve as the Board of Directors, chaired by the Chancellor, and the Vice Chancellor serves as Chief Executive Officer. The Board is accountable for the University's operations. The University Academic Senate serves as the principal academic advisory body to the Vice Chancellor, who also leads the University Management Committee. This Committee comprises members, including the Provost and Faculty Executive Deans. The Faculty Executive Committee serves as the central decision-making body for the Faculty, reporting to the University Management Committee and connected with other governance bodies, including the First Nations Health Committee and Heads of Programs. The First Nations Health Committee operates as an Advisory Committee reporting to the Executive Dean and the Faculty Executive Committee.

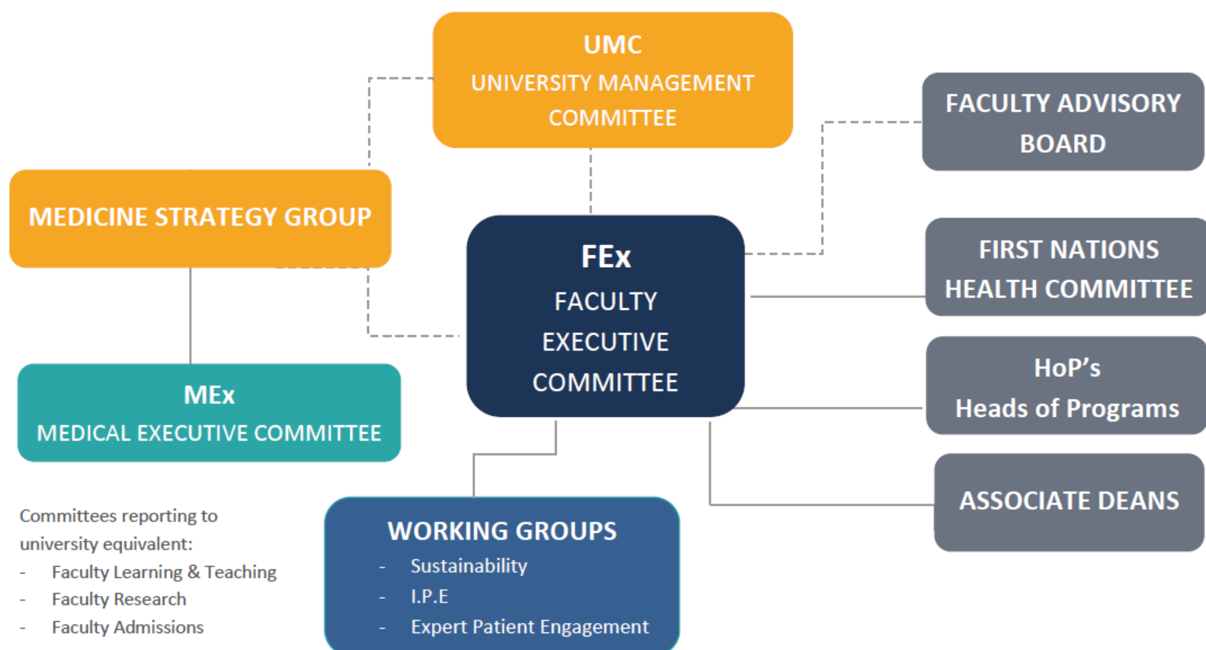

Figure 1: HSM Faculty Governance

The Program's governance demonstrates the capacity to review and respond to the need for change. There is a Faculty Review Policy to guide regular reviews, which the Faculty conducts at least once every seven years to ensure continuous improvement and best practice. Evidence shows regular reviews of the structure to ensure leadership and committees can achieve Program outcomes, with the 2023 governance review of the medical program leading to the current framework. The revised framework establishes a clear structure defining executive, strategic and operational roles. Each committee has a documented composition, terms of reference and reporting relationships.

The key medical program committees are:

Committee	Roles and Responsibilities
Medicine Strategy Group	Serves as a key advisory body to the Medicine Executive Committee. Chaired by the Executive Dean of the HSM Faculty and including the Vice President Operations, it provides guidance, direction, and risk mitigation to sustain high-quality, contemporary medical education.
Medicine Executive Committee (Mex)	Provides high-level strategic direction and oversight. Chaired by the Dean of Medicine, it ensures strategic leadership and alignment with university-wide objectives, reporting to the Medicine Strategy Group. It oversees MeLT, MeRC, and the Medicine Admissions Committee.
Medicine Learning & Teaching Committee (MeLT)	Reports to MEx and oversees curriculum design, review, and implementation, ensuring compliance with AMC accreditation standards. Specialised task groups focus on curriculum enhancement, assessment improvements, and faculty development.
Medicine Research Committee (MeRC)	Reports to MEx and supports research engagement, scholarly activities, and research planning to contribute to the Medical Program's long-term development.
Medicine Admissions Committee	Reports to MEx and ensures transparency and academic rigor in student selection processes, contributing to the integrity and quality of student admissions.

Figure 2: Roles and responsibilities of governance entities

The lack of an independent role for evaluation is noted, and it will be important to ensure some level of external review as changes are proposed. There are clear processes to ensure oversight of the curriculum revisions is maintained, e.g. for subject outcomes, with minor changes going through the Program governance and major changes going through Faculty-level learning and teaching committees and their review process.

The team found that the University and Faculty's governance structure, roles, and responsibilities are clearly defined and documented, with academic and professional oversight of the Program. The Dean of Medicine reports to the Executive Dean of the Faculty, and the structure of a Dean and co-leads, with clinical discipline leads, year convenors, domain leads, and a sub-Dean, amongst other roles functions well. This structure ensures a breadth of input to, and oversight of, the Program.

The Associate Dean, Learning and Teaching is a key role for oversight of curriculum development and academic quality. Student support and progress is managed by the Associate Dean, Student Affairs and Service Quality. The leadership structure appears to be working well, and having two co-leads for the Program makes the leadership team more sustainable. It will be important to ensure people understand the team structure and that the Dean of Medicine is not solely relied upon for decision-making to ensure continuity and reduce single-point decision risk

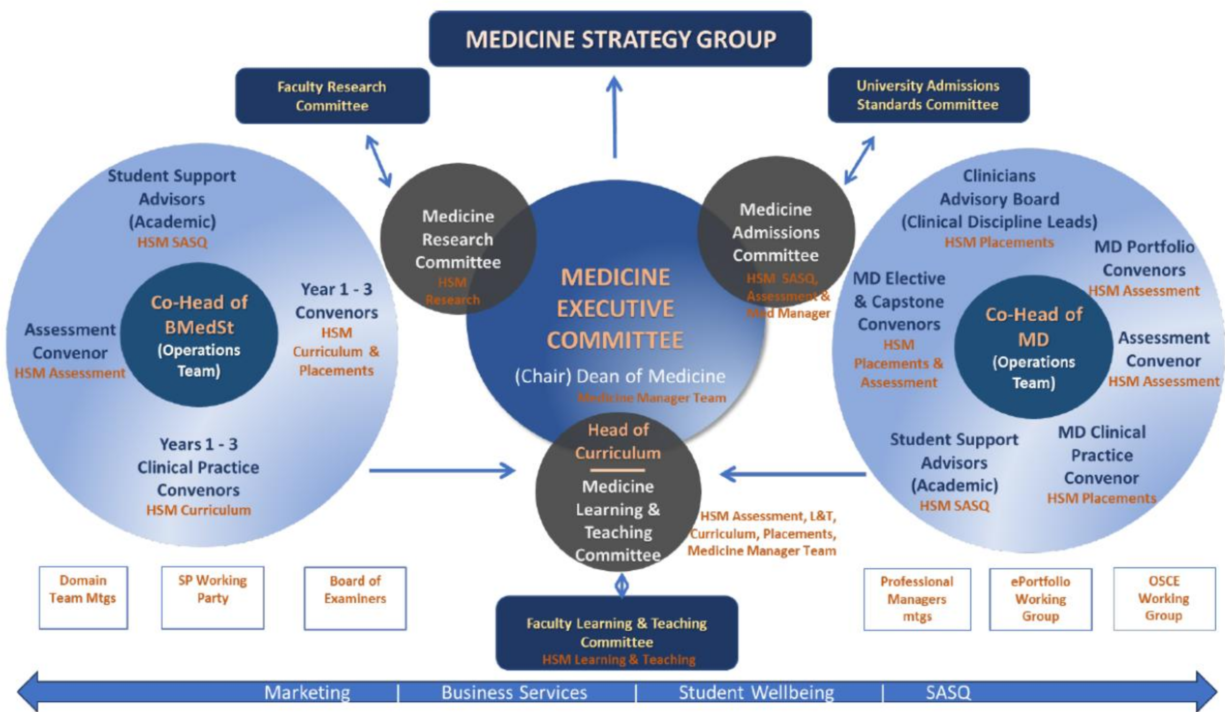

Figure 3: Medicine Strategy Group

The team observed a strong commitment to curriculum development and innovation, along with a student-centred approach in the Program. There is clear evidence of curriculum renewal, broad staff engagement, and effective academic oversight. The Clinicians Advisory Board offers a valuable forum for feedback on students' preparation for clinical placements, their performance during placements, and the design of placements to enhance learning. There is evidence of sufficient professional staff support to meet Program needs, and as student numbers have increased, the team has expanded accordingly.

There is a commitment to embed students in formal governance structures, and student representative roles are included in key committees, including the Medicine Learning and Teaching Committee (MeLT). The Student-Staff Liaison Committee serves as the formal advisory body providing a conduit between students and staff, enabling students to raise concerns and collaborate on Program objectives. The team noted the minutes from MeLT and the Student-Staff Liaison Committee (SSLC) demonstrate the extent to which the Program leadership are covering issues relating to students and being open or responsive to feedback. While there appear to be formal mechanisms for student involvement in the governance of the Program, feedback from students indicates a general lack of involvement in decision-making and a sense of partnership in the process. Further support from the program is needed to promote meaningful participation of students in decision-making. It will be important for the Program to explore where the mismatch in perceptions occurs and how partnership with students can be strengthened, including improving support to participate in Program governance and decision-making. There seemed to be a differing perception of the frequency of meeting with the Executive and Dean, so it may be valuable to formalise these meetings and expectations, particularly given the agile nature of the Program.

The Faculty and Program aim to progress the inclusion and engagement of Aboriginal and/or Torres Strait Islander people across the Faculty by consulting widely and advising on the development and implementation of the Aboriginal and/or Torres Strait Islander health curriculum and research activities. The team notes Aboriginal and/or Torres Strait Islander staff are represented in all levels of governance within the Program and at the Faculty level as members on various committees. The Professor of First Nations Health has a close

formal working relationship with the Dean and the Executive Dean, which enables contribution to high-level strategy and decision-making. Aboriginal and/or Torres Strait Islander academics participate in the governance and decision-making of the Program, noting there is a small team at this stage and a continued risk of overload.

Aboriginal and/or Torres Strait Islander staff and clinical supervisors are essential in shaping the outcomes of the Program, and in the implementation of the First Nations Health Curriculum Framework. The implementation will require Program leadership and the Executive Dean to provide oversight, evaluation, and suitable resources. The University should consider establishing an identified position within senior governance levels, such as PVCI or DVCI, to ensure the goals of improving Aboriginal and/or Torres Strait Islander health and equity are effectively achieved.

There are university-wide policies to manage the Code of Conduct and Faculty guidelines for declaring interests, followed by the medical program. A structured conflicts of interest disclosure process is applied in various activities, including candidate selection, teaching and assessment, clinical and research supervision, board memberships, and external roles. These disclosures must be reported to the Faculty Executive Dean, Dean of Medicine or Manager in accordance with the relevant clause in the Staff Code of Conduct Policy.

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

The University has the financial resources to sustain the Program and its requirements. There is evidence of structured financial planning and commitment to investment in resources and infrastructure, and there are no concerns about resource adequacy. Students in the Program are primarily full-fee-paying domestic students, with a small number of full-fee-paying international students through the lateral entry pathway. An annual budget planning process exists, and strategic requirements for capital and human investment are identified and discussed at the Medicine Strategy Group, chaired by the Executive Dean. Given the imminent need to implement the First Nations Health Curriculum Framework and improve support of Aboriginal and/or Torres Strait Islander student success, the Faculty is encouraged to consider ways to ensure that resources are aligned accordingly.

As discussed in Standard 1.3.3, the Dean of Medicine and the academic leadership team have clearly defined roles and are committed to delivering a high-quality, high-impact medical program. Since the governance review in 2023, the Dean of Medicine is supported by a well-qualified leadership team with defined roles covering curriculum, assessment, and program management. The development of shared MD and BMedSt Program leadership roles provides support for the development of leadership capacity as well as leadership continuity around periods of leave. During the visit, Program staff confirmed that senior staff (aside from the

Dean, Head of Curriculum and Head of Assessment) have been appointed to service roles allowing flexibility to change roles after a period of time (usually three years).

Given the governance structure is relatively new, the effectiveness of this structure and the realisation of more distributed and shared decision making will need monitoring over time. There is significant expertise across the senior academic staff involved with the Program, and it is noted that the six most senior staff reporting to the Dean of Medicine have active programs of research. The capacity to balance research activity associated with leadership roles should be enhanced with co-lead-type academic role appointments.

There are identified senior academic roles that have been appointed, with responsibility for Aboriginal and/or Torres Strait Islander health, including leading the development of culturally relevant curricula (Standard 1.3.5 and 1.4.4). The employment of a Professor and an Assistant Professor as senior Aboriginal and/or Torres Strait Islander academics in the Faculty is a positive. These appointments have appropriately defined responsibility, authority and expertise. The Faculty has budgeted for a further 1.0FTE Aboriginal and/or Torres Strait Islander academic to support teaching coordination and organisation. There are plans to expand the First Nations Health team, noting that the team will play a key role in teaching, curriculum development and continuous improvement of the Program. While the First Nations Health team is highly skilled and well-placed to provide leadership in the Program, there are currently only three identified positions to deliver on the curricula and other related work, and these are not specific to the Program. It is evident that there is a vast range and volume of work to be done relating to Aboriginal and/or Torres Strait Islander health, and the appropriate expertise is needed to deliver this important work. As mentioned in the above accreditation standards, the implementation of the plans will require the significant resourcing of Aboriginal and/or Torres Strait Islander academic staff, clinical supervisors and professional staff. The Faculty needs to prioritise recruitment and expansion within the Program, including consideration for expanding Aboriginal and/or Torres Strait Islander research.

The University ensures its qualifications align with the Tertiary Education Quality and Standards Agency (TEQSA) and the Australian Qualifications Framework and has Commonwealth Register of Institutions and Courses for Overseas Students (CRICOS) registration until 2031. The Program operates within University policies and governance frameworks, under the oversight of the University Academic Senate.

The Bond University website provides all the relevant information about the Program, and the Faculty staff regularly review the information. To support clinical educators who may find it difficult to access the University's SharePoint intranet, a Clinical Educators website has been developed to provide dedicated access to all relevant documents and information required.

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 Program has a defined structure and outcomes, with a new First Nations Health Curriculum Framework in development. Significant effort has gone into Program enhancement and to ensure alignment with AMC graduate outcomes and the revised accreditation standards. The team observed that the Program outcomes for graduates are consistent with the Australian Medical Council (AMC) graduate outcome statements. This is evidenced via a completed program learning outcome (PLO) mapping exercise against the AMC graduate outcome statements, and implementation of a revised curriculum based on the identified learning outcomes (LO), which is reviewed periodically. The Program structure allows for two exit awards (Associate Degree of Medical Studies and Bachelor of Medical Studies), which can be a valuable pathway when needed.

The Program demonstrates a well-structured, spiralled curriculum that integrates foundational sciences, clinical skills, and professional development across all years. A spiralled curriculum design, breadth and depth of learning opportunities and exposure, and the increasing complexity of LOs as learners progress through the Program, allows for the development and consolidation of knowledge and skills, encouraging a safe transition to supervised practice in an internship.

Based on the defined PLOs, there remains an opportunity to further strengthen the integration of research skills throughout the curriculum, and an example of this would be through the incorporation of Indigenous research methodologies to allow for drawing on broader approaches. There are clear PLOs that focus on the needs of the communities the provider serves; however, these are mostly aimed at the general population, and there remains a lack of consideration for place-based cultural and spiritual needs of equity groups, especially regarding Aboriginal and/or Torres Strait Islander Peoples and communities.

More attention is needed to understand these needs as determined by the First Nations Health Committee and how they can be integrated into the curriculum. In future monitoring reports, the AMC will be keen to hear how progress with the First Nations Health Curriculum Framework and other initiatives within the Faculty will help address this gap.

The Program facilitates a range of learning and supervisory experiences for medical students. The clinical placements, community placements, voluntary placements (including the coordination of these) and Bond CORE Curriculum are set up to promote effective communication, critical thinking skills, responsibility and civic discourse.

Furthermore, the Clinical Placement Coaches (CPC) located at each of the clinical learning environments provide peer-to-peer support to students to achieve clinical assessment outcomes. This model enhances clinical safety, is a strengths-based approach through the engagement of lived experience (CPCs are often junior doctors) and provides good orientation to clinical practice and support for the student cohort.

The knowledge and skills developed through the capstone opportunities are a positive component of the Program and contribute to students achieving assessment outcomes. There are also gaps in evidence regarding the Program meeting the needs of community groups who experience inequities. Resourcing to support student learning is primarily adequate and effective across teaching sites. However, there are

concerns pertaining to the Aboriginal and/or Torres Strait Islander health and cultural safety space, both within the Faculty and clinical placements, where Aboriginal and/or Torres Strait Islander staff are scarce and often have a high workload.

Students receive varying experiences in cultural safety within clinical environments, with reports of a non-Indigenous clinician teaching students about culturally safe practices at one clinical site. Furthermore, the Program has scope to enhance interprofessional education opportunities for students within both clinical and non-clinical learning environments.

Most feedback received by the team suggests Bond medical students and recent graduates are comparable to graduates from other medical schools, with many senior medical clinician supervisors expressing no concern about their preparedness for internship. There is a perception about the Program's ability to provide students with equitable experiences, especially in the context of private versus public hospital placements. Notably, 18 respondents of the student survey (49/972 respondents in total, as recorded in The Medical Students Society of Bond University (MSSBU) report) indicated that they have rarely or never received equitable access to learning and supervisory experiences. The team acknowledges the small number of students responding to the survey, indicating they are allocated very little placement time in public hospital settings. However, the program should consider ways to address these perceptions of anxiousness and feeling unprepared for an internship due to a lack of understanding and exposure to the public healthcare system, which may persist in the wider study body that did not respond to the survey and was reflected in meetings with the student body.

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

The Program demonstrates a well-structured, spiral curriculum that promotes progressive development and integrates foundational sciences, clinical skills, and professional development across all years. The integration of the Bond CORE curriculum into Year 1 of the Medical Program in 2025 aligns medical students with the broader university community and enhances interdisciplinary learning. The program adopts an integrated, case-based curriculum that emphasises small-group learning, simulation, clinical training, early placement exposure, and evidence-based education across four domains:

1. Clinical Practice
2. Health & Society
3. Professionalism & Leadership
4. Science & Scholarship

The Program is designed as an intensive, trimester-based structure with a focus on patient-centred care and enabling students to gain exposure to clinical care in the early years of the medical program.

BMedSt (Years 1 to 3) Building Foundational Knowledge and Skills

The first three years build foundational medical knowledge, clinical reasoning, and professional skills.

Year 1 Human development across the lifespan through authentic patient cases,

Students participate in Small-Group Learning (SGL), combining learning across all four domains. Early clinical training includes history taking, procedural skills, and communication with simulated patients, along with foundational biomedical sciences, medical ethics, and the healthcare system.

Year 2 Body systems, with a focus on pathophysiology, diagnostics and patient safety.

Students refine clinical examination skills, explore behavioural sciences, Indigenous health, and health psychology, and develop ethical reasoning and professionalism. Community-based clinical placements provide hands-on experience

Year 3 Guides students towards clinical practice, emphasising diagnosis, investigations, and patient management across key disciplines such as surgery, general practice, medicine, emergency medicine, children’s health, women’s health, and mental health.

Hands-on learning includes Bond Virtual Healthcare (BVH), simulation-based training at Robina Hospital, and clinical placements, enhancing clinical reasoning, teamwork, and research skills in preparation for the MD phase.

MD (Years 4 to 5) Clinical Placements and Advanced Training

The final two years include clinical placements in various healthcare settings, such as general practice, critical care, orthopaedics, emergency medicine, surgery, community health, child health, mental health, and women’s health.

Year 4 Combines clinical placements with structured on-site educational sessions and Medical Program learning activities. Students enhance their clinical reasoning, diagnostic, and management skills while collaborating within healthcare teams, demonstrating professional and ethical practice.

Students participate in research and clinical activities to develop their MD e-Portfolio, which demonstrates their ability to apply scientific inquiry and incorporate research evidence into clinical practice. The e-Portfolio operates on a points-based system that requires completing both core and elective activities.

Year 5	Focuses on advanced clinical training through placements in local, interstate, and international healthcare settings, with opportunities for electives or a Capstone experience. Students enhance their ability to manage undifferentiated diagnoses and common conditions while strengthening skills in multidisciplinary teamwork, care coordination, and clinical decision-making. Students continue building their MD e-Portfolio, complete their MD Project, and present their research at the annual Faculty MD conference, preparing them for the transition to internship training.

The educational framework underpinning this design is taken largely from components of the cognitive domain of Bloom's Taxonomy, a robust, evidence-based model where learning is cumulative and progressively complex. This is a well-accepted approach to curriculum design and aligns with the cumulative development of capabilities required for safe and effective clinical practice. The team considers the design of the Program to be educationally sound.

The First Nations Health Curriculum Framework is at an early stage and will require ongoing refinement and implementation to fully incorporate Aboriginal and/or Torres Strait Islander health perspectives throughout the curriculum. While the Program's Aboriginal and/or Torres Strait Islander health curriculum exists, it is not consistently embedded or integrated throughout the broader BMedSt/MD Program. It is acknowledged, however, that the First Nations Health Curriculum Framework, which is currently being developed, will guide this curriculum development and integration, including clinical aspects related to Aboriginal and/or Torres Strait Islander health across all medical disciplines. The AMC will be interested in how this work progresses, including plans for how the framework and subsequent curriculum will be implemented and integrated, and how non-Indigenous Program staff will engage effectively with this process.

The Program's revised Aboriginal and/or Torres Strait Islander health curriculum is under development, pending completion of the First Nations Health Curriculum Framework. While the current clinical cases involving Aboriginal and/or Torres Strait Islander Peoples are supported by evidence in terms of higher disease prevalence (e.g., sleep apnoea), the current curriculum does not have a strengths-based framework, with language such as 'Indigenous issues' reinforcing a deficit discourse. The inclusion, leadership and authorship of Aboriginal and/or Torres Strait Islander health experts in the First Nations Health Curriculum development process is to be commended. The work on the First Nations Health Curriculum Framework is being done by senior, skilled staff, and appears to be comprehensive and uses appropriate methodologies. As above, the AMC will be interested in how this work progresses into the future.

There is commendable research activity across the Faculty, and in particular, the Program's Health Professions Education Research Group and the Collaboration for Research in Understanding Stigma in Healthcare (CRUSH) are notable research programs with clear potential for translation to inform learning, teaching, and assessment. The Program itself contributes to global research outputs, including areas such as:

- Integration of Research into the Curriculum, where students are required to complete an MD project (either research or professional) at the Australian Qualifications Framework (AQF) Master-Extended level. Bond academics and clinical partners support these projects, which have resulted in peer-reviewed publications.
- Planetary Health Spiral Curriculum, spanning both BMedSt and MD programs, integrates themes of planetary science, environmental determinants of health, and environmentally sustainable healthcare. This has resulted in multi-year research on planetary health and recommendations for practical solutions for sustainable development goals. Providing opportunities for students to engage with themes around Planetary Health is an admirable approach, and the Program might think about integrating learning across the curriculum to strengthen its commitment to health equity.
- LGBTQIA+ Healthcare Curriculum Review: Program students conducted a narrative review on best practices for LGBTQIA+ healthcare education and clinical practice. This research suggested improvements to the preclinical curriculum, which were under review at the time of the assessment.

- Aboriginal and Torres Strait Islander health research conducted by Bond University academics, notably by Professor Michelle Jack, focused on enhancing the well-being of Aboriginal and/or Torres Strait Islander children aged 5 to 12.

There is a distinct dedication to research across the University, Faculty, and Program levels. The team observes that, although these programs and individuals have contributed to Aboriginal and/or Torres Strait Islander health research, increased capacity is required to support Aboriginal and/or Torres Strait Islander academics in actively participating in and leading research in Aboriginal and/or Torres Strait Islander health and medical education, thereby enriching learning, teaching, and assessment processes.

There is clear alignment between the Program outcomes, learning and teaching methods, and assessments. The Program uses a variety of learning and teaching strategies, including forums, workshops, simulations, and clinical placements, to support students in achieving the Program's overall outcomes. The assessment methods mirror the diverse didactic and experiential approaches, featuring a range of written (Clinical vignettes - MCQ, SAQ) and clinical (Observed Structured Clinical Examination (OSCE) and workplace-based assessments (WBAs)) assessments.

The spiral curriculum design combined with a Case-Based Learning (CBL) model and the Bond Virtual Healthcare (BVH) sessions in Year 3 allows students to revisit and integrate knowledge, skills, and professional behaviours in a structured, safe, and interprofessional environment, building competence and confidence for application in clinical practice. The adoption of these models and design is highly commendable. Early observational clinical placements enable students to understand clinical environments and patient-centred care while developing capacity to participate more meaningfully within interprofessional teams. It will be important to carefully consider the potential of private hospital placements for capacity building in vital acute skills (e.g., primary and secondary trauma assessment), as well as the significant reliance on simulation as a teaching and learning method compared to real-life clinical experience, to ensure intern ready graduates.

The structure of the curriculum and overall Program encourages self-directed learning and subsequently lifelong learning. The volunteering initiative is commendable and promotes a sense of responsibility, including in the context of students' learning and development. From 2025, the introduction of the Continuing Professional Development (CPD) portfolio from Year 1, alongside the MD e-Portfolio and Capstone project, is also to be commended. The CPD Portfolio aims to enhance confidence of the Program's ability to meet graduate outcomes in the Professionalism and Leadership Domain. In addition, students are supported to develop self-directed learning and reflective practice skills.

The curriculum design and duration enable graduates to demonstrate achievement of all medical program outcomes and AMC graduate outcome statements. The extensive curriculum mapping, thoughtful and robust curriculum design, and integration of non-traditional components (e.g., Poverty and its Effects on Health, Deaf Culture and Healthcare) identified through structured round table discussions is to be commended. Furthermore, the development and implementation of the Core Clinical Conditions and Competencies Matrix (4CM), which establishes a framework for essential clinical conditions and competency levels for graduating medical students, is a positive initiative.

The provider has mapped learning outcomes for each year of the Program against AMC graduate outcome statements, adopting a phased approach. These have then been broken down into specific learning outcomes for each subject and teaching session. These are made available to all staff and students via the subject descriptions on the online learning platform, iLearn.

Students have numerous opportunities to pursue their preferred areas through assessments (e.g., Planetary Health), volunteering, local, interstate, or overseas electives, and clinical or non-clinical (e.g., research) selectives. Additionally, students can select a research, capstone, or professional project to meet their MD portfolio requirements. Notably, the capstone project offers a unique experience for students to engage in a resource-limited healthcare environment, investigating health disparities and social determinants of health locally, interstate, or internationally.

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 employs a variety of diverse, fit-for-purpose learning and teaching methods and has introduced several innovative approaches, including Case-Based Learning (CBL), simulation, workshops, lectures, and clinical placements, among others. The small group learning model is appreciated by students as they are able to have more time with their educators, usually a 4:1 student-to-staff ratio. The workshops, physiology sessions and anatomy labs are conducted in one-third cohort groups or smaller, and the Advanced Clinical Skills Rotation (ACSR) has about 40 students per session, with six to seven students in subgroups. Additionally, students gain early and progressively increasing clinical experiences, culminating in comprehensive clinical rotations during the MD program.

The Program is currently undergoing a major timetabling revision project, which deserves recognition. The aim of the project is to reduce large timetable gaps and improve scheduling to achieve a balanced workload, adequate breaks, and better cognitive load management for students. The ongoing timetabling revision project presents an opportunity to optimise student learning experiences and workload distribution. The AMC looks forward to receiving an update on the implementation of this project and any evaluation done to identify the impacts on students' learning and well-being.

Exposure to a range of learning and teaching methods, including simulation (Simulated Patient Program) and CBL (Case Based Learning), allows students to consider increasing complexity in patient presentations, preparing them to engage with patients in clinical settings. Over 75 Simulated Participants are engaged in the Program, and the Program was co-designed with them to ensure authentic learning experiences for students. The significant exposure to senior clinical supervisors via private hospital placements promotes a

quality learning experience for students and allows supervisors to spend more time with students, guiding meaningful patient interactions.

The Faculty established the Engagement of Patients with Lived Experience Working Group to formalise and strengthen the involvement of individuals with lived experience in medical education. This Working Group was launched in 2025 and includes participation from the medical program. The AMC will be interested to learn more about how this working group impacts the ongoing improvement of the medical program, as well as any evaluation outcomes conducted on the Child and Young Person Simulated Participant program introduced in 2025.

The Program has a number of simulated interprofessional learning experiences for students, including

- The Interprofessional Escape Room in Year 2
- Bond Virtual Hospital in Year 3, collaborating with Occupational Therapy (OT) students
- Pitching the Story in Year 4, collaborating with OT and Physio students on communication in a simulated setting
- Geriatric Emergency Medicine bootcamp in Year 5, where students work together to make patient discharge decisions.

There are examples of medical and occupational therapy students having the opportunity to collaborate; however, these tend to be infrequent and reliant on location-specific opportunities. It is acknowledged that the Cultural Immersion Workshop and Interprofessional Escape Room Experience provide early exposure to interprofessional learning outside of the clinical context; however, clinical-based learning (e.g., through the Simulated Patient Program) would enhance collaborative skills, preparing students to work in interprofessional clinical environments. Current methods are also not formally assessed.

The team considers interprofessional learning with other health professionals and students an identified opportunity for improvement and heard many opportunities that could be explored. While opportunities for simulated learning for interprofessional education have currently been incorporated, chances to experience interprofessional and collaborative practice in placement settings are unclear, incidental, and limited in scope.

The introduction of the University's CORE subjects and their associated assessments in Year 1 presents a valuable opportunity to explore and embed interprofessional learning and this experience could be developed to strengthen collaboration across disciplines. The governance structure around IPL should be considered, in addition to the resources required to ensure robust experiences.

The team observed that students often had access to senior medical clinicians to develop and practice skills before applying them in a clinical setting. Students are provided ample opportunities to engage in simulation activities focusing on an array of skills. These opportunities are designed to develop the skills necessary for clinical practice. The team acknowledges this is a strength of the Program. Some students, primarily those in the mid-year intake, indicated that they had completed clinical placements prior to participating in simulation activities and were supported by Clinical Placement Coaches to develop clinical skills, such as suturing. The team recognises that the purpose of the Coaches is to support bedside teaching, procedural skills development, and coaching in history-taking, physical examination, and patient management.

Currently, there are 11 part-time Clinical Placement Coaches (a total of 3.3 FTE) available across the program, and as agreed in other sections of this report, they are a valuable component to student learning and support. Given the concerns raised by some students about the sequencing of learning activities, it may be beneficial for the program to ensure that students are aware that the support from the Coaches includes procedural skills development, especially if they have not yet undertaken simulation activities relevant to the clinical placement prior to clinical placements. Conversely, it is expected the Coaches have the necessary skills and capacity to train students on particular procedures, especially if the program intends to expand the scope and valuable role of Coaches for teaching and learning.

From Year 1 to 3, students engage in supervised placements to build foundational clinical skills, commencing with an aged care placement in Year 1.

Medical Program Year	Subject	Placement Location	Duration
1	MEDI11-101 to MEDI11-102	Community (Volunteering)	2 sessions x 6hrs (12hrs) or 3 sessions x 4hrs (12hrs)
	MED11-102	Residential Aged Care Facilities	1 placement x 4hrs (4hrs)
2	MEDI12-201 MEDI12-202 MEDI12-203	Public and Private Hospital Clinic	3 placements x 4hrs 1 placement per subject (12hrs)
3	MEDI13-301 or MEDI13-302 or MED13-303	General Practice	6 AM or PM sessions (across 3 days) x 3hrs (18hrs)
		Public and Private Hospital Clinic	2 sessions x 4hrs (8hrs)
		The Wesley	1 session x 8hrs (8hrs)

Figure 4: Placements for Years 1 to 3

Students progressing to the MD program complete 12 seven-week clinical rotations over two years in hospital, community, or primary care settings. Feedback to the team indicated that surgical rotations in private hospitals, where students have the opportunity to be in theatre and spend time with consultants, were well-received, compared with placements in ED or general medicine.

Senior clinical supervisors provided positive feedback regarding students' clinical skills competency, often expressing comparability to students from other medical programs. Those students placed in private hospital settings were often afforded greater time with clinical supervisors and patients to develop their clinical skills, particularly within surgical rotations. Despite this, some students have concerns regarding the limitations of private vs public placements for procedural skills development (e.g., blood cultures), in preparation for a public-based internship. As discussed in Standard 2.2.6, the Program may need to consider other ways to expand or complement procedural skills development in the curriculum, given this was reported as a deficiency by some students.

The introduction of the Clinical Placement Coaches (CPC) program is a strength of the Bond Program in terms of student mentorship and clinical skills development. This model facilitates students' access to clinical skills experience, enhancing their clinical capability and independence. There is evidence of the importance of the Clinical Placement Coach role in curriculum delivery and student support. The role appears to be working well in expanding on the student learning on clinical placements and providing targeted extra teaching where students have requested it. The coaches are adequately resourced in terms of staffing allocation and are provided with effective induction and support. A plan to formally evaluate this initiative for effectiveness in relation to benefits for students and capacity building will have benefits in enhancing the Program and the broader medical education community.

The Program has a strong commitment to community placements as it does to clinical placements – this is extremely positive and bodes well for the medical program cohorts overall. There is evidence of effective coordination to ensure students are enabled to discuss placements during tutorials and the Program is encouraged to ensure there is continuity and succession planning in this role.

Commendable work has been done to provide students with experiences in various communities. These include student reviews of the LGBTQIA+ curriculum, addressing stigma associated with disability, a focus on social justice within the Health and Society domain, and opportunities for Capstone Placements in areas such as the Pilbara, Solomon Islands, India, Taiwan, and South Africa. As indicated in Standard 2.3.5, there are opportunities for students to have community placements, however, feedback on the utility and application

to future practice of some of these experiences varied. The Program is encouraged to consult with students as well as the communities which it serves on how the curriculum and learning experiences can be more robust.

As mentioned, progress remains to be made regarding the First Nations Health curriculum, guided by the First Nations Health Curriculum Framework. While there is evidence of students learning about the diverse needs of Aboriginal and/or Torres Strait Islander communities, the current curriculum lacks the necessary critical approach. The team has confidence that the new curriculum will address this concern and apply the critical lens required for students to appreciate this discipline and affect positive outcomes in clinical and community healthcare settings for Aboriginal and/or Torres Strait Islander people. The AMC looks forward to seeing how this space progresses in future monitoring reports.

Currently, there are no formal plans, policies or procedures in place that address or inform culturally safe learning and teaching for Aboriginal and/or Torres Strait Islander peoples within the Program, including staff, students, and community members. The Program is committed to expanding the First Nations Health team and strengthening the curriculum. This will contribute to enhancing the cultural safety of learning and teaching within the Program, informed by Aboriginal and/or Torres Strait Islander knowledge systems.

The team heard reports of Aboriginal and/or Torres Strait Islander students experiencing peer-to-peer racism and feeling culturally unsafe during specific instances while participating in the Program. This must be seen as both deeply concerning and a priority to address by the Program staff and broader Faculty. It is recommended that the Faculty executive and those involved in contributing to the Program critically reflect on and engage with Aboriginal and/or Torres Strait Islander staff and students to understand how cultural safety can be enhanced within the Program.

While students are provided with an array of opportunities through community placements, volunteering initiatives, selectives, electives, and capstone projects, some students reported that they could benefit from more experiences in public hospital settings as discussed in Standard 2.3.5. There is also a lack of structured learning experiences situated across regional, rural, and remote health settings. There is significant simulation training in Year 3 with BVH, and while there is no minimum requirement for face-to-face experiential learning, the program should assess and consider how it could increase face-to-face experiential learning experiences in clinical environments for students, particularly in rural and remote settings.

The team recognises the Program has adopted an integrated curriculum approach to preparing students for internship, with Bond students engaging in clinical care early in their medical education. While the ACSR is designed to strengthen cross-disciplinary generalist skills essential for intern preparedness, there remains a clear lack of a defined pre-internship program, which does not meet this standard. The team understood from some students that there can be a sense of lack of preparedness for internship, and some have indicated varied degrees of preparedness of students for the next phase in their medical education. Favourable comparisons about the effectiveness of the ACSR compared to the Critical Care Orthopaedic term were made. The ability for students to be assured of their readiness to commence an internship with confidence is key to successful integration into working as part of clinical teams, particularly in public hospital settings.

The Program must consider how it will work to develop a defined pre-internship program to meet this standard. In the development of the pre-internship program, the Program should evaluate current mechanisms with its stakeholders, particularly clinical supervisors and students, as well as other medical programs in the region with embedded pre-internship programs. Students and clinical supervisors should also be integral to the design and implementation of a pre-internship program.

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 Faculty outlines a comprehensive assessment system that aligns with principles of fairness, flexibility, equity, validity, and reliability, supported by research and evaluation evidence. Their approach to assessment as essential for supporting learning and determining competence is demonstrated through the careful design of the assessment blueprint, the scaffolding of assessment formats across the Program, and the emphasis on authentic assessment and low- and no-stakes assessments alongside those used to evaluate competence and progression.

Responsibility for assessment is shared between two Academic Assessment Leads—one for the Bachelor of Medical Studies phase and the other focused on the MD—supported by an Assessment Manager who leads a larger team of professional staff assisting with assessment across the faculty. The Assessment Leads have clearly defined roles, responsibilities, and complementary skills, working closely with Domain Leads to develop the assessment blueprint for each of the formats used throughout the Program. There is a well-defined process for implementing assessment changes, which can be initiated by academic staff or domain leads and requires justification, review of evaluation reports, student feedback, and adherence to best practices. The Medical Program Rules of Assessment and Progression (MedRoAP) have been developed to specify phase-specific rules for progression. These rules are aligned with the broader Bond University Assessment Policy and Procedures.

The assessment system shows a clear progress from lower levels of Miller's pyramid to higher levels, such as workplace-based assessment, over the Program. In the Bachelor of Medical Studies, assessment areas include knowledge (written tests), clinical skills (clinical practice assessments and OSCEs), in-semester assessments, and competency evaluations. The use of Direct Observation of Clinical Skills (DOCS) in Year 3 helps students prepare for their end-of-year OSCE and transition to more clinical learning in the MD. During the MD, there is a stronger focus on clinical assessment through OSCEs, procedural skills, and workplace-based assessments, including mini-CEX and In-Training Assessments (ITAs) with entrustable professional activity rating scales. The recent launch of the Osler ePortfolio student dashboard allows for easy tracking and visibility of students' clinical skill development throughout the Program.

Investment in platforms such as ExamSoft and the Osler ePortfolio supports robust assessment delivery, enhances feedback quality, and enables systematic tracking of student progress. The Program innovatively uses technology, including ExamSoft for written examinations and the Osler ePortfolio for workplace-based assessments, and collaborates effectively with partner institutions in the design of WBAs to minimise supervisor

burden. ExamSoft provides personalised, meaningful category performance reports after each written examination.

The Medical Program Assessment Blueprint demonstrates the principles of programmatic and spiralling assessment, with multiple assessment data points collected over time to provide a comprehensive view of each student's skills, knowledge, and behaviour for progression. These are aligned to curriculum, medical program and AMC graduate outcomes. Assessment domains are integrated across subjects with an independent pass requirement at the end of the academic year to determine progress.

These domains include:

- Knowledge (Written Examinations)
- Clinical skills (Clinical Practice Assessments and OSCE)
- In-semester Assessments (ISA)
- Competency Assessment (Pass/Fail)

This structured combination of assessment domains enables students to develop skills at different rates over time. Weightings and compensation support the scaffolding of developmental skills, particularly in the early years of medicine, as demonstrated in the example below:

Example: BMedSt Assessment Clinical Domain

Academic Year	Weighting	Assessment
Year 1	14%	These are aligned to the curriculum, medical program and AMC graduate outcomes.
Year 2	20%	The weighting increases, reflecting the increasing importance of achieving core clinical skills in communication and physical examination. Clinical practice assessments must now be passed independently.
Year 3	40%	This is the final checkpoint on student safety to practice before entering MD clinical years, where students will apply their skills to patients in the health care setting. YR3 OSCE (40%) has an increased weighting and must be passed independently, highlighting the importance of this transition from BMedSt to MD. Student preparations for the end-of-year OSCE include the newly introduced (2025) Direct Observation of Clinical Skills (DOCS), which is a competency (Pass/Fail) clinical skills assessment.

MD Assessment Structure

Students in academic Years 4 and 5 engage in the OSCE, procedural skills and WBAs conducted in clinical settings as evidence of competency in clinical skills and professional behaviour. Methods include:

- ITA: Assesses student knowledge, skills, communication, and behaviour during placement, requiring a minimum of four Mini-CEX assessments per placement at “Level 3: Clear Pass – performs tasks competently with minimal supervisor input or intervention.
- Use of entrustable ratings scales in the Griffith/Bond University co-designed Mini-CEX aligns with Entrustable Professional Activities (EPAS).
- MD Osler Portfolio provides students with evidence of progression and evolving skills across 12 placements over the duration of the MD.

Expectations of professionalism are outlined in the Bond University Student Code of Conduct Policy and the Medical Program Attendance Requirements. In the Bachelor of Medical Studies, professionalism is evaluated through attendance, the CPD portfolio, and community placements, whereas in the MD Program, it is

assessed via in-training assessments. Professional behaviour can result in non-progression in the program, with decisions supported by the University.

The introduction of the CPD Portfolio as part of the BMedSt, provides a supportive framework that promotes professionalism, and encourages student autonomy and accountability through a structured 100-point-per-semester system.

The Program demonstrates an outstanding and well-communicated assessment blueprint, exemplified by the "typical student journey in assessment" in both the comprehensive five-year staff-facing and annual student-facing formats. This blueprint provides clear guidance through key Program transitions. Curriculum mapping and blueprinting are of a high standard, ensuring alignment of assessments with Program outcomes.

The Program has a comprehensive medical assessment blueprint that outlines assessment types, weightings, and timings across the course, providing clarity for staff. Additionally, they produce a single-year student-facing version, promoting transparency for students. Detailed curriculum mapping and assessment blueprinting are undertaken at each stage of the Program. Each year-long subject within the Bachelor of Medical Studies has a specific assessment blueprint based on the curriculum map, and each exam has a blueprint to guide academic staff in preparing the required assessment items. For the MD, OSCE stations are blueprinted by clinical practice leads using organ systems, disciplines, and clinical skills; mapping of the Medical Deans of Australia and New Zealand (MDANZ) core clinical competencies and prevocational medical training EPAs inform WBA activities, while examination blueprints are developed based on core conditions and patient presentations from the junior doctor framework and MD curriculum.

The Program's system of assessment includes a wide range of fit-for-purpose assessment methods such as written exams, OSCEs, WBAs, and portfolios. They offer various formative assessment opportunities to support student learning and prepare for summative examinations. The Program has invested in several assessment technologies, including Quitch, Elsevier formative assessment tools, and eMedici, and has demonstrated flexibility in adapting to the introduction of two cohorts and the emergence of generative Artificial Intelligence (AI), showing responsiveness to changing educational needs. More recently, they have introduced innovative assessments like the Gen-AI Literacy assessment.

Program staff demonstrate agility and responsiveness to emerging challenges, including managing dual cohorts and addressing the impact of generative AI, reflecting a proactive and adaptive approach to contemporary educational needs. The Program has continued to develop their MD Procedural Skills Program, which has been rolled out in stages over recent years. The Program currently has 16 procedural skills and clinical tasks and will increase to 17 procedural skills in 2026 with inclusion of the First Nations Cultural Safety WBA. The Skills Program aims to expand to 20 procedural skills and clinical tasks over the next five years.

The Program demonstrates a clear and multi-layered assessment approach, utilising various methods including written exams, OSCEs, workplace-based assessments, portfolios, and integration of simulation-based assessments that are well aligned with program outcomes.

The medical education provider employs appropriate standard setting methods, including a Modified Cohen for written exams and a Modified Angoff panel approach for small cohort assessments. Borderline Regression is utilised to establish standards for OSCEs. Standards are clearly outlined in marking rubrics for competency evaluations. The Program reports regular reviews of cut score methodologies by the Board of Examiners. Students scoring within half a standard deviation above the cut score are identified and advised to seek additional academic support, which is good practice in recognising and assisting students at risk of academic failure.

Assessment in Aboriginal and/or Torres Strait Islander health is integrated across the Program through Aboriginal and/or Torres Strait Islander health content in assessments from Year 1 onwards. There is involvement of Aboriginal and/or Torres Strait Islander academics in writing and quality assuring exam items. There has been the development of a WBA focused on interaction with an Aboriginal and/or Torres Strait Islander patient. Mapping of the MD Core Clinical Competencies has identified a number of areas of Aboriginal and/or Torres Strait Islander Health as not specifically or consistently assessed and it is expected

that capacity to assess Aboriginal and/or Torres Strait Islander health and culturally safe practice will increase upon implementation of the First Nations Health Curriculum.

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.

Students are provided with multiple structured opportunities to receive feedback, including through formative assessment tools, in-semester assessments, and simulation debriefings as outlined in the Year Assessment summary blueprints. Students can select from a suite of formative assessment technologies in order to test their understanding of core areas, on demand, as they move through the Program. As part of the structured program, they are provided with feedback after in-semester assessments (within two weeks of submission), tutor feedback on clinical performance assessments during the semester and in mock exam environments, and simulation debriefing sessions on performance.

ExamSoft produces personalised, performance-based reports as a knowledge-based assessment platform, which has helped deliver customised performance summaries after written exams. The Osler ePortfolio supports providing feedback on clinical interactions and allows tracking assessment completion and progress over time. The Clinical Placement Coaches also help improve real-time (informal) feedback during placements. However, the Program's prompt and thorough OSCE feedback has not fulfilled expectations because the assessment technology used for OSCE marking has not yet been fully integrated with ExamSoft.

The Program provides multiple opportunities for students to seek, discuss and be provided with feedback on their performance throughout the Program. These opportunities are outlined in the Year assessment summary blueprints and highlighted in orientation and the annual Welcome to Assessment forum that assessment staff lead at the start of each semester, which also focuses on building student assessment literacy. A key enabler for students to effectively use assessment for learning is their understanding of the intent and purpose of each assessment format. Assessment literacy is increasingly recognised as a core skill that supports students in learning from assessment.

There are clear processes for identifying students who are underperforming, including early detection through tutorials, formative assessments, and summative exams. Targeted remediation plans are developed in collaboration with Student Support Leads, and a Special Topic subject has been implemented to provide extended clinical placements for students struggling with OSCE performance (identified as lacking core clinical skills through repeated OSCE failures). The Program uses an Academic Monitoring Register to track and support at-risk students.

Data on student cohort performance is shared with academic staff through committees and meetings—MeLT, phase-specific committee meetings, and external meetings. Workplace-based assessment completion rates are monitored and reported to clinicians. There is an opportunity to enhance the consistency of feedback provided to clinical sites so that it can be used more effectively to drive curriculum improvement.

The Faculty uses feedback to understand student achievement and drive curriculum improvement. For the BMedSt, this involved exam evaluation reports, ISA evaluation reports, and individual item writer reports. For the MD, this involves assessment evaluation reports, cohort performance data for OSCE and Progress test performance, student survey feedback on placement experiences and clinical site performance data for workplace-based assessments. The WBA data are presented at Leads and Deans meetings where leaderboards are used to show clinical staff completion rates of WBA to encourage clinician engagement with WBA.

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 program has implemented thorough blueprinting, standard setting, and review processes to ensure assessment validity and reliability. It has established robust assessment governance through comprehensive blueprinting, standard setting, and regular review processes that support assessment validity and reliability. Ongoing review of key documents such as the Medical Program Rules of Assessment and Progression (MedRoAP) and the Medical Program of Assessment Blueprint demonstrates a commitment to maintaining a fair and fit-for-purpose assessment system.

The Program regularly reviews its assessment system—including policies, blueprints, and standard-setting methods—using both quantitative and qualitative data. This process is informed by internal and external stakeholder feedback, including students, psychometric data, and participation in benchmarking initiatives such as Australian Medical Schools Assessment Collaboration (AMSAC) and Australasian Collaboration for Clinical Assessment in Medicine (ACCLAiM). Participation in national and international benchmarking activities (e.g., AMSAC, International Databases for Enhanced Assessments and Learning (IDEAL) Consortium) ensures comparability of standards with other medical schools. There is also a strong commitment to ongoing staff professional development in assessment.

The Program has a detailed schedule of review timelines and responsible parties related to key assessment documents, which includes a regular review of the Medical Program Rules of Assessment and Progression (MedRoAP) and Medical Program of Assessment Blueprint.

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. Although there is little site variation within the Bachelor of Medical Studies program, there is significant diversity in MD student clinical placements. The Program uses a Student-Clinician Handbook to ensure consistency in expectations across different clinical sites and has introduced a Clinicians Advisory Board (CAB) to share best practices in clinical education and assessment.

Recently developed online supervisor training modules for Work-Based Assessment (WBA) aim to further standardise clinical supervisor expectations across sites. The WBA requirements booklet outlines requirements for students on placement. Assessment leads address issues related to equity in the conduct of WBA across clinical sites. The quality of WBA for progression is assured through structured processes and a panel of reviewers (both academics and professional staff) for the submission of WBAs upon completion of clinical placement.

The Program continues to innovate in its assessment methods and practices in both the BMedSt and MD Programs, and the AMC will be interested in the progress of development, implementation and any subsequent evaluation of the following activities in subsequent monitoring submissions:

BMedst Program	MD Program
• Introduction of Bond Core subjects in Years 1 and 2.	• Prescribing Safely Assessment (PSA) exam becomes summative for graduation in 2026
• Introduction of the CPD portfolio	• Expansion of the Procedural Skills program to 20 skills by graduation over next 5 years

- Scholarly investigation into the benefits of transitioning from scored grading to competency grading
- Enhanced OSCE feedback for students
- Progress Test OSCE for combined Year 3 and MD OSCE with shared stations
- Close monitoring of Limited Open Book Progress Tests performance data
- Access to online WBA training modules for all clinical supervisors across sites to inform best practices and expectations for student WBA evaluation
- Provision of Osler ePortfolio site data to all key sites
- Introduction of long cases to the ACSR

STANDARD 4: Students

4.1 Student cohorts and selection policies	
4.1.1	The size of the student intake is defined in relation to the medical education provider's capacity to resource all stages of the medical program.
4.1.2	The medical education provider has defined the nature of the student cohort, including targets and strategies for recruiting Aboriginal and/or Torres Strait Islander and Māori students, students with rural backgrounds and students from equity groups to support increased participation of these students in medical programs.
4.1.3	The medical education provider complements targets and strategies for recruiting Aboriginal and/or Torres Strait Islander and Māori students, students with rural backgrounds and students from equity groups with infrastructure and supports for student retention and graduation.
4.1.4	The medical education provider supports inclusion of students with disabilities.
4.1.5	The selection policy and admission processes are transparent and fair, and prevent racism, discrimination and bias, other than explicit affirmative action, and support the achievement of student selection targets.

The Program's intake is defined and was recently expanded in 2020. As a response to COVID-19, Bond introduced a September intake cohort in 2020, with the first cohort graduating and starting their internship in July 2025. While the Medical Students' Society of Bond University's (MSSBU) student report expressed concerns about perceived differences in quality between the September and May cohorts, the program has demonstrated its capacity to provide equitable learning experiences for both cohorts, with assessment outcome data showing no differences between cohorts, and students reporting a positive collegiality. It is important that the Program continues to monitor the quality of these cohorts to ensure any differentials, real or perceived, are managed. The team heard there are adequate clinical placements and supports for this additional cohort of students. The Program is well-resourced to meet the growing student intake with a robust, centralised selection process and support structures for students with different needs.

The University indicates it is a diverse and global academic environment with domestic and international students from over 90 countries. At the time of the assessment, the University had 5,940 students, of which 61.2% are domestic, 56.6% female, and 46% undergraduate cohorts. 30.1% are enrolled in the Faculty of Health Sciences and Medicine. The Indigenous Education and Workforce Strategy acts as a guide to creating an inclusive and supportive environment for Aboriginal and/or Torres Strait Islander students and staff. The key long-term goal is to increase the enrolment of Aboriginal and/or Torres Strait Islander students to achieve population parity. The Program has set a 95+ ATAR requirement for admission into all identified pathways.

Recruitment of Aboriginal and/or Torres Strait Islander Students

The Program has dedicated pathways to support Aboriginal and/or Torres Strait Islander students:

- The First Nations Medical Scholarship Program, established in 2016, aims to increase Aboriginal and/or Torres Strait Islander student representation in medicine.
- The First Nations Medical Program Pathway, which is a competency-based pathway assessing a student's ability to thrive in a medical school. This is a separate admissions pathway from the Direct Entry admission process.

These supports are acknowledged; however, the team considers them inadequate to achieve the goal of increasing recruitment and retention of Aboriginal and/or Torres Strait Islander students or attaining population parity for the Program. The Program does not have defined targets for recruiting Aboriginal and/or Torres Strait Islander students. Further development of clearly defined and adequately resourced strategies is needed to engage, recruit, and retain Aboriginal and/or Torres Strait Islander students, as current mechanisms are limited to the following:

First, available scholarships for Aboriginal and/or Torres Strait Islander students are constrained and only available through fundraising. In 2025, it is notable there is:

- One full tuition scholarship covering 100% of fees (plus a living allowance per semester for both the BMedSt and MD programs), and
- One partial scholarship covering 50% of tuition fees (plus a living allowance for the first semester of the BMedSt program).

The team believes these scholarships are insufficient to effectively support the Program's goal of increasing the recruitment and participation of Aboriginal and/or Torres Strait Islander students in a full fee-paying context. While philanthropy currently contributes significantly to funding these scholarships, the Program could consider other mechanisms for funding additional scholarships, such as reallocation of areas of their budget. The Faculty may wish to explore alternative ideas for supporting Aboriginal and/or Torres Strait Islander students' recruitment into the program outside of scholarships. This may include the potential for subsidisation of fees.

Second, the Assistant Professor of First Nations Health is currently playing an integral role in the recruitment of Aboriginal and/or Torres Strait Islander students, with the admissions team reaching out to self-identifying Aboriginal and/or Torres Strait Islander students, who preference the Bond Medical Program either first or second on their Queensland Tertiary Admissions Centre (QTAC) application. Aboriginal and/or Torres Strait Islander students are then directly contacted by the Assistant Professor of First Nations Health and supported through a designated First Nations Medical Program Pathway.

Though the role of the Assistant Professor of First Nations Health in admissions is a strength in supporting Aboriginal and/or Torres Strait Islander students being recruited in the Program, consideration of alleviating the load on this staff member (who also has responsibilities across governance, clinical teaching, and curriculum development) is needed.

Third, outreach work to recruit students from Aboriginal and/or Torres Strait Islander communities is currently limited and incidental. Executive staff members visit local high schools to promote recruitment of Aboriginal and/or Torres Strait Islander students. Efforts should be made to significantly expand these outreach activities in a coordinated way that is guided by Aboriginal and/or Torres Strait Islander people.

Further work could be done to increase community awareness of the pathways available to Aboriginal and/or Torres Strait Islander applicants.

Students from Rural and Equity Groups

The Program has begun collaborating more closely with placement providers and community stakeholders to align recruitment strategies with workforce needs. It has started to recognise the importance of prioritising local applicants to support graduate retention in regional areas, such as Queensland and the Tweed border region from 2025. However, beyond this initiative, the team did not identify any systematic strategies or targets for intentionally recruiting students from rural backgrounds or from other groups facing health inequities.

The Program has strategies and supports in place to support the retention of Aboriginal and/or Torres Strait Islander students, students from rural backgrounds, and students from equity groups. These are embedded for students through university-wide and program-specific initiatives, including financial supports, supports for LGBTQIA+ and neurodiverse students. In 2025, the University also introduced a First Nations student orientation to better support Aboriginal and/or Torres Strait Islander students.

The Nyombil Indigenous Support Centre has an important role in supporting Aboriginal and/or Torres Strait Islander students in the Program and promoting their retention and graduation. The Centre provides students with access to culturally safe support, including a free peer-assisted mentoring and tutoring program, and engagement with Aboriginal and/or Torres Strait Islander staff for support and mentoring. While Aboriginal and/or Torres Strait Islander students generally expressed a view of the Nyombil Indigenous Support Centre as a place of safety and support, some students noted a lack of awareness of the supports and resources available at the Nyombil Indigenous Support Centre. The Nyombil Indigenous Support Centre

is currently significantly under-resourced (particularly in terms of staff), and further resourcing for the centre is required to ensure it can provide adequate support to Aboriginal and/or Torres Strait Islander students.

The University has partnered with Autism Queensland to undertake a review of and improve its support for neurodiverse students. The Student Affairs and Service Quality (SASQ) team has set up a Neurodiversity Interest Group with the aim of informing and educating staff on supporting neurodiverse students.

Bushfire (the Bond University Rural Health Club) is a student-led club that supports students from rural backgrounds in the Program. The club runs workshops, organises participation in rural health conferences, and provides opportunities for peer support. Further infrastructure in the Program, beyond student-run initiatives, is needed to support the retention and graduation of students from rural backgrounds.

Tailored university-wide initiatives, including an Ally Network, and the Bond Pride Alliance student-led group, provide services and support for LGBTQIA+ students.

The provider supports inclusion of students with disabilities. The BondAbility program supports students in disclosing disabilities and subsequently accessing support from the Accessibility and Inclusion team and applying for reasonable adjustment plans. The BondAbility program facilitates confidential communication with professional staff for students on clinical placements and access to designated clinical and academic leads as contact points for students.

Students commented on generalised stigma in the medical profession around disclosing neurodivergence. Staff on the Student Affairs and Service Quality (SASQ) team expressed an awareness of this stigma, and a commitment to working to reduce it, and to creating an inclusive and supportive environment for disclosing neurodivergence.

The University's selection process is well outlined and defined for the undergraduate, graduate, and lateral entry pathways. Comprehensive information about the application, selection, and admission is publicly available on the Bond University website. The Medical Admissions Committee is chaired by the Dean of Medicine and supported by the Manager of Student Affairs to oversee a three-step selection process.

(1) Academic Assessment – Applicants submit their academic records via QTAC. Those meeting the minimum ATAR of 95+ progress to the next stage.

(2) Psychometric Testing – Eligible applicants complete an online psychometric test, which incurs a direct fee. Since September 2021, this test has been invigilated to ensure fairness and integrity.

(3) Multiple Mini Interviews – The psychometric test results determine eligibility for an MMI.

A consistent process is followed for both May and September intakes, with placements determined by candidate preference, availability, and random allocation to prevent bias. The team did not hear of any significant issues faced by students during the selection and admission process and considers it to be generally rigorous, well-defined, fair, and equitable.

The team did hear conflicting information as to whether central admissions ask applicants to identify as Aboriginal and/or Torres Strait Islander. The University should clarify this procedure, as it enables Aboriginal and/or Torres Strait Islander students who have applied to receive carriage and care by the Medical Program, especially the First Nations Health team, in the first instance. The team heard that new students found this support to be invaluable and the approach supports retention in the program. Additionally, the team heard concerns from students about delays in the timing of information shared with students, for instance, finding out with only five days' notice of the need to travel for testing. The team did not have substantive evidence to identify a systemic issue; however, the University should monitor the regularity of these complaints, if not already, to ensure students, particularly Aboriginal and/or Torres Strait Islander students, students with rural backgrounds, and students from equity groups, are not unduly disadvantaged by administrative delays.

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.

The team found academic and professional staff to be committed to student well-being and to providing a supportive and fair learning environment. Extensive well-being support is available to students, and strategies are in place to support student well-being and inclusion. This includes support from BondCare (a centralised university support service), the Student Affairs and Service Quality (SASQ) team (a faculty-specific team which coordinates and delivers both academic and wellbeing support), student coordinators and support leads, academic advisors, and peer mentoring.

There are various levels of support offered at the University, Faculty, and Program levels. The University offers a range of support services, including counselling, medical services, learning support, career development, and a crisis line. The team heard some students reported that counsellors were unresponsive and limited in availability, which is concerning and may place students at risk, though no serious incidents were brought to the team's attention.

The Faculty offers tailored support for students through the SASQ, Medical Program Student Coordinators, Student Counsellors and Student Success Advisors. Mental Health First Aid training is also offered to all medical students, delivered by external providers and student counsellors where available.

At the program level, students have access to BMedSt and MD Student Support Leads, Peer and Professional Mentoring, and Clinical Placement Coaches. Attendance is monitored to enable early identification of students who may need support, and a Wellbeing Curriculum is taught to students, covering topics such as stress management, burnout prevention, and coping strategies.

Aboriginal and/or Torres Strait Islander students reported a lack of awareness of the supports available to them when incidents of racism have occurred. Further work is needed to ensure Aboriginal and/or Torres Strait Islander students have access to safe, accessible and culturally safe support when faced with culturally unsafe environments or racist behaviours, with appropriate procedures for reporting concerns.

The Program makes sure that students needing extra health and learning support are recognised and can receive adjustments quickly. Early disclosure is promoted via the Accessibility and Inclusion website, and a list of Frequently Asked Questions about the medical program is readily available online. Learning Access Plans can be accessed through Bond Ability, and the introduction of Clinical Placement Coaches offers a helpful way to identify students who need extra support and direct them to additional resources. The Support for Students Policy provides guidance for supporting students who need specific academic or personal assistance.

The Program has safe and confidential processes for voluntary disclosure of information required to facilitate additional support. Program staff are responsive to student needs and willing to make necessary adjustments. The Program also has adequate processes in place to support self-disclosure of information before and during the transition to internship.

As discussed in Standard 4.2.2, Aboriginal and Torres Strait Islander students need access to specific safe, confidential culturally safe supports, and these need to be developed.

There is evidence that the Program has mechanisms in place to support flexible study in line with student needs. The Program has policies outlining attendance and flexible study requirements, including the University's Enrolment Policy, Support for Students Policy, Pregnancy and Your Studies Guideline, and the Medical Program Attendance Policy. Further opportunity for flexibility in attendance requirements and taking personal leave would further support student success.

Whille the Program enables students to access leave for cultural purposes on a case-by-case basis, policies and procedures that streamline and facilitate accessibility of cultural leave should be considered to reduce the burden and stress on students, who may need to access this leave on short notice. The policy and procedure should seek a supportive approach for students seeking to access cultural leave to support personal wellbeing and academic success.

The Program's processes for provision of student support are separated from decision-making processes about academic progression. BondCare, Health Sciences and Medicine (HSM) Student Counselling, central counselling services and the Bond crisis line are all confidential services available for student support. BMedSt and MD Student Support Leads serve as a first point of contact for students who have not independently accessed services, and these staff then refer students to support services as appropriate. BMedSt Student Support Leads are not involved in academic decision-making. MD Student Support Leads participate in academic progression discussions to provide context in relation to the attendance and professionalism of students, but the Board of Examiners take on the decision-making role in these discussions.

There are policies in place relating to bullying, harassment, racism and discrimination, including Bond University's Anti-Discrimination and Anti-Racism Policy, Student Charter, Student Code of Conduct Policy, Student Grievance Management Policy, and the Student Review and Appeals Procedure. In many cases, there was evidence of these policies functioning effectively, with appropriate reporting mechanisms and timely follow-up and support being provided. In cases where Aboriginal and/or Torres Strait Islander students were made to feel culturally unsafe, particularly in placement settings & during class, these students reported being unaware of policies and processes available to support them. Further work is needed to ensure these policies adequately ensure the cultural safety of learning environments.

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.

There are strong and appropriate policies and procedures in place for identifying and managing professionalism and fitness to practice concerns. The documentation of these processes is comprehensive. The role of staff in the SASQ team in the process of managing these concerns and supporting students throughout the process is commendable, and staff on the team have an extensive understanding of the relevant policies and processes for supporting students when concerns about their professionalism and/or fitness to practise are raised. The Program works with students to develop study plans that prioritise both the student's safety and the safety of others following a concern being raised.

There are many constructive informal mechanisms and formal pathways to raise these concerns and to declare information relating to student professionalism and fitness to practice. Confidentiality is upheld throughout these processes.

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

The provider ensures that medical students are adequately indemnified and insured for all educational activities. The provider has policies insuring students for academic-related travel, personal injury, property damage, medical malpractice, and liability risks in professional settings.

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.

Students and staff have access to well-maintained, high-quality facilities across the campus and clinical sites. The University, Faculty and Program have demonstrated a sustained commitment to investment in physical infrastructure to support projected growth in student numbers, with the HSM building expansion, Bond University Clinical Education and Research Centre (BUCERC) extension, and Bond Institute of Health and Sport (BIHS) North expansion all underway. The forthcoming Futures Building will provide additional capacity, including an anatomy laboratory and large teaching and event spaces, further strengthening the Program's ability to meet the needs of increased cohorts. There were not specific concerns about current resources, given the breadth of materials available in the form of anatomical / prosection samples.

The Tweed Education Hub is a purpose-built facility providing ample space for small and large group teaching, computer-based learning, and simulation activities. Located a short walk from the new hospital building, the Hub offers significant capacity for future growth in student numbers. The adjacent hospital facility, which is not yet operating at full bed capacity, presents further opportunities to expand clinical learning. Professional and academic staff, including clinical educators, demonstrate a strong commitment to the Program and the student learning experience, which enhances the quality of the educational infrastructure available.

Placement sites are of a high quality and are readily accessible to students. The Program works with training sites to facilitate access to amenities, including accommodation for students on placement away from their usual residence. The team notes the Program does not cover costs of accommodation for students placed in Brisbane, Tweed or Gold Coast Areas. The team notes student feedback on the rising cost of accommodation, limited accommodation in certain placement locations, and challenges to transport for some placement schedules. This should be monitored especially as the Program looks to expand student numbers.

Student preferences are considered in placement allocation, although these are subject to availability and Program requirements. For international Capstone placements, the cost of flights, accommodation, and transport is partially covered, with a stipend. A comprehensive pre-departure process ensures students are well-prepared and supported during these placements.

The Program makes effective use of a wide range of technologies to support high-quality teaching, learning, assessment, and research. Students can access learning materials via iLearn Ultra, with Cadmus used as the online assessment platform. The Program's investment in the Osler ePortfolio and ExamSoft further

demonstrates its commitment to resourcing appropriate educational technologies. The adoption of generative AI as a teaching and learning support is a notable strength. These digital resources, in combination with other physical and online supports, are integrated effectively across teaching sites.

Students have equitable access to clinical and educational application software and digital health technologies, enabling them to engage fully with the Program and prepare for practice. Systems such as iLearn Ultra, Cadmus, Osler ePortfolio, and ExamSoft are accessible across all settings, including during clinical placements. The Program has ensured that the provision of these technologies is consistent and reliable, supporting learning and assessment for all students regardless of location.

Comprehensive information services are available to students and staff, including extensive library and reference resources and dedicated support staff. The Bond University library provides broad access to materials, databases, and digital collections, with arrangements in place to ensure seamless access for students on clinical placement. Wi-fi connectivity is maintained across learning sites. Library staff actively support the development of students' information literacy skills through bookable online sessions and on-call assistance during semester time. Student support is further enhanced by the BMedSt/MD Student Support Leads, who review requests for special consideration and prioritises accommodation of individual needs where possible. The Student Affairs and Service Quality (SASQ) team provides targeted assistance to students experiencing extenuating circumstances, contributing to an inclusive and supportive learning environment.

5.2 Staff resources	
5.2.1	The medical education provider recruits and retains sufficient academic staff to deliver the medical program for the number of students and the provider's approach to learning, teaching and assessment.
5.2.2	The medical education provider has an appropriate profile of professional staff to achieve its purpose and implement and develop the medical program.
5.2.3	The medical education provider implements a defined strategy for recruiting and retaining Aboriginal and/or Torres Strait Islander and Māori staff. The staffing level is sufficient to facilitate the implementation and development of the Aboriginal and/or Torres Strait Islander and Māori health curriculum, with clear succession planning.
5.2.4	The medical education provider uses educational expertise, including that of Aboriginal and/or Torres Strait Islander and Māori people, in developing and managing the medical program.
5.2.5	The medical education provider recruits, supports and trains patients and community members who are formally engaged in planned learning and teaching activities. The provider has processes that are inclusive and appropriately resourced for recruiting patients and community members, ensuring the engagement of community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori communities.
5.2.6	The medical education provider ensures arrangements are in place for indemnification of staff with regard to their involvement in the development and delivery of the medical program.

The Faculty has invested in an academic and professional staff profile that provides an excellent staff–student ratio, with plans to maintain this as student numbers grow. Experienced and committed clinicians, together with skilled educators, deliver a student-centred experience across the Program. Teaching capacity for the pre-clinical phase has been strengthened through the expansion of the academic team, and the Program benefits from a large pool of sessional staff and many adjunct academics who contribute specialist clinical teaching. Discipline Leads contribute specialist expertise to curriculum design and delivery. Sub-Deans, all senior clinicians, oversee student and staff experiences at major teaching sites in collaboration with clinical leads to ensure high-quality delivery.

Student placement coordinators are highly valued for their on-site support, and the recruitment of Clinical Placement Coaches has further strengthened the Program. These coaches play a key role in workplace-based

assessments and education activities, ensuring clinical environments are effective learning spaces and preparing students for the transition to internship.

The Program benefits from an appropriate profile of professional staff who contribute to its effective implementation and development. The Clinicians Advisory Board provides a valuable forum for Clinical Leads, Discipline Leads, Sub-Deans and other senior staff to address common issues. Recent appointments, including a lead for Community Clinical Education and a lead for the Advanced Clinical Skills rotation, are expected to enhance the Program's reach and quality.

Clinical placement staff at certain sites are responsible for a wide range of tasks, requiring them to be both skilled and adaptable. As student numbers grow and placement models develop, considering staff workload at these sites will be vital to maintaining the quality of the placement experience.

The Program has made senior appointments of Aboriginal and/or Torres Strait Islander academics who contribute significantly to the work of the Program and the broader Faculty. However, further work is required to develop a defined strategy for recruiting and retaining Aboriginal and/or Torres Strait Islander staff, including succession planning. As discussed in earlier accreditation standards, current staffing levels are not sufficient to fully implement and develop the First Nations Health Curriculum Framework or appropriately support increased recruitment of Aboriginal and/or Torres Strait Islander students. The planned strengthening of the Aboriginal and/or Torres Strait Islander academic team is a positive step, and it will be important that this initiative is prioritised and appropriately resourced to support the implementation of developments such as the First Nations Health Curriculum Framework.

The First Nations Health team plays an extensive and highly valuable role in developing the First Nations Health Curriculum, engaging with community, and supporting Aboriginal and/or Torres Strait Islander students. The contributions of the Professor of First Nations Health and the Assistant Professor of First Nations Health are significant, and their work is commendable.

The Program has established processes to involve patients and community members in learning and teaching activities, as seen in the Simulated Patient Program (Standard 2.3.2). The Expert Patient Engagement Working Group is a promising initiative to support this work and ensure that engagement processes are inclusive and well-resourced. Through the recent Curriculum Staff Restructure, the position description for one of the Curriculum Officers has recently been updated to include patient engagement projects and will contribute to the portfolio across the Faculty. It is noted that the Faculty expects greater opportunities for community and patient engagement, especially for those experiencing health inequities, and the AMC looks forward to reports on progress in monitoring submissions. Bond's Elder In Residence is a key figure in fostering cultural and community connections through various immersion opportunities for students and staff. In line with the development of the First Nations Health Framework, the Program needs to increase and strengthen this engagement, particularly with Aboriginal and/or Torres Strait Islander communities.

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

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

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

The University has a defined appointment and promotions process that supports a diverse workforce, with equitable opportunities for career progression for all staff. Academic staff can be appointed to balanced, teaching-focused, or research-focused roles, ensuring flexibility to match skills with institutional needs. The Faculty Development Working Group, established in early 2024, streamlines clinician-educator recruitment, training and evaluation, and provides support to those Program staff who are not formally evaluated through Bond University's performance review processes.

While these frameworks are well established, there is currently no defined, culturally safe system for the appointment and promotion of Aboriginal and/or Torres Strait Islander staff. This process should be formalised to ensure cultural safety principles are embedded and to strengthen equity and inclusivity in recruitment and advancement.

Staff are well supported in their roles, with a range of professional development activities available. The Faculty Development Working Group (HELP, Health Educators Learning Program working group), established in 2024, plays a key role in coordinating support, especially for clinician educators, and helps improve the ongoing development of the academic and clinical teaching workforce. Those staff involved in the Medical Program who are not formally assessed through the Bond University performance review processes are supported by the HELP Working Group. The group consistently supports staff involved in the Medical Program who do not undergo formal evaluation through Bond University's review system.

Aboriginal and/or Torres Strait Islander staff are provided with broad and meaningful opportunities for professional development, as well as opportunities to work in teams and contribute to the Program. Staff value these opportunities, which help build capacity within the Program.

The First Nations Health Committee, a University community of practice, meets three times a year to support collaboration, knowledge-sharing, and professional growth. Aboriginal and/or Torres Strait Islander educators also work with Griffith University and the University of Queensland through a South-East community of practice to strengthen mentoring and resource-sharing. These initiatives are backed by Bond's Indigenous Education and Workforce Strategy and Reconciliation Action Plan. The Faculty's First Nations Health team is active in the University's Indigenous Staff Network, giving Aboriginal and/or Torres Strait Islander staff formal opportunities to collaborate, mentor, and contribute to the Program and the wider university community.

Cultural safety training is offered and actively promoted as part of the University's Reconciliation Action Plan (RAP). Staff are encouraged to complete the 'Becoming Culturally Aware' online modules, and many clinicians involved in the program undertake cultural safety training mandated by Queensland Health, New South Wales Health, or their specialty medical college.

Students participate in a cultural immersion program that includes an on-country experience, guided learning, and engagement with Elders and community leaders. The Cultural Immersion Program gives students an opportunity to further their understanding of Aboriginal and/or Torres Strait Islander culture. It could be a good foundation for further activities involving stakeholders. This is currently only one day, with an alternative provided for students who have missed attending this important learning experience.

While these initiatives provide a solid foundation, the Program needs to expand on this work to ensure cultural safety training is fully integrated across the program for staff, clinical supervisors, and students, with ongoing professional development in this area for all participants. It will be important to promote reflection on cultural safety learning and to record evidence of participation and impact in both public and private clinical settings. Existing guidelines can help embed these practices consistently, and ongoing evaluation is necessary to measure the value and impact of the training.

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.

The Program provides students with access to diverse and high-quality clinical learning environments, supported by simulation facilities and committed supervision. Graduate outcomes are generally met, with feedback from Clinical Placement Coaches (CPCs) and students indicating that the learning environments are focused on ensuring intern preparedness.

As student numbers grow in the region, it will be important to continue developing innovative solutions to secure adequate placement opportunities and quality supervision, particularly in high-demand disciplines. Concerns between all education providers, including the University of Queensland and Griffith University, over placement capacity was noted. While the Medical Schools Liaison Group, which meets quarterly with Queensland Health, provides a forum for discussion, placement decisions remain with individual hospitals and health services under the devolved model.

Staff involved in organising placements are committed to maintaining quality, but face increasing pressure. Initiatives such as the Integrated Care model, which uses general practice placements alongside hospital settings, offer promising opportunities but require careful mapping to learning outcomes. Consideration should also be given about the balance of hospital experiences (private, public and international) and how electives can be used to address any gaps.

While some students have opportunities to provide health care to Aboriginal and/or Torres Strait Islander people, more work is needed to ensure that all students gain this experience during the Program. Efforts to recruit Aboriginal and/or Torres Strait Islander patients for simulation units are ongoing. Discipline-specific advisory groups are well-placed to share information and will play a key role in integrating the First Nations Health Curriculum Framework to ensure learning outcomes in this area are achieved across all placements.

Further engagement with Aboriginal Liaison Officers and health units at clinical sites could offer valuable learning opportunities for students. It is essential to consider the capacity of Aboriginal Liaison Officers and health units in this process, as the extra workload of supervising students may be unmanageable. When engagement is suitable, efforts must be made to ensure the relationship is mutually beneficial.

The Program works with co-located health profession education providers to secure clinical facilities and teaching capacity, but increasing student numbers will require ongoing collaboration to maintain sustainable access. Plans to increase placements across Northern New South Wales will provide significant opportunities for students. However, consideration will need to be given to managing student travel and accommodation. In the context of wider capacity pressures, it will be important to continue building cooperative arrangements with other education providers to ensure high-quality placement experiences can be maintained.

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.

Clinical supervisors across the Program are well supported in their roles, with clear expectations and accessible resources to guide their work. A multi-tiered governance and operational framework underpins the supervision system, ensuring that clinical teaching is consistent and aligned with program outcomes. The introduction of Clinical Placement Coaches (CPCs) has been particularly valuable, especially in private hospital settings, where they provide an additional layer of guidance and mentoring to both students and supervisors.

Supervisors benefit from a structured learning pathway that builds skills in supervision, assessment, and the use of educational technologies. CPCs undertake mandatory onboarding, modelling best practice for clinical educators and contributing to a culture of well-prepared, confident, and supported supervision.

Orientation to supervisory roles and expectations is evident across sites. A structured learning pathway for clinical supervisors is in place, and CPCs have undertaken mandatory onboarding. The Health Educators Learning Program (HELP) provides a comprehensive framework for training and supporting clinical supervisors. However, some supervisors indicated they were not aware of professional development opportunities available to them, suggesting a need to improve communication and uptake of these programs.

The MD Operational Team meets regularly to review operations, placement logistics, and feedback from supervisors. Supervisor performance is actively monitored, and feedback is provided where behaviours require modification. This structured approach ensures that supervision standards are maintained and aligned with program outcomes.

The team noted an opportunity to streamline processes for monitoring supervisors to ensure timely sharing of student data experience from Local Health Networks (LHNs) with the Program and clinical supervisors. The upcoming renewal of LHN agreements presents an opportunity to formalise this process.

Student placement agreements outline the Program’s expectations for supervision, and university-funded Sub Deans are well placed to ensure adequate supervision. Given the anticipated increase in student numbers moving through placements in the coming years, it may be necessary to review the current approach to ensure teaching time remains sufficient and sustainable without compromising clinical service delivery. Ongoing evaluation of these arrangements will be important to maintain high-quality supervision and learning experiences.

Student placement agreements clearly define hospital and community practitioners' responsibilities and the Program’s commitments to them. This clarity helps ensure mutual understanding and supports consistent program delivery across varied clinical settings. The Program is actively strengthening relationships with GPs, with significant engagement over the last six months to create reciprocal benefit.

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.

In 2025, the program implemented a comprehensive evaluation protocol into its routine activities and project-specific processes. The protocol is built on a six-pillar model for comprehensive evaluation and incorporates data from multiple stakeholders and diverse perspectives.

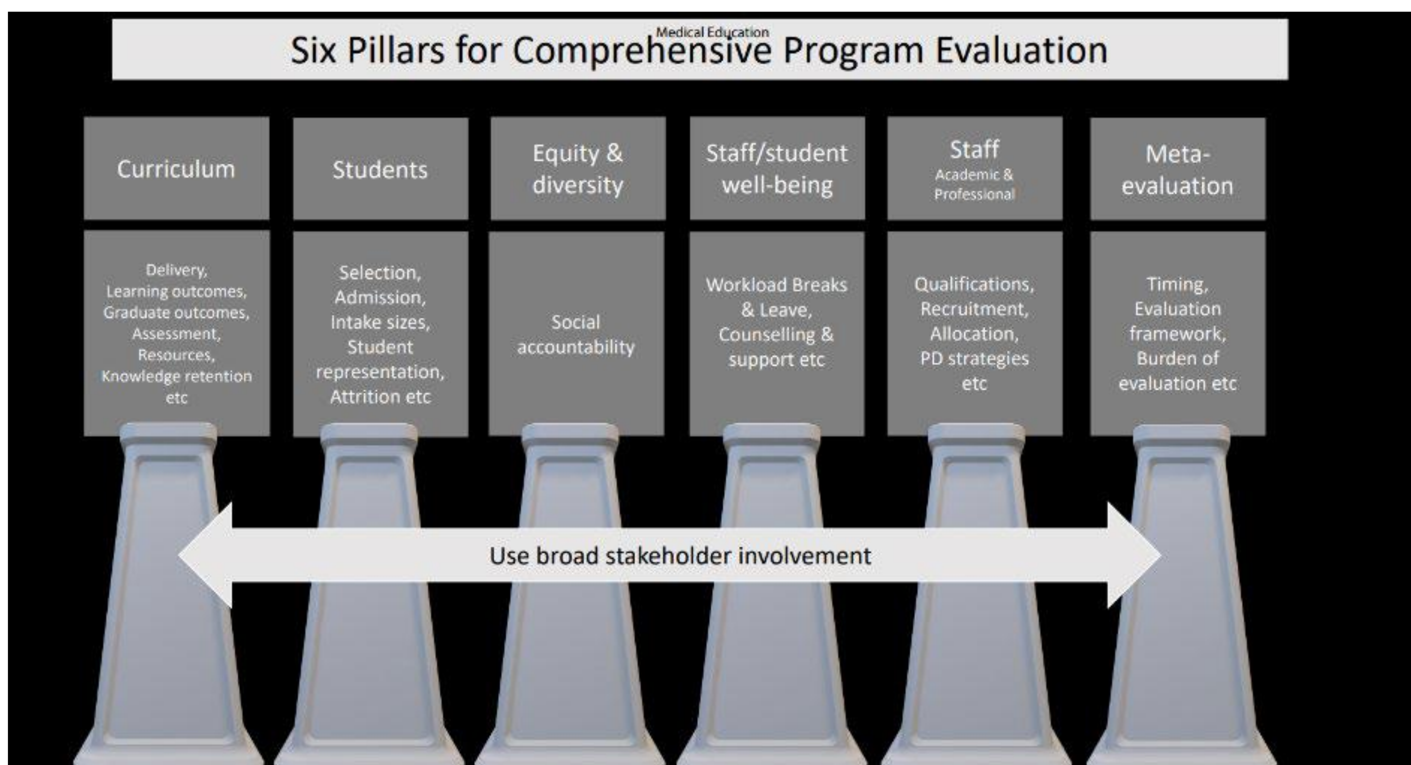

Figure 5: Six pillars for comprehensive program evaluation

Operational oversight is provided through the Medical Studies Operation Team (MSOT) and MD Operational Team (Doctor of Medicine/Phase 2) (MDOT) committees, which meet twice monthly. Findings are escalated to the Medicine Learning and Teaching Committee (MeLT) for strategic oversight. Areas of ongoing review, evaluation, and improvement include:

- Revising Program and Subject Outcomes (Including Exit Awards)
- Program of governance and assessment

- Core Clinical Conditions and related competencies framework
- Introduction of two CORE subjects into the Program

- Small Group Learning (SGL) Program Review
- Learning Technologies for Formative Assessment (Quitch)

The team observed that there does not appear to be an independent or evaluation lead for the Program, noting that an integrated approach has been adopted for the Program's evaluation. Given the current and expected rate of change in the Program, it may be wise to consider a different approach, as the current mechanism could create systemic weaknesses since those responsible for delivering the program are also evaluating it with additional oversight and expertise.

The Program has avenues for regularly and systematically seeking and analysing the feedback of students and other stakeholders. Regular meetings between the Dean of Medicine, clinical/hospital executives, and placement coordinators foster engagement with key stakeholders and a clear feedback-to-action process through MeLT and the Medical Executive. Response rates to student evaluation channels are currently low, and there is an opportunity to explore new strategies to promote students' engagement in evaluation.

The University's Program Quality Assurance Process ensures that the Annual Academic Program Portfolio Reporting is conducted annually in collaboration with the Office of Strategy and Planning, the Executive Dean, and the Heads of Program. The reporting cycle includes various quality indicators, including data derived from eTEVAL surveys and the National QILT surveys (Graduate Outcomes & Student Experience), as well as graduate employment rates. The Student Experience Survey results are thematically reviewed to identify key areas for improvement and identify pressing need for strategies to enhance student engagement. The program notes consistently low student response rates.

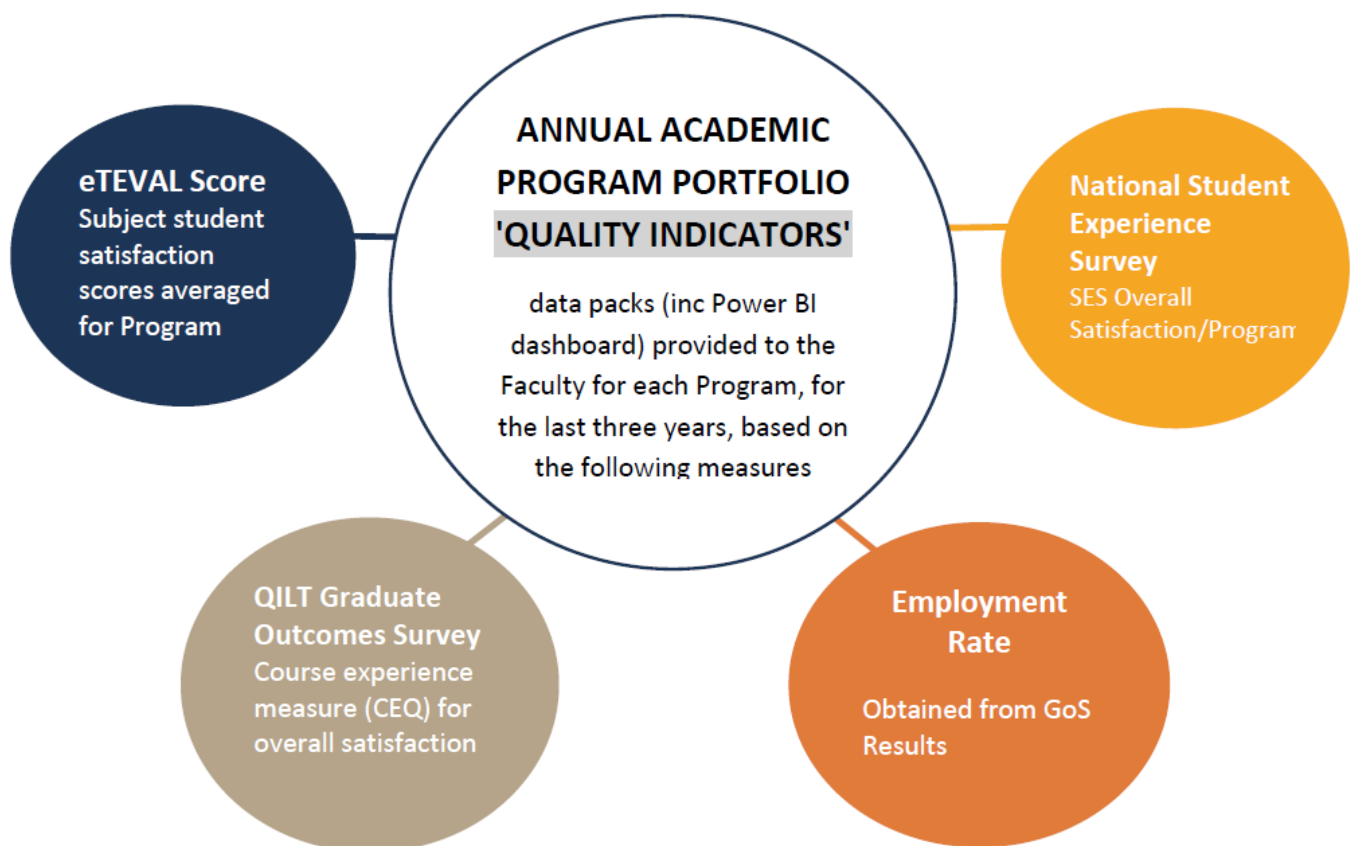

Figure 6: Quality program assurance process and quality indicators

While there is evidence that the Program seeks and analyses feedback, it is unclear that this feedback is systematically utilised to inform program improvement. There is also limited evidence of how the communities the program serves contribute to the evaluation and continuous improvement of the medical program.

As the First Nations Health Curriculum Framework is implemented, the Program will need to ensure that feedback from Aboriginal and/or Torres Strait Islander Program stakeholders is appropriately sought, analysed and used to inform improvements.

There is evidence that the Program is collaborating with other medical education providers in evaluation and participating in national and international medical education initiatives. Joint Placement Committee Meetings have provided a valuable platform for collaboration on evaluation between co-located schools. As noted in Standard 5.4.1, tension around clinical placements needs to be better managed and communicated in response to feedback provided.

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 Program aims to have a structured, data-driven approach to monitoring and analysing student performance to ensure program effectiveness. Feedback is systematically gathered through multiple channels, including national surveys (Student Experience Survey (SES) and the Graduate Outcomes Survey (GOS)), liaison committees, year-specific co-convenors, discipline-specific advisory groups, and real-time digital channels (Zoom chats), providing timely and multi-layered insights into the student experience. The use of the OSLER platform to collect and share supervisor and Clinical Placement Coach feedback shows a strong mechanism for continuous monitoring of clinical teaching quality.

The Program analyses cohort performance to ensure consistency in its outcomes across three intakes: May and September (Direct Entry) and Lateral Entry (LE). The Board of Examiners closely monitors and reviews the performance of Lateral Entry students compared with Direct Entry students to ensure academic parity. This ongoing evaluation has helped to identify knowledge gaps between cohorts and allow for targeted interventions. The Program also reviews results from the National QILT Graduate Outcomes Survey and Medical Schools Outcome Database reports.

There are two levels of oversight to ensure student performance data is systematically analysed and shared with key committees to inform continuous improvement and decision-making. At the university level, a Student Admissions and Progress Committee is convened at least once a semester and provides high-level reports on academic standing based on student characteristics like gender, disability, and First Nations status. At the program level, the Medicine Admission Committee reviews selection processes, integrating performance data from curriculum and assessment teams to align admissions criteria with student success. These mechanisms are complemented by the roles of the Board of Examiners in monitoring student outcomes related to assessment.

It was not evidenced that student performance is considered in relation to student characteristics/demographics and specific pathways to inform future development. At present, evaluation

data from the Program's students at sites such as Gold Coast University Hospital and the Wesley Hospital are not clearly separated from the data of other co-located students. Clarifying data pathways and strengthening the interface with the Clinicians Advisory Board will support more targeted evaluation and quality improvements to student selection, curriculum and student support.

The Program has begun work to evaluate outcomes of the Program for cohorts of students from equity groups. While the outcome data of Aboriginal and/or Torres Strait Islander students and students from rural backgrounds have been collected, the process for the evaluation of these student outcomes is unclear. Evaluation of Aboriginal and/or Torres Strait Islander cohorts must be informed by Aboriginal and/or Torres Strait Islander education experts.

6.3 Feedback and reporting	
6.3.1	The outcomes of evaluation, improvement and review processes are reported through the governance and administration of the medical education provider and shared with students and those delivering the program.
6.3.2	The medical education provider makes evaluation results available to stakeholders with an interest in graduate outcomes, particularly prevocational training providers, and considers their views in the continuous evaluation and improvement of the medical program.

The Program has a structured governance framework to ensure systematic reporting of evaluation, improvement, and review outcomes. The outcomes of evaluation, improvement, and review processes are consistently and effectively shared through the medical education provider's governance and administration. Outcomes are shared through the Medial Schools Outcomes Database (MSOD), MDOT, and MeLT committees. Evaluation outcomes are communicated to students in accordance with the University Evaluation of Learning & Teaching Policy, primarily through the "Closing the Loop" process on iLearn and discussions at the SSLC meetings.

As discussed in Standard 1.3.4, further work is needed to ensure students and student representatives feel more included in the governance and decision-making processes of their program. Evaluation outcomes, improvement, and review processes need to be shared more explicitly with students and those delivering the program in a structured manner, as there is a perception that current mechanisms are inadequate.

The Program participates in the Medical Schools Liaison Committee (MLSC), which is a valuable mechanism for sharing evaluation results with stakeholders, including co-located schools and health services. Formal procedures to make evaluation outcomes available to stakeholders, including students and prevocational training providers, could be strengthened. Work is needed to ensure feedback from these stakeholders is subsequently considered by the Program to close the loop and inform continuous evaluation and improvement of the Program.

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
4CM	Core Clinical Conditions and Competencies
ACCHO	Aboriginal Community-Controlled Health Organisation
ACCLAiM	Australasian Collaboration for Clinical Assessment in Medicine
ACSR	Advanced Clinical Skills Rotation
AI	Artificial intelligence
AMC	Australian Medical Council
AMSAC	Australian Medical Schools Assessment Collaboration
AQF	Australian Qualifications Framework
BMedSt/MD	Bachelor of Medical Studies/Doctor of Medicine
BIHS	Bond Institute of Health and Sport
BVH	Bond Virtual Healthcare
BondCare	University support service
BUCERC	Bond University Clinical Education and Research Centre
CAB	Clinicians Advisory Board
CBL	Case-based learning
CPC	Clinical Placement Coach
CPD	Continuing Professional Development
CRICOS	Commonwealth Register of Institutions and Courses for Overseas Students
CS	Cultural Safety
DOCS	Direct Observation of Clinical Skills
DVCI	Deputy-Vice Chancellor Indigenous
EPAS	Entrustable Professional Activities
GP	General Practice
HELP	Health Educators Learning Program Working Group
HETI	Health Education and Training Institute (in New South Wales)
HSM	Health Sciences and Medicine (Faculty)
ISA	In-semester assessments
IDEAL	International Databases for Enhanced Assessments and Learning Consortium
IUIH	Institute for Urban Indigenous Health

Term	Definition
LO	Learning outcome/s
LHN	Local Health Networks
MDANZ	Medical Deans of Australia and New Zealand
MCNZ	Medical Council of New Zealand
MeLT	Medicine Learning and Teaching Committee
MedRoAP	Medical Program Rules of Assessment and Progression
MSLC	Medical Schools Liaison Committee
MSOD	Medical Schools Outcome Database
MSSBU	Medical Student Society of Bond University
National Law	Health Practitioner Regulation National Law
OT	Occupational Therapy
OSCE	Observed Structured Clinical Examination
PLO	Program Learning Outcome/s
PSA	Prescribing Safely Assessment
PVC	Pro-Vice Chancellor
QILT	National suite of surveys for higher education that focus on Quality Indicators for Learning and Teaching
Quitch	Learning Technologies for Formative Assessment
RAP	Reconciliation Action Plan
SES	Student experience survey
SGL	Small-group learning
SSLC	Student-Staff Liaison Committee
TEQSA	Tertiary Education Quality and Standards Agency
WBA	Workplace-based assessment/s

Appendix 3: Membership of the 2025 AMC Assessment Team

Name	Role
Professor Alison Jones (Chair), BA (Hons), PhD, GAICD	Professor, College of Medicine and Public Health, Flinders University
Associate Professor Paul Saunders (Deputy Chair), MBBS, MPH, GradCert-IRL, PhD	Academic Lead, Indigenous Health, University of Wollongong
Ms Paula Davey, MAICD	Member, Mental Health Tribunal Victoria Co-Surveyor, Australian General Practice Accreditation Limited
Ms Emma Milliss, M. Research, B. Ed (Primary), Dip. ParamedSc, Dip (WHS), Dip. Bus (Leadership)	Academic, Indigenous Health Education, Macquarie University
Dr Haseeb Riaz, MD MHPEd, BBiomedSc	Intern, Royal Perth Hospital (East Metropolitan Health Service) Recent Graduate, Doctor of Medicine, University of Western Australia
Professor Anna Ryan, MBBS, PhD, B.App.Sc(Clin)/B.Chiro.Sc., Grad Dip.Acu., Grad Dip VET, Grad Cert Uni Teaching	Head of Department, Department of Medical Education, University of Melbourne
Dr Greg Sweetman, MBBS, DipRACOG, DA (UK), FRACGP, FACEM, MClinEd, DDU, MHSM	Chair & Lead Surveyor, Post Graduate Council of Western Australia
Juliana Simon	Head of Accreditation Assessments, Australian Medical Council
Melissa Johnson	Cultural Strategic Facilitator, Indigenous Policy and Programs, Australian Medical Council
Clare Stuparich	Program Coordinator, Medical Schools Accreditation, Australian Medical Council
Melissa Longmuir	Policy and Governance Officer, Prevocational Accreditation, Australian Medical Council

Appendix 3: Summary of the 2025 AMC Assessment Team's Accreditation Program

Meetings	Roles engaged with
Monday 14 July 2025 ***Health Sciences and Medicine Building, Bond University***	
Acknowledgement of Country and Welcome	Executive Dean, Faculty of Health Sciences and Medicine Acting Deputy Executive Dean, Faculty of Health Sciences and Medicine Dean of Medicine, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine First Nations Health Lead, Faculty of Health Sciences and Medicine Co-head of BMedSt, Faculty of Health Sciences and Medicine Faculty Business Director, Faculty of Health Sciences and Medicine
Governance and Medical Program Management	Dean of Medicine, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine Co-head of BMedSt, Faculty of Health Sciences and Medicine Assessment Lead, Faculty of Health Sciences and Medicine Head of Curriculum, Faculty of Health Sciences and Medicine Co-head of BMedSt, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine First Nations Health Lead, Faculty of Health Sciences and Medicine Associate Dean, External Engagement and Chair of Medicine Research Committee Domain Leads representative, Faculty of Health Sciences and Medicine Manager, Medical Program, Faculty of Health Sciences and Medicine
Furthering Aboriginal and/or Torres Strait Islander Health Equity	Head of Curriculum, Faculty of Health Sciences and Medicine First Nations Health Lead, Faculty of Health Sciences and Medicine Assistant Professor, First Nations Health, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine Associate Dean, Student Affairs and Service Quality and Simulated Participant Program Lead
Aboriginal and/or Torres Strait Islander Staff	First Nations Health Lead, Faculty of Health Sciences and Medicine Assistant Professor, First Nations Health, Faculty of Health Sciences and Medicine Bond University Elder Manager, First Nations Cultural Education & Acting Head, First Nations Student Success
Community Engagement	Co-head of MD, Faculty of Health Sciences and Medicine Associate Dean, External Engagement, Faculty of Health Sciences and Medicine Professor, Community Placements, Faculty of Health Sciences and Medicine

Meetings	Roles engaged with
	Head of Service, Career, Employment & Experiential Learning, Career Development Centre Staff members, Mudgeeraba Special School Operations Manager, local charity
Medical Program Outcomes and Structure	Head of Curriculum, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine Co-head of BMedSt, Faculty of Health Sciences and Medicine Associate Dean, Learning and Teaching, Faculty of Health Sciences and Medicine Assistant Professor, First Nations Health Domain Lead Representatives
Aboriginal and/or Torres Strait Islander Community Stakeholders	Bond University Elder Manager, First Nations Cultural Education, Office of Provost Co-lead of the Community Rotation Executive Director Organisational Development, Institute for Urban Indigenous Health Acting Senior Medical Officer, Hedland Health Campus Representative, REFOCUS Aboriginal and Torres Strait Islander Child and Family Service
Professional Staff	Acting Deputy Executive Dean, Faculty of Health Sciences and Medicine Faculty Business Director, Faculty of Health Sciences and Medicine General Manager, Academic Services General Manager, Education Services and Partnerships Manager, Medical Program, Faculty of Health Sciences and Medicine
Student Experience	Bond University students from a range of years
Aboriginal and/or Torres Strait Islander Students	Aboriginal and/or Torres Strait Islander Bond University students
Meeting with University of Queensland, Faculty of Medicine	Dean, Medical School, University of Queensland
Tuesday 15 July 2025 ***Health Sciences and Medicine Building, Bond University***	
Vice Chancellor and President	Vice Chancellor
Provost	Provost Deputy Provost Education
Faculty Executive	Executive Dean, Faculty of Health Sciences and Medicine Acting Deputy Executive Dean, Faculty of Health Sciences and Medicine Faculty Business Director, Faculty of Health Sciences and Medicine
Teaching and Learning	Associate Professor, Faculty of Health Sciences and Medicine Assistant Professor, Year 1, Faculty of Health Sciences and Medicine

Meetings	Roles engaged with
	Assistant Professor, Year 2, Faculty of Health Sciences and Medicine Senior Teaching Fellow, Small Group Learning, Year 1 and 2, Faculty of Health Sciences and Medicine Assistant Professor, Year 3, Faculty of Health Sciences and Medicine Assistant Professor, Faculty of Health Sciences and Medicine
Evaluation	Head of Curriculum, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine Co-head of BMedSt, Faculty of Health Sciences and Medicine Assistant Professor and Domain Lead Clinical Practice, Faculty of Health Sciences and Medicine Assistant Professor, MD, Faculty of Health Sciences and Medicine
Meeting with Prevocational Training Provider: Health Education and Training Institute	Medical Director, Health Education and Training Institute Manager, Allocation, Accreditation and Faculty, Health Education and Training Institute
Assessment Strategy	Assessment Lead, Faculty of Health Sciences and Medicine BMedSt Assessment Lead, Faculty of Health Sciences and Medicine Assistant Dean, Learning and Teaching, Faculty of Health Sciences and Medicine
Admissions and Selection	Chair, Medical Program Admissions Committee, Faculty of Health Sciences and Medicine Head of Curriculum, Faculty of Health Sciences and Medicine Assistant Professor, First Nations Health, Faculty of Health Sciences and Medicine Associate Dean, Student Affairs and Service Quality Manager, Student Affairs and Service Quality Head of Admissions
Assessment in Practice	Assessment Lead, Faculty of Health Sciences and Medicine Assessment Lead (BMedSt), Faculty of Health Sciences and Medicine Assistant Professor, Medical Program, Faculty of Health Sciences and Medicine Assessment Manager, Faculty of Health Sciences and Medicine
Student Wellbeing	Director, Student Success and Wellbeing Student Support Lead, Medical Program, (BMed Studies), Faculty of Health Sciences and Medicine Student Support Leads, MD Program, Faculty of Health Sciences and Medicine Medical Program Student Coordinator (BMedSt), Faculty of Health Sciences and Medicine Medical Program Student Coordinator (MD), Faculty of Health Sciences and Medicine
Students Involved in Medical Program Governance	Medical Students' Society Bond University members

Meetings	Roles engaged with
Meeting with University of Sydney, Sydney Medical School	Head of School and Dean, Sydney Medical School
Meeting with Prevocational Medical Accreditation Queensland	Senior Director, Medical Advisory and Prevocational Accreditation Unit
Meeting with Primary Care Lead and Education Team	Head of General Practice, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine
Meeting with Primary Care Clinical Supervisors and Sites	Head of General Practice, Faculty of Health Sciences and Medicine Professor, Community Placements, Faculty of Health Sciences and Medicine Supervisor, Mermaid Central Medical Clinic Supervisor, Robina Bulk Billing Medical Centre Supervisor, Lake Orr Family Practice Supervisor, Tamborine Mountain Medical Practice Supervisor, Our Medical Home Gold Coast Supervisor, Numinbah and Southern Highlands Addiction Retreats
Tuesday 15 July 2025 ***Bond Institute of Health and Sport***	
Interprofessional Learning	Emergency Physician and Assistant Professor in Medical Education and Simulation, Director of Bond Simulation Program Co-Head of MD, Faculty of Health Sciences and Medicine Head of Physiotherapy, Faculty of Health Sciences and Medicine Assistant Dean, Teaching and Learning, Faculty of Health Sciences and Medicine General Manager Academic Services, Expert Patient Coordinator, Faculty of Health Sciences and Medicine
Tour of Facilities	
Meeting with Griffith University, School of Medicine and Dentistry	Dean of Medicine, School of Medicine and Dentistry, Griffith University Head of School of Medicine and Dentistry, Griffith University
Wednesday 16 July 2025 ***Gold Coast University Hospital***	
Hospital/Site Executive (CEO/CMO)	Co-director for Clinical Education, Gold Coast University Hospital, Chief Medical Officer, Gold Coast University Hospital
Clinical Site Leadership	Clinical Sub Dean Co-director for Clinical Education, Gold Coast University Hospital Co-head of the MD Program, Faculty of Health Sciences and Medicine Assistant Professor, Faculty of Health Sciences and Medicine

Clinical Placement Supervision and Strategy	Clinical Sub Dean Co-head of the MD Program, Faculty of Health Sciences and Medicine Clinical Placements Manager, Faculty of Health Sciences and Medicine Medical Student Manager Student Coordinator, Program Coordinator, Assistant Medical Student Manager Assistant Professor, Faculty of Health Sciences and Medicine
Students	Bond University students from first and final clinical years
Clinical Supervisors	Clinical Supervisor (Emergency) Clinical Supervisor (General Medicine) Clinical Supervisor (Intensive Care Unit) Clinical Supervisor (Mental Health) Clinical Supervisor (Orthopaedics) Clinical Supervisor (Surgery) Clinical Supervisor (Anaesthetics) Clinical Supervisor (Child Health) Discipline Lead (CCO) Discipline Lead (Emergency) Discipline Leads (Women's Health) Discipline Leads (Child Health)
Junior Medical Staff	Junior Medical Staff Clinical Placement Coaches
Virtual Meeting with Other Clinical Training Sites	Attendees from Pindara and Gold Coast Private Hospital including clinical supervisors, student coordinator and clinical placement coach
Wednesday 16 July 2025 ***The Wesley Hospital Brisbane***	
Hospital/Site Executive (CEO/CMO)	Head of School, The Wesley Hospital Brisbane Chief Academic Medical Officer, The Wesley Hospital Brisbane CEO, The Wesley Hospital Brisbane
Clinical Site Leadership	Program leads
Clinical Placement Supervision and Strategy	Head of School, The Wesley Hospital Brisbane Practice Manager Chief Academic Medical Officer, The Wesley Hospital Brisbane Head of Curriculum, Faculty of Health Sciences and Medicine Team Leader, Clinical Placements, Faculty of Health Sciences and Medicine
Students	Bond University students currently on placement
Clinical Supervisors	Clinical Supervisor (Child Health) Clinical Supervisor (Women's Health)

	Clinical Supervisor (Intensive Care Unit, St Andrew's) Clinical Supervisor (General Medicine) Clinical Supervisor (Anaesthetics) Clinical Supervisor (Surgery) Coordinators
Junior Medical Staff	Junior Medical Staff
Virtual Meeting with Other Clinical Training Sites	Clinical Supervisor (General Medicine) Student Coordinators, St Andrew's War Memorial Hospital
Wednesday 16 July 2025 ***Tweed Valley Hospital***	
Hospital/Site Executive (CEO/CMO)	Director Medical Services, Tweed Valley Hospital
Clinical Site Leadership	Clinical Sub Dean, Intensivist, Tweed Valley Hospital Co-head of MD, Faculty of Health Sciences and Medicine Assessment Lead, Faculty of Health Sciences and Medicine
Clinical Placement Supervision and Strategy	Clinical Sub Dean, Intensivist Co-head of MD, Faculty of Health Sciences and Medicine Assessment Lead, Faculty of Health Sciences and Medicine Medical Student Coordinator, Tweed Valley Hospital
Students	Students currently on placement
Clinical Supervisors	Clinical Supervisor (Anaesthetics) Clinical Lead (Paediatrics) Clinical Lead (Mental Health) Clinical Lead (General Medicine) Clinical Lead (Emergency) Clinical Lead (General Surgery)
Junior Medical Staff	Junior medical staff
Aboriginal Liaison Officer	Aboriginal Liaison Officer
Virtual Meeting with Other Clinical Training Sites	Clinical supervisors from John Flynn Private Hospital Student coordinator from John Flynn Private Hospital Sub-dean, John Flynn Private Hospital
Thursday 17 July 2025 ***Health Sciences and Medicine Building, Bond University***	
Aboriginal and/or Torres Strait Islander Staff	First Nations Health Lead, Faculty of Health Sciences and Medicine Assistant Professor, First Nations Health, Faculty of Health Sciences and Medicine Bond University Elder Manager, First Nations Cultural Education and Acting Head, First Nations Student Success, Nyombil Centre Provost Staff member, Nyombil Centre

Professionalism and Fitness to Practice	Associate Dean, Student Affairs and Service Quality, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine Co-head of BMedSt, Faculty of Health Sciences and Medicine Manager, Student Affairs and Service Quality, Faculty of Health Sciences and Medicine
Additional Meeting	Executive Dean, Faculty of Health Sciences and Medicine Provost Dean of Medicine, Faculty of Health Sciences and Medicine
Meeting with Primary Care Lead and Education Team	Professor of Community Clinical Education, Faculty of Health Sciences and Medicine Partnerships Manager Student Placements
Meeting with Queensland Health	Chief Medical Officer, Queensland Health
Friday 18 July 2025 ***Health Sciences and Medicine Building, Bond University***	
Final Debrief	Dean of Medicine, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine Co-head of BMedST, Faculty of Health Sciences and Medicine Head of Curriculum, Faculty of Health Sciences and Medicine Executive Dean, Faculty of Health Sciences and Medicine First Nations Health Lead, Faculty of Health Sciences and Medicine Acting Executive Deputy Dean, Faculty of Health Sciences and Medicine Chair of the Medical Research Committee, Faculty of Health Sciences and Medicine Assessment Lead, Faculty of Health Sciences and Medicine Manager, Medical Program, Faculty of Health Sciences and Medicine Assistant Professor, First Nations Health, Faculty of Health Sciences and Medicine Co-head of MD, Faculty of Health Sciences and Medicine Associate Dean, Student Affairs and Service Quality, Faculty of Health Sciences and Medicine Manager, First Nations Cultural Education and Acting Head, First Nations Student Success, Nyombil Centre Professor, Community Placements, Faculty of Health Sciences and Medicine Co-head of BMedSt, Faculty of Health Sciences and Medicine Assistant Professor, Faculty of Health Sciences and Medicine Associate Professor, Faculty of Health Sciences and Medicine Senior Teaching Fellow, Small Group Learning, Faculty of Health Sciences and Medicine Accreditation Officer, Faculty of Health Sciences and Medicine Curriculum and Accreditation Manager, Faculty of Health Sciences and Medicine

	General Manager, Academic Support Services, Faculty of Health Sciences and Medicine Assistant Professor, Faculty of Health Sciences and Medicine Assistant Professor, MD, Faculty of Health Sciences and Medicine Head of Physiotherapy, Faculty of Health Sciences and Medicine Associate Professor, Faculty of Health Sciences and Medicine Assistant Professor, Faculty of Health Sciences and Medicine Manager, Student Affairs and Service Quality, Faculty of Health Sciences and Medicine Medical Program Student Coordinator, Faculty of Health Sciences and Medicine Medical Program Student Coordinator (MD), Faculty of Health Sciences and Medicine Student Support Lead, MD Program, Faculty of Health Sciences and Medicine Faculty Business Director, Faculty of Health Sciences and Medicine

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