

Accreditation Report: University of Notre Dame Australia, National School of Medicine

Medical School Accreditation Committee

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Acknowledgement of Country

The Australian Medical Council (AMC) acknowledges the Aboriginal and/or Torres Strait Islander Peoples as the original Australians, and Māori as Tangata Whenua 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 University of Notre Dame Australia main medical campuses are located on the lands of the Whadjuk Noongar People in Fremantle, the Yawuru People in Broome, and the Gadigal, Dharawal and Dharug People in Sydney. The Program operates across many other lands in Western Australia, New South Wales and Victoria.

We acknowledge that learning, teaching and healing have taken place on these lands far before the establishment of modern medicine. 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 University of Notre Dame Australia (UNDA; the University) has had two medical programs accredited by the AMC: the School of Medicine, Fremantle was first accredited in 2004; and the School of Medicine, Sydney was first accredited in 2007.

In 2021, the University adopted a new Faculty structure, merging its Fremantle and Sydney Schools of Medicine into a single National School of Medicine. Since 2024, the University has reported to the AMC as one National School of Medicine; however, it has continued to deliver two separately accredited medical programs across the Fremantle and Sydney campuses. The 2026 reaccreditation assessment is the AMC's first assessment of the national Doctor of Medicine (MD) program.

An overview of each Program's accreditation and monitoring history by the AMC is provided below:

Year & Assessment type	Decision
<i>School of Medicine, Fremantle</i>	
2004: Accreditation assessment	Initial accreditation granted until 31 December 2010
2009: Follow-up assessment	Accreditation granted until 31 December 2013
2012: Accreditation extension submission	Accreditation extended until 31 December 2016
2015: Material change	Planned transition from MBBS to MD not considered a material change and assessed in conjunction with 2016 reaccreditation assessment
2016: Reaccreditation	Accreditation granted until 31 March 2018 (MBBS) and 31 March 2023 (MD)
2022: Accreditation extension submission	Accreditation extended until 31 March 2027

Year & Assessment type	Decision
School of Medicine, Sydney	
2007: Accreditation assessment	Initial accreditation granted until 31 December 2013
2013: Accreditation extension submission	Accreditation extended until 31 December 2017
2015: Material change	Planned transition from MBBS to MD not considered a material change and assessed in conjunction with 2017 reaccreditation assessment
2017: Reaccreditation	Accreditation granted until 31 March 2022 (MBBS) and 31 March 2024 (MD)
2023: Accreditation extension submission	Accreditation extended until 31 March 2027

Accreditation process

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

When undertaking 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*.

For more information about the AMC's accreditation process in Australia and Aotearoa New Zealand, see Appendix 1.

2026 reaccreditation

An AMC team (the team) conducted a reaccreditation assessment of the University of Notre Dame Australia, National School of Medicine's medical program, and met with staff (academic and operational), medical students, clinical supervisors and other groups involved in the delivery of the program. The team visited UNDA campuses in Fremantle, Broome and Sydney, as well as clinical training sites in Perth, Broome, Lithgow and Sydney from Monday 23 February to Friday 6 March 2026. The full team member composition can be found in Appendix 2, and the list of meetings held by the team can be found in Appendix 3.

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 10 August 2026 meeting resolved:

- i. that the medical program of the University of Notre Dame Australia, National School of Medicine substantially meets the accreditation standards;
- ii. that accreditation of the four-year Doctor of Medicine (MD) medical program of the University of Notre Dame Australia, National School of Medicine be granted accreditation for six years, to 31 March 2033;
- iii. that accreditation of the medical program is subject to meeting the conditions contained in the accreditation report and to meeting the monitoring requirements of the AMC.

Conditions on accreditation

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

Condition		To be met by
Standard 1: Purpose, context and accountability		
1	Identify and consult with community groups within the national MD footprint to develop and implement program-wide strategies that improve and adapt the medical program. These should include: a. A plan for systematic community engagement to help identify changing healthcare needs and community priorities, enabling the creation of targeted programs that address place-specific requirements and inform resource allocation. b. An overarching community engagement strategy that facilitates mutual benefit between the School and its community members. (Standard 1.1.2 and 1.2.1)	2029 Provide plan/ strategy in 2027 Demonstrate implementation in 2028
2	To ensure Aboriginal and/or Torres Strait Islander voices and participation are effectively and consistently integrated throughout the national MD program: a. Formally embed Aboriginal and/or Torres Strait Islander leadership in the executive team, senior leadership team, and relevant decision-making processes for the School. b. Ensure Aboriginal and/or Torres Strait Islander representation is embedded in all levels of program governance to lead development and ensure cultural safety as a shared responsibility across the program. (Standard 1.1.4, 1.3.1, 1.3.5 and 1.4.4)	2027
3	Provide evidence that all partnerships for student clinical placements are supported by up-to-date formal agreements. (Standard 1.2.2 and 5.4.3)	2027
4	Formalise and strengthen collaborative partnerships with Aboriginal and/or Torres Strait Islander individuals and organisations, ensuring mutual benefit	2028

Condition	To be met by
and supporting the long-term sustainability of community health services. (Standard 1.2.3 and 2.1.1)	
5 Clearly define the roles and responsibilities of leadership positions, committees, and working parties responsible for program and academic oversight. The outcome of the review should ensure clarity about delegations, decision-making authority, and reporting relationships, and provide a revised governance framework that details all relevant committees, working groups, and leadership roles, including approved terms of reference for key committees and working parties. (Standard 1.3.1, 1.3.2 and 1.3.3)	2027
6 Develop, document and implement structured and formal processes to ensure meaningful student participation in governance and decision-making of the national MD program, including defined representation requirements and feedback mechanisms across all campuses and national committees. (Standard 1.3.1 and 1.3.4)	2027
Standard 2: Curriculum	
7 Develop and implement a program-wide strategy with appropriate resourcing to advance Aboriginal and/or Torres Strait Islander health equity and education across the program. This should: a. Document the Indigenous Health and Medicine (IHM) domain curriculum. b. Effectively resource the IHM team to enable their participation in curriculum development, cross-team planning and work, and assessment. c. Embed a strength-based framework in the implementation of an evidence-based curriculum that is led and authored by Aboriginal and/or Torres Strait Islander health experts. d. Demonstrate evidence of integration, effectiveness and co-design of assessment by Aboriginal and/or Torres Strait Islander health experts in the transition to the national MD assessment program. (Standard 2.2.2, 2.2.3, 2.3.6 and 3.1.6)	a. 2027 b. 2027 c. 2029 d. 2029
8 Finalise the development, implementation, and plan for evaluation of the pre-internship program. (Standard 2.3.9)	2027
Standard 3: Assessment	
9 As part of the implementation of the national MD program, demonstrate that the assessment system: a. Achieves consistent standards of student performance across all assessment settings, sites and cohorts, supported by defensible and comparable standard-setting processes. b. Produces evidence from regular, systematic evaluation showing continuous improvement in the reliability, validity, fairness and equity of assessment methods and decisions. (Standard 3.1.5 and 3.3.1)	2028
10 Provide evidence of the integration and co-design of assessment in Aboriginal and/or Torres Strait Islander health, ensuring that culturally safe practices are incorporated, led and guided by the expertise of Aboriginal and/or Torres Strait Islander Peoples. (Standard 3.1.6)	2027

Condition	To be met by
Standard 4: Students	
11 Provide evidence that the Kimberley Centre for Remote Medicine Training (KCRMT) has sufficient, sustainable and appropriately supervised clinical placements in Years 3 and 4 to support the planned student cohort, and that offers and allocation of students to the KCRMT are aligned to confirmed placement capacity and secured through formal agreements. (Standard 4.1.1 and 4.1.3)	2027
12 Demonstrate that Aboriginal and/or Torres Strait Islander students across all sites experience timely, culturally safe, accessible, and effective academic and pastoral support through a consistently implemented and adequately resourced support system that has been developed in consultation with cultural experts and students. The framework must result in: a. Clearly understood and utilised pathways for access to culturally informed academic and pastoral support. b. Transparent, safe and effective procedures for reporting, escalating, and responding to racism, discrimination, and barriers to student wellbeing. c. Evidence that reported matters are addressed promptly, appropriately, and in ways that support student safety and wellbeing. (Standard 4.1.3, 4.2.2 and 4.2.3)	2028 a. 2027 b. 2027 c. 2028
13 Demonstrate consistent identification and support of students at academic risk, equitable application of special consideration processes, and effective implementation of Learning Access Plans, resulting in uniform student experiences and outcomes across all cohorts. (Standard 4.1 and 3.2.2)	2028
14 Review and update the Professional Practice and Fitness to Practise Policy, including governance procedures, to ensure suitability for the national MD program. Clearly define roles, responsibilities, and escalation pathways, maintain separation between student support, academic, discipline, appeals, and fitness-to-practise decisions, and document processes for identifying and managing conflicts of interest. (Standard 4.2.6 and 1.3.6)	2027
15 Establish a confidential reporting pathway for students in the national MD program to raise wellbeing, bullying, harassment, discrimination, racism, or unprofessional conduct concerns in all learning environments, including clinical placements. The pathway must clearly define its scope, triage and escalation, roles (separating operational and pastoral duties), confidentiality and privacy requirements, timely student feedback where possible, and routine monitoring for continuous improvement. (Standard 4.2.7)	2027
Standard 5: Learning environment	
16 Collaborate with General Practice domain leads to develop and implement a sustainable staffing model that supports the ongoing delivery of primary care education across the program. (Standard 5.2.1)	2029
17 Develop and implement a structured, sustainable plan for the recruitment of Aboriginal and/or Torres Strait Islander health staff to facilitate the development and implementation of improvements to the Indigenous Health and Medicine domain curriculum, learning and assessment, and delivery of culturally safe practice. This should include a culturally safe system for measuring the success of Aboriginal and/or Torres Strait Islander staff, and	2028

Condition	To be met by
formalising professional development opportunities and culturally specific support. (Standard 5.2.3, 5.2.4, 5.3.1 and 5.3.3)	
18 As part of the transition to the national MD program: a. Demonstrate that research and scholarship are adequately resourced and systematically integrated across the National School. b. Demonstrate that scholarship and the medical education evidence base is informing program development and continuous improvement. (Standard 5.2.4 and 2.2.4)	2029
19 Develop and implement a formal framework, in consultation with simulated patients, to strengthen the recruitment, engagement and support of simulated patients and community members across the program. This framework should include: a. Recruitment processes that actively engage community groups experiencing health inequities, including Aboriginal and/or Torres Strait Islander communities, underpinned by written agreements that clearly articulate the mutual obligations and responsibilities of the School and simulated patients. b. Structured orientation, training and quality assurance processes appropriate to the simulated patient role, including clear processes for managing adverse events arising during learning and teaching activities. (Standard 5.2.5)	2029
20 Strengthen approaches to Aboriginal and/or Torres Strait Islander health education and cultural safety by: a. Developing and implementing regular and ongoing cultural safety training, in line with the National Scheme definition, for all staff, clinical supervisors and students. (Standard 5.3.4 and 2.3.7) b. Ensuring all students have clearly defined, supervised, and assessable clinical experiences involving the provision of healthcare to Aboriginal and/or Torres Strait Islander patients. This should include explicit learning objectives, appropriate clinical placements or encounters, cultural safety integration, and mechanisms to monitor, document, and verify that each student achieves these experiences. (Standard 5.4.2, 2.1.1, 2.2.3, 2.2.4 and 3.1.6)	a. Develop by 2027, implement in 2028 b. 2028
21 Develop and implement a consistent, formalised orientation process and plan for monitoring the performance of clinical supervisors. (Standard 5.5.2 and 5.5.3)	2027
Standard 6: Evaluation and continuous improvement	
22 Establish a process for monitoring student performance against student characteristics, ensuring findings are regularly shared with the committees responsible for student selection, curriculum and student support. (Standard 6.2.3)	2027

Commendations

A	The School leadership team operates collegially and effectively, strengthening the program through strong relationships. There is a strong commitment to building positive relationships within the School, Faculty and University, which enables institutional commitment for the strategic development and success of the national MD program. (Standard 1.3 and 1.4)
B	The Dean of Medicine has been pivotal in modelling and promoting a culture of collegiality and collaboration across the School and the Faculty, and with its stakeholders, demonstrating strong strategic and educational leadership. (Standard 1.4.2)
C	The initiative to establish the Broome campus within the medical program through the KCRMT reflects a genuine institutional commitment to improve rural and remote medical workforces. (Standard 1.1.2 and 4.1.3)
D	There is a clear and strong emphasis on aligning learning outcomes with weekly learning objectives and teaching activities, offering students, academic staff and clinical supervisors improved clarity in teaching and learning. (Standard 2.2.5 and 2.2.9)
E	The primary care education teams in both Fremantle and Sydney are effective in their roles and dedicated to a positive student learning experience. (Standard 2.3.8)
F	The cultural immersion program conducted at and by the Australian Museum team in Sydney is exemplary in teaching culturally safe practice and critical reflection. (Standard 2.2.3)
G	There is a coordinated approach to interprofessional education opportunities throughout the curriculum, including local opportunities to learn with and from other health professional students. (Standard 2.3.3)
H	The assessment program demonstrates a strong commitment to quality and consistency, with a clear program-level approach, well-defined expectations, and processes that support fair judgment of student achievement, and strong evidence of continuous improvement informed by item analysis and student feedback. (Standard 3.1 and 3.3)
I	The strong and effective partnership between MSAND and MANDUS with the School's senior leadership team is a key strength that ensures the student voice is included in the program's delivery. (Standard 4.2.1)
J	At its best, the pastoral support model is of high quality and valued by students. The relational, accessible approach of staff reflects a genuine strength of the program and is affirmed by students across many campuses. (Standard 4.2.2)
K	The dedication and expertise of the School's professional staff, including site coordinators and clinical school administrative staff, demonstrate a breadth of contribution and responsiveness that makes them highly valued by clinicians, staff and students as an essential point of contact and support across the program. (Standard 5.2.2)
L	The strong ethos of collaboration and collegiality is demonstrated through the School's partnerships with co-located schools at several sites, fostering productive and mutually beneficial working relationships. (Standard 5.4.3)
M	The School's tri-annual student evaluation process and the effective communication and use of evaluation findings by hospital coordinators and heads of clinical schools drives continuous improvement. (Standard 5.5.4 and 6.1.2)
N	The National Quality Committee and its Evaluation Framework provide a strong foundation for transparent and systematic quality assurance, ensuring stakeholders receive regular updates to foster a culture of continuous improvement and enabling data-driven analysis of cohort outcomes on a national scale. (Standard 6.1, 6.2 and 6.3)

Recommendations for improvement

I	Consider auditing interprofessional learning opportunities to identify consistency and equality of student access to opportunities. (Standard 2.3.2)
II	Consider developing a policy and associated processes to ensure appropriate diversity of clinical placements, so that students are not predominantly or exclusively placed in private settings. (Standard 2.3.8)
III	Review the process to ensure primary care supervisors and hospital clinical supervisors receive evaluation and student performance feedback. (Standard 3.2.3)
IV	Consistent with the expanding program footprint, evaluate the system for supporting students in financial need to determine how it acknowledges place-based circumstances and accounts for timely and equitable participation in the medical program, including placement-related travel and accommodation, and emergency support. (Standard 4.2.2)
V	Consider introducing additional education for students on culturally safe ways to engage with patients and teaching on the importance of identification of Aboriginal and/or Torres Strait Islander patients. (Standard 5.4.2)

Appreciation

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

Assessment against the accreditation standards

Standard 1: Purpose, context and accountability			
1.1	Purpose	Substantially Met	This Standard is Substantially Met
1.2	Partnerships with communities and engagement with stakeholders	Substantially Met	
1.3	Governance	Substantially Met	
1.4	Medical program leadership and management	Substantially Met	
Standard 2: Curriculum			
2.1	Medical program outcomes and structure	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	Substantially Met	
Standard 4: Students			
4.1	Student cohort and selection policies	Substantially Met	This Standard is Substantially Met
4.2	Student wellbeing	Substantially Met	
4.3	Professionalism and fitness to practise	Substantially Met	
4.4	Student indemnification and insurance	Met	
Standard 5: Learning Environment			
5.1	Facilities	Met	This Standard is Substantially Met
5.2	Staff resources	Substantially Met	
5.3	Staff appointment, promotion and development	Substantially Met	
5.4	Clinical learning environment	Substantially Met	
5.5	Clinical supervision	Substantially Met	
Standard 6: Evaluation and continuous improvement			
6.1	Continuous review, evaluation and improvement	Met	This Standard is Substantially Met
6.2	Outcome evaluation	Substantially Met	
6.3	Feedback and reporting	Met	

ITEMISED OUTCOME OF ACCREDITATION ASSESSMENT

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

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

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

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

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

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

Key:
Met
Substantially Met
Not Met

STANDARD 1: Purpose, context and accountability

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

The medical program

For the past 20 years, the University of Notre Dame Australia (UNDA; the University) has offered its medical program in Western Australia at its Fremantle campus on Whadjuk Country, and for 17 years in New South Wales at the Sydney campus on Gadigal, Dharug and Dharawal Country. During this time, the medical program transitioned from a graduate-entry Bachelor of Medicine, Bachelor of Surgery (MBBS) to a Doctor of Medicine (MD). In 2021, UNDA introduced a Faculty structure, bringing its two Schools of Medicine together into a single, National School of Medicine (the School).

The clinical schools associated with the Sydney campus are located on Wiradjuri Country (Wagga Wagga and Lithgow, New South Wales), Wadawurrung and Dja Dja Wurrung Country (Ballarat, Victoria) and on the traditional lands of the Bunurong and Wadawurrung Peoples (Werribee, Victoria) of the Kulin Nation.

In 2025, the School opened the Kimberley Centre for Remote Medical Training (KCRMT), an end-to-end rural medical program on Yawuru Country in Broome, Western Australia, expanding its footprint for foundation-year delivery.

The School is transitioning to a national MD program, embedding an end-to-end program in Broome and incorporating a governance and operational structure for its Broome, Fremantle, Sydney and rural clinical schools under one umbrella. The scope of the reaccreditation of the UNDA medical program focuses on this transition and how the program is currently meeting the accreditation standards for primary medical programs.

The purpose of the medical program

The School has a clearly defined purpose:

to provide excellent education, research and scholarship in the context of Catholic values with respect for human life, dignity and social justice. To foster the development of graduates and staff who provide ethical, professional and caring service that improves health and health equity in local, national and global communities.

This purpose aligns with the University's five key strategic pillars, which outline its commitment to build a stronger and brighter future for students, staff and the community.

The School has a broad physical footprint across Australia with a strong commitment to accounting for place-based community needs in its curriculum and delivery, which aligns with the School's purpose. A key challenge for the team was to understand the systematic way in which the healthcare needs of local communities were addressed through its national curriculum design and delivery (Standards 2.2 and 2.3). For example, the development of the new curriculum did not explicitly incorporate learning outcomes aligned with the competencies required for rural or remote practice, where clinicians often have limited or no access to on-site investigations or tertiary services.

Commitment to Aboriginal and/or Torres Strait Islander health equity

The School affirms the central importance of the Aboriginal and/or Torres Strait Islander Peoples of Australia, including their communities, cultures, languages, diversity and histories. It is committed to working collaboratively and in genuine partnership with Aboriginal and/or Torres Strait Islander Peoples, their families and communities to improve health and wellbeing and to achieve equitable outcomes.

Although the School has professed a commitment to advancing Aboriginal and/or Torres Strait Islander health equity and cultural safety education, the team observed that the current engagement methods can be perceived as lacking reciprocity and limiting self-determination. There is limited evidence of a structured, program-wide approach that uses local health data, community priorities and service realities to inform curriculum decisions and cultural safety. This is explored in detail under Standards 2.2, 4.1, 5.3.1, 5.3.4 and 5.4.

1.2 Partnerships with communities and engagement with stakeholders	
1.2.1	The medical education provider engages with stakeholders, including community groups who experience health inequities and Aboriginal and/or Torres Strait Islander and Māori people and organisations, to: • define the purpose and medical program outcomes • design and implement the curriculum and assessment system • evaluate the medical program and outcomes of the medical program.
1.2.2	The medical education provider has effective partnerships to support the education and training of medical students. These partnerships are supported by formal agreements and are entered into with: • community organisations • health service providers • local prevocational training providers • health and related human service organisations and sectors of government.
1.2.3	The medical education provider has mutually beneficial partnerships with relevant Aboriginal and/or Torres Strait Islander and Māori people and organisations. These partnerships: • define the expectations of partners • promote community sustainability of health services.

Stakeholder and community engagement

There are examples of touchpoints with the community for whom the medical program serves, such as through:

- multi-day rural immersion programs in the Wheatbelt region and Derby (Western Australia), and the Blue Mountains (New South Wales)
- workshops and panels for students to learn from the lived experiences of patients, with recent topics including domestic violence, sexual and gender diversity, mental illness and living with diabetes.

These experiences provide students with exposure to rural life and foster empathy towards diverse populations. However, there is no clear evidence of a structured, nationally contextualised, reciprocal and sustained approach to community engagement that directly informs curriculum design, assessment and program outcomes. Engagement appears largely activity based rather than strategic, and there is limited clarity for stakeholders on how they can contribute meaningfully to program development. There are variations to the curriculum to incorporate local context and community learning; however, it is unclear whether there are structural opportunities to embed local community perspectives from the planning stage. With the move to a national MD program that is distributed across a large footprint, it is important that the School ensures incorporation of structured, strategic input of community needs into the curriculum.

The inclusion of patient lived experience in the program is a strength, though this is not yet complemented by systematic or reciprocal partnership models that influence governance, curriculum or evaluation. While there have been efforts to improve inclusivity in curriculum content relating to other community groups who experience health inequity, including the LGBTIQ+ community (e.g. problem-based learning [PBL] cases), these changes have not been clearly informed by direct community engagement or partnership. It is important that the School continues to develop this content through consultation with relevant community groups and organisations.

There is a significant opportunity, particularly through the KCRMT, to develop stronger, place-based and community-led partnerships.

Stakeholder partnerships

Agreements for student clinical placements in Western Australia, New South Wales and Victoria are generally formalised. Notably, the Rural Clinical School of Western Australia (RCSWA) consists of a tripartite partnership agreement between the medical programs of UNDA, the University of Western Australia (UWA) and Curtin University (Curtin) to coordinate rural and remote clinical placements, training and student support. The UWA supports the operational functions of the program, and there is a formal funding agreement between all three universities for contributions to operating costs. The KCRMT is part of the RCSWA agreement for clinical rotations in Years 3 and 4.

The School maintains a register of agreements, some of which additionally cover interprofessional education in other University programs, such as nursing. The team notes that some of these agreements are being renewed, while others, such as primary care in private settings, do not seem as formalised.

Engagement with Aboriginal and/or Torres Strait Islander communities and organisations

There was limited evidence of purposeful interaction and information sharing with Aboriginal and/or Torres Strait Islander communities and service partners at the School's campus or clinical sites to ensure their needs are met in the design of the national MD program's curriculum. In particular, there is minimal evidence of genuine co-design with Aboriginal and/or Torres Strait Islander communities in defining program purpose, curriculum priorities or evaluation processes. The absence of a clear community voice within these domains represents a significant gap. The partnership with the Australian Museum was an exemplar in co-design, and the revisit in the second year provides students with genuine follow-up and engagement. Exemplars such as this show potential for this approach to inform the development of similar activities across the program.

Formal, mutually beneficial and sustainable partnerships with relevant Aboriginal and/or Torres Strait Islander Peoples and organisations have been initiated but need to be further developed, strengthened and integrated into the purpose of the national MD program and its outcomes. The current model demonstrates a willingness to engage with Aboriginal and/or Torres Strait Islander partners, providing a foundation for further meaningful collaboration and co-design. There is an opportunity to strengthen these partnerships to enable Aboriginal and Torres Strait Islander voices to actively influence the program's direction.

1.3 Governance	
1.3.1	The medical education provider has a documented governance structure that supports the participation of organisational units, staff and people delivering the medical program in its engagement and decision-making processes.
1.3.2	The medical education provider's governance structure provides the authority and capacity to plan, implement, review and improve the program, so as to achieve the medical program outcomes and the purpose of the medical education provider.
1.3.3	The medical education provider's governance structure achieves effective academic oversight of the medical program.
1.3.4	Students are supported to participate in the governance and decision making of their program through documented processes that require their representation.

1.3.5	Aboriginal and/or Torres Strait Islander and Māori academic staff and clinical supervisors participate at all levels in the medical education provider's governance structure and in medical program decision-making processes.
1.3.6	The medical education provider applies defined policies and processes to identify and manage interests of staff and others participating in decision-making processes that may conflict with their responsibilities to the medical program.

The National School of Medicine has a documented governance structure that appears organisationally adequate, with appropriate oversight provided by the Faculty's Executive Dean, who is part of the University's senior executive team. The team heard multiple examples of operational matters and decision-making processes that require the Dean's approval or direct involvement. With the move to the National School of Medicine, it is timely to clarify all committee and program leadership roles, delegations and responsibilities.

Program management and committees

The School of Medicine governance and committee reporting structure is depicted in Figure 1.

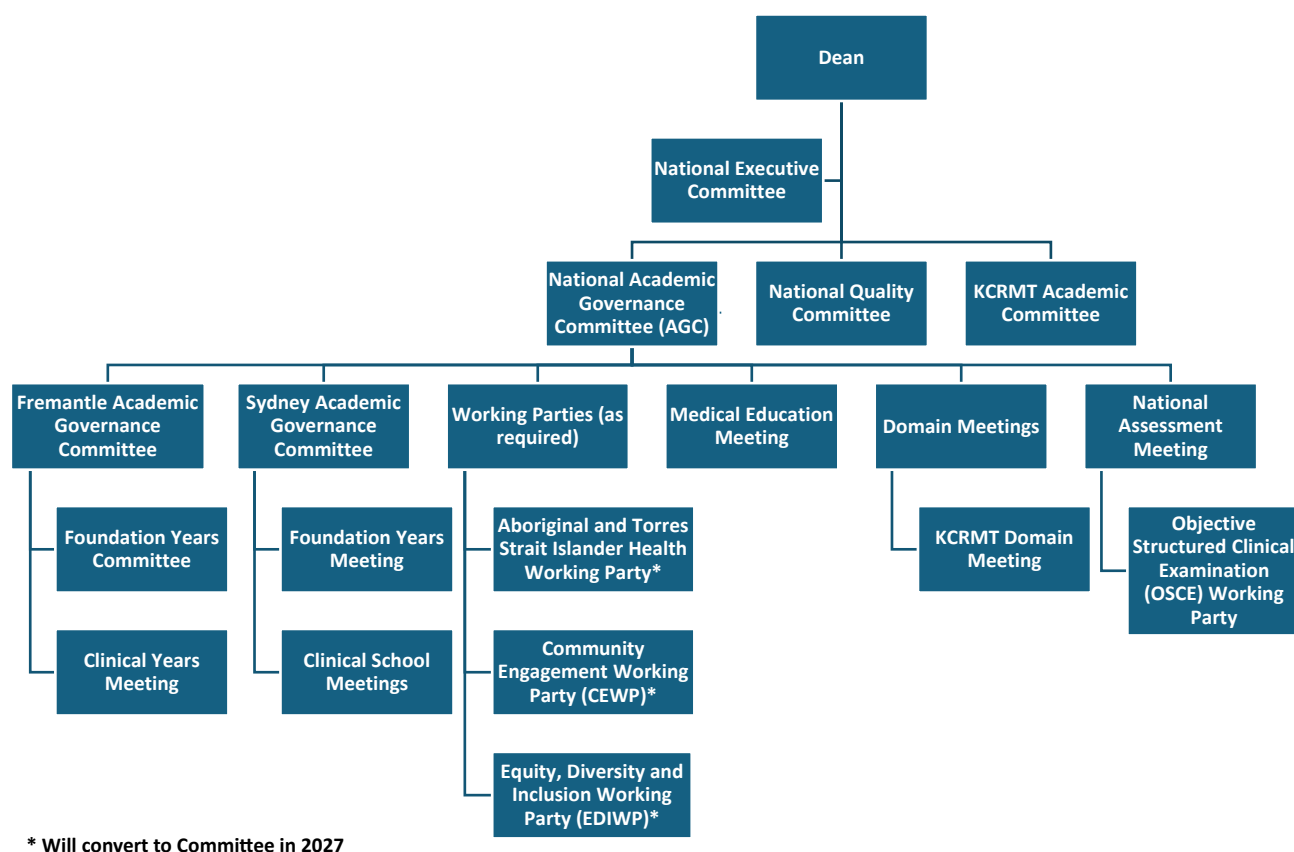


Figure 1: UNDA School of Medicine governance structure

Clear definitions and delegations of decision-making processes, including terms of reference, for the relevant organisational units involved in delivering the national MD program are needed to ensure appropriate authority and capacity are allocated to plan, implement, review and improve the program. The School has several working parties, particularly those involved in developing the national curriculum, that do not yet clearly fit within the School's governance structure. This poses a risk of variation in decision making and unclear authority.

Examples of this include the initiation of the Aboriginal and Torres Strait Islander Health Working Party, the Community Engagement Working Party, and the Equity, Diversity and Inclusion Working Party, which will provide strategic advice and support to the School in the review of the national MD program outcomes, curriculum and assessment systems. These groups are likely to facilitate strategic partnerships with public,

private and community organisations. The team notes that the creation of these working parties are positive steps and demonstrate the School's strong understanding of the importance of accounting for community needs. However, these groups need to be further formalised and embedded into the School's governance, with a more deliberate, evidence-informed and co-designed approach to ensure that place-based intent is consistently realised in practice throughout the program. The School intends to transition these working parties to formal committees in late 2026, which will support this.

The Joint Curriculum Advisory Committee (also known as the RCSWA Penultimate Year Program Committee), representing UNDA, UWA and Curtin, meets monthly to ensure the curriculum encompasses all three programs in the RCSWA.

While these current mechanisms have enabled progress during a period of transition, they now present a risk to consistency, accountability and quality assurance as the program moves to a fully national model. Strengthening the integration of all curriculum-related activities into formal governance structures will be important to ensure robust and sustainable oversight.

Student involvement in governance

The team met with representatives from two student bodies in the National School of Medicine, the Fremantle-based Medical Students' Association of Notre Dame (MSAND) and the Sydney-based Medical Association of Notre Dame University Sydney (MANDUS). Both MSAND and MANDUS are represented in their respective campus MD Academic Governance Committees, the national MD Academic Governance Committee and the National Quality Committee (NQC). Representatives from MSAND and MANDUS have indicated that regular meetings occur with the Dean, Deputy Deans and Heads of Foundation and Clinical Years at various campuses; these engagements are positive indicators of the School's commitment to engaging with student representatives. This demonstrates student participation in governance and engagement with senior leaders including a comprehensive evaluation process being in place (covered under Standard 6). However, a structured, formalised student feedback process is yet to be embedded to ensure meaningful, consistent and representative engagement across campuses and at a national level.

In addition, these interactions currently lack formalised mechanisms to guarantee comprehensive, diverse and ongoing input from the broader student body. Decision-making processes are at times characterised as consultative rather than fully co-designed, with significant reliance on student societies and informal relationships. Beyond student experience surveys, the team did not identify clear, standardised processes for all students—especially those not affiliated with student societies—to raise concerns, provide feedback or participate meaningfully in decision making and governance on issues related to their education.

The implementation of the national MD program and curriculum is an opportune time to establish a process for the entire student body to be included. In addition, the School must ensure timely and consistent responses to student issues, such as resolving the lack of a Year 1 learning space at the Broadway (Sydney) campus and improving clarity around staff points of contact and channels for student engagement. These measures will be essential as the School transitions to a national MD program to ensure all students are appropriately represented and engaged in governance.

Aboriginal and/or Torres Strait Islander Peoples

The School demonstrates a commitment to the representation of Aboriginal and/or Torres Strait Islander academic staff at various levels across its governance structure. The recent appointment of a senior Aboriginal and/or Torres Strait Islander leadership role, as Domain Lead, with oversight of the Indigenous Health and Medicine (IHM) domain and its team, is an important step forward, providing leadership in strengthening curriculum and assessment, cultural safety and the recruitment of Aboriginal and/or Torres Strait Islander staff and students.

Building on this foundation, further opportunities exist to ensure the Domain Lead's expertise and perspective are included within the School's most senior leadership group, strengthening the influence of Aboriginal and/or Torres Strait Islander academic staff at the highest level, including representation on the National School of Medicine Executive Committee.

Beyond academic positions, the School should also consider ways to involve members of Aboriginal and/or Torres Strait Islander communities in the governance of its medical program, given the program's broad footprint and the need to appropriately meet place-based needs in these communities.

Managing conflicts of interest

There is a clearly documented process for declaring and managing conflicts of interest during meetings. The team identified issues with separating decision making from support provision for fitness to practice, which will be discussed further in Standard 4.

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 School has the financial resources to sustain its medical program and, in general, the team did not identify significant concerns with its resourcing to meet its purpose. The support from the University, particularly from the Vice Chancellor, was noted positively. The establishment of the end-to-end program at the KCRMT, which has significant potential to improve rural, remote and Aboriginal and/or Torres Strait Islander medical workforces is commendable. It will be critical to ensure ongoing financial and logistical resources to support its ongoing viability. Further consideration should be given to the potential to reallocate or reprioritise resources to improve recruitment of staff, community members and students.

Medical program leadership

The School has a clearly dedicated and defined head of the program, who has the authority and responsibility to manage it. The team recognised that the Dean's leadership is highly respected by her team and the University leadership team, as well as many School staff and students, and this is to be commended. The School's Dean is well supported by Deputy Heads of School in both the Fremantle and Sydney campuses, who oversee day-to-day operations, and a dedicated senior program leadership team that has the appropriate authority and resources to deliver the program.

Under the Dean's leadership, the team was impressed by the senior program leadership team's collegiality, effective collaboration, and commitment to fostering effective working relationships to achieve the program's goals and outcomes. It is recommended that greater decision-making authority be allocated to the Dean and program leadership team, relative to their level within the University and School, to support the advancement of the national MD program, and necessary recruitment of academic and professional staff (see Standards 5.2 and 5.3).

The team noticed that senior health service leaders often contacted the Dean, rather than communicating through formal campus governance channels. This is likely caused by unclear or unfamiliar reporting lines,

which led to different interpretations of the School's governance structure among various stakeholders. Consequently, program implementation may depend on established personal relationships, which, while beneficial, can be unsustainable and introduce potential risks.

Although these arrangements are suitable for transitional periods, the School would gain from implementing more devolved authority structures to enhance decision making and management coverage across various levels. Clearly defining the roles and responsibilities of key leadership personnel could minimise dependence on informal communication channels when addressing operational matters.

Appointment of Aboriginal and/or Torres Strait Islander leadership position

In Standard 1.1.4, the School's commitment to advancing Aboriginal and/or Torres Strait Islander health equity was noted; however, the extent to which these commitments are consistently translated into visible and sustained action remains a key challenge.

It is imperative that the incumbent has responsibilities defined by the appropriate authority or delegations, and that resources, finances and expertise be allocated to achieve the goals of the program and the needs of the community. The absence of Aboriginal and/or Torres Strait Islander representation within the School's senior leadership team may limit the effectiveness of these efforts. It also signals an opportunity to further strengthen the School's commitment to advancing health equity and leadership participation for Aboriginal and/or Torres Strait Islander Peoples. A leadership role warrants representation on the senior leadership team to reflect its standing at the executive level.

The breadth and quantity of work for the IHM team heading into the creation of the national MD program is high, and the amount of resources, particularly staff resources, should reflect this expected workload to ensure adequate capacity.

Nationally approved qualifications

There is a well-defined process for assessing the level of qualification offered against national standards. The School meets the requirements for an Australian Qualification Framework (AQF) Level 9E (Extended) qualification, with relevant policies, procedures and frameworks to ensure compliance. In 2024, the programs in both the Fremantle and Sydney campuses were accredited for an additional five years, while the planned national MD program has been approved through the University's academic governance since 2025.

Access to program information

Relevant information about the program and the University's policies and procedures is available and accessible to the public, applicants, students, staff and clinical supervisors through several platforms. Publicly available information about the program is available on the National School of Medicine website, and the University policies, procedures and guidelines are mostly easily accessible on the UNDA website.

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 School has aligned its learning outcomes with AMC graduate outcomes, enabling students to demonstrate the knowledge and skills required for graduation in anticipation of delivering the national MD program from 2027. The Sydney- and Fremantle-based programs currently delivered are centred on six domains of learning:

- basic and clinical sciences
- communication and clinical practice
- Indigenous health and medicine
- public health
- personal and professional development
- medical research and innovation

This process also encompasses aligning individual PBL scenarios with the AMC graduate outcomes, while concurrently mapping curriculum domains and their respective content to the graduate outcomes, as well as program, course and domain learning outcomes. Students participating in the RCSWA during Year 3 engage in distinct coursework from the UNDA, UWA and Curtin schools of medicine; however, the School has ensured that RCSWA learning outcomes are mapped to the UNDA course and program learning outcomes. Graduate outcomes reflect the needs of communities experiencing health inequities, including Aboriginal and/or Torres Strait Islander communities, though curriculum gaps persist (discussed further in Standard 2.2) and will need monitoring as the national MD program is implemented.

The School has community advisory boards in situ across its landscape to assist with understanding the place-based needs of the communities it operates within and to provide space for community insight and involvement. Increasing voice and agency of these advisory groups is encouraged, along with greater visibility of the School's existence in the region. Reports state that some members of the community are not aware that UNDA has clinical schools and/or students learning in their region, which removes opportunity for people in the community to define their needs. Additionally, views of Aboriginal and/or Torres Strait Islander community members are obtained using an informal and ad hoc approach at some sites.

The move to the national MD program is being carefully considered for equitable delivery across sites. The School plans for a consistent general outline, such as tutorial size and program structure, but delivery in some locations will be contextualised and draw on available resources as discussed in other standards. Resourcing and access to learning facilities and workplace technologies differed greatly, particularly at clinical sites. The School is encouraged to align resourcing such as anatomy educational materials, access to internet and patient medical records across all years and sites to allow improved learning opportunities. The curriculum framework and delivery lacks certainty across teaching sites, whereby staff have limited visibility of what is delivered and assessed elsewhere.

A key issue related to ensuring there is equitable access to supervisory experiences of comparable quality. The team found this to be quite varied across the program's footprint, particularly in primary care. This will be further discussed under Standard 5.5. The School will be asked to provide evidence of the effectiveness

of the implementation of the national MD program in relation to student success and meeting place-based needs.

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.

Curriculum design and structure

The School offers a four-year postgraduate MD program with an educational philosophy of inquiry-based learning where students are expected to proactively navigate their learning journey, preparing them for independent medical practice and continuous professional development. The School is currently ‘teaching out’ its campus-specific MD program curriculum as it moves towards the national MD program. All curriculum content is located on Blackboard, the School’s learning management system (LMS).

An MD program conceptual framework has been developed to guide the selection and sequencing of learning and teaching content. The framework was developed based on relevant literature, government and non-governmental policies, contemporary medical education guidelines, and discussion papers from national and international sources. Key components of the educational philosophy are integration of experiential learning and critical reflection.

The curriculum is spiralled with increasing complexity year on year, and outcomes expected are clearly articulated and mapped to support student learning. The curriculum is delivered across four years – Years 1 and 2 are described as foundational years, and Years 3 and 4 as clinical years. The six domains are scaffolded to support both horizontal and vertical integration, each with its own learning outcomes across the four years of study.

University of Notre Dame Australia Graduate Outcomes	AMC Graduate Outcomes and Standards	
	Program Learning Outcomes	
	Course Learning Outcomes	
	Domain Learning Outcomes	
	Foundation Years	Clinical Years
	Weekly Learning Objectives	Discipline Learning Objectives

Figure 2: UNDA School of Medicine graduate outcomes

Aboriginal and/or Torres Strait Islander health curriculum and content

The team observed that the School has identified social and health disparities faced by Aboriginal and/or Torres Strait Islander communities within its footprint, supported by socioeconomic and health data analysis. However, these data do not appear to be actively used to directly inform curriculum development strategies to improve health outcomes for these communities, nor are partnerships effectively translated into actionable steps to provide reciprocal benefit. These data are viewed as quantifiable information for student learning opportunities, rather than a recognition of lived experience for Aboriginal and/or Torres Strait Islander Peoples, further lacking a sense of humanity around the subject. Situating this knowledge in a strengths-based framework with authorship and delivery from community instead of non-Indigenous academic staff may result in clearer knowledge translation and a relational lens for students.

There is evidence of Aboriginal and/or Torres Strait Islander health content gradually being integrated into the curriculum, mainly in Years 1 and 2, mapped to content and learning activities. Specific, structured curriculum content is less clearly articulated in placement Years 3 and 4; expanding this content into later years of study is essential, as is ensuring students can apply their knowledge in real-world situations, as specified in the standards below. The curriculum, in its current form, does not yet adequately demonstrate how it prepares students to serve Aboriginal and/or Torres Strait Islander communities and to practice in culturally safe ways. This is observed in both metropolitan and rural/remote settings; however, is particularly important in resource-constrained areas, where access to investigations and specialist support is limited. The stage of curriculum development does not appear to be in step with the School's focus or commitment to rural and remote workforce development.

The following factors were observed to impact the true integration and embedment of Aboriginal and/or Torres Strait Islander health content into the curriculum:

- there is ongoing curriculum mapping work and variation in program delivery across Western Australia and New South Wales; without complete curriculum mapping and blueprinting, the full picture of integration is not visible
- many examples of content in the curriculum and in teaching activities are not yet consistently implemented
- the IHM Domain Lead is based in Fremantle, which has likely meant the structure is more established for the Fremantle program, with a more explicit, specific flow in the foundation years.

The IHM team is primarily responsible for embedding Aboriginal and/or Torres Strait Islander health curriculum content aligned with related learning outcomes. The team observed ongoing improvements in the review and update of the IHM content and encourages the School to support continued progress by the IHM team. Active engagement and collaboration among the IHM team, curriculum coordinators and MD program team are essential in developing and implementing the curriculum. Leadership and authorship by Aboriginal and/or Torres Strait Islander health and cultural experts are vital to maintain a strengths-based, culturally safe approach.

Aboriginal knowledge as a knowledge system of primacy, in comparison with western approaches, should be privileged, particularly when relating to significant central ways of knowing, being and Indigenous spirituality. At present, the discipline of planetary health is delivered from a standpoint separate to Indigenous

knowledges. This translates to an opportunistic approach compared with design implementation. The School is encouraged to interrogate this approach, due to the central importance of Country and the relationality of living with and caring for Country, along with the relation of Country's health impacting Aboriginal and/or Torres Strait Islander community health and wellbeing.

Ensuring the IHM team is properly resourced is crucial for advancing this work, as both staff and students have shown enthusiasm for including a diverse range of content experts. The School should consider revising its approach to include cultural experts from Aboriginal and/or Torres Strait Islander communities who may not be medical doctors or academics in the process of reviewing and mapping the curriculum. The team encourages the School and the University to view knowledge holders as content experts, with Aboriginal and/or Torres Strait Islander cultural knowledge and knowledge systems recognised as equivalent to western knowledge and qualifications. The team strongly recommends that, as curriculum mapping is completed and the national MD program is introduced, the School establish robust mechanisms to monitor the transition and ensure that the curriculum outcomes are met.

The transition to the national MD program presents a valuable opportunity to thoroughly and sustainably incorporate Aboriginal and/or Torres Strait Islander health topics and strengths-based methods at every stage of the curriculum. These processes should ensure the comprehensive inclusion of Aboriginal and/or Torres Strait Islander health content and establish clear criteria to evaluate its effectiveness throughout the curriculum.

Research and scholarship

The School, Faculty and University are actively engaged in research and scholarship, and the National School of Medicine is supported by its National Research Committee. A comprehensive list of the University's publications in medical education research was provided to the team. Through the KCRMT, UNDA has a relationship with the Nulungu Research Institute and the Majorlin Kimberley Centre for Remote Health, based at the Broome campus, with a research focus on Aboriginal wellbeing and health.

There is clear evidence of medical education research and scholarship throughout the program, demonstrating staff's commitment to advancing learning, teaching and assessment practices. However, these activities are currently dispersed and lack an overarching structure to connect or amplify their impact. Due to the dispersed approach, the team heard a lack of confidence that curriculum development was actively or intentionally informed by research. Establishing stronger links between research efforts, the evaluation team, and staff involved in curriculum review and quality improvement would help ensure research more directly informs program development.

A more systematic and coordinated approach, potentially overseen by the National Research Committee in partnership with educational committees and leads, would facilitate finalising the national MD program and ensure its continued responsiveness to emerging research. This is especially relevant for the development and delivery of the Aboriginal and/or Torres Strait Islander health curriculum, where established systems should include involvement from the IHM team.

With the School moving to a national structure, this is an optimal moment to establish formal systems and clear channels for collaboration across campuses, allowing research and scholarship to influence curriculum, teaching and assessment at the program level.

Alignment of medical program outcomes, learning and teaching methods and assessment

The School was found to be committed to aligning its medical program outcomes, teaching strategies and assessment processes with AMC graduate outcomes. Staff, clinical supervisors and students the team met were generally able to articulate expectations for each year of learning and related assessment activities. The curriculum is structured around PBL, an instructional strategy that supports experiential learning by engaging students with weekly real-world clinical cases. The School takes a hybrid approach to PBL, supporting students with additional learning and teaching activities and resources that complement and integrate with the week's PBL. The communication and clinical practice (CCP) domain is responsible for supporting procedural, clinical and communication skill development.

There are dedicated domain leads for each of the six domains based in both Western Australia and New South Wales. Dedicated leads for each discipline of medicine are assigned to coordinate the curriculum content from that discipline, with many also taking on roles in coordinating student clinical placements in their discipline. Some discipline leads work closely with their co-lead on curriculum content, and others expressed an interest in having stronger connections with their counterparts across the country.

There have been historical shifts towards certain curricular elements in some places, leading students to feel that peers in other contexts may have greater access to histology or anatomy teaching. The move to a national MD program should alleviate this pressure, and the team saw evidence of proactive responses, such as flying anatomists to Broome to support teaching and learning at KCRMT.

Curriculum mapping for the national MD program is ongoing, with Year 1 finished and remaining years progressing alongside the national MD program rollout. Work remains to fully integrate the IMH curriculum. The AMC will be interested in an update on these activities, including anticipated completion dates, as well as relevant assessments to be developed, which will be discussed under Standard 3.

Integration of knowledge and lifelong learning

The program's design aligns its curriculum horizontally and vertically to ensure students have a comprehensive, integrated learning experience. Year 1 builds a strong science foundation. Year 2 centres on disease processes, pathophysiology and clinical sciences. Foundation years offer integrated subjects like communication and clinical reasoning to prepare for later studies. Years 3 and 4 emphasise diagnostic skills, management planning and clinical practice.

Each course learning outcome (CLO) is mapped to relevant broad domains, ensuring coherence with the overall program structure and facilitating the progressive development of knowledge, skills and professional behaviours. Some CLOs are linked to multiple domain learning outcomes, emphasising the curriculum's interconnectedness and preparing graduates to be safe and effective practitioners.

The team were impressed by students' ability to self-direct and self-manage their learning and related activities. The PBL program, which is a key learning activity in the foundation years, is supported by the process of clinical debriefing during personal and professional development (PPD) tutorials, which encourages reflective practice, an ongoing skill required of medical professionals.

Curriculum design and duration

The team found that the design and duration of the current, pre-national MD program curriculum generally support students to demonstrate achievement of medical program learning outcomes at different levels. The curriculum outlines multiple levels of learning outcomes scaffolded across the domains of learning. Specific learning outcomes are clearly outlined and communicated through the LMS Blackboard, student handbooks and other resources.

As the national MD program is implemented, it will be important to clearly communicate any changes to learning objectives and outcomes to students, staff and clinical supervisors. This will support the reduction of variability of experiences discussed under Standard 2.3.

There are opportunities for students to pursue studies of choice, specifically in elective clinical placements. The School has an opportunity to make accommodations for student-specific circumstances when considering preferences and requests, such as a student's interest in practising rurally, which may be strengthened by additional rural placements, or a student's request to work in an Aboriginal community controlled health organisation, which will bolster their learning. There was interest among students, program staff and stakeholders in expanding access to local opportunities.

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.

Teaching and learning methods

The School has adopted a broad range of methods to engage and support students' learning and achievement of knowledge and skills throughout the program. The curriculum is taught through a range of both in-person and digital learning and teaching methods across all campuses. In the foundation Years 1 and 2, PBL underpins the delivery of lectures, small-group tutorials, laboratories, and the teaching of procedural and clinical skills. Small group sessions cover:

- exploration of PBL cases with a population health lens
- clinical debriefing to encourage reflective practice, exploring values, beliefs and attitudes in a given situation
- review and discussion of journal articles
- yarns with an Aboriginal patient to develop culturally safe communication within a clinical context for Year 1 students.

The development of clinical and procedural skills is a central component of the clinical placement years, with simulation-based teaching serving as a valuable adjunct to direct clinical practice experience. Clinical placements in a variety of settings in Years 3 and 4 build on this learning, with students returning to classroom study for back-to-base days once a week. A supportive measure is the 'clinical partner' system or 'buddies' in matching rotations, as well as clinical study groups providing opportunities for peer-to-peer learning and encouragement. Students undertaking the RCSWA in Year 3 participate in learning and teaching activities run by the RCSWA, which culminate in RCSWA assessments. With the implementation of the national MD program, the School appropriately seeks to streamline the learning and teaching methods used at each site, while still allowing for unique, location-specific learning and teaching on back-to-base days.

At the University level, there are complementary libraries and other resources available to students, including the University-led Peer Assisted Study Sessions (PASS), which provide free weekly revision sessions facilitated by a successful senior student.

Partnerships with patients

The team had the privilege of meeting with patient volunteers and recognising the critical role they play in helping students develop communication and clinical skills. These individuals were very committed to their role and connection with the School and program. There is an opportunity for the School to progress from the current episodic model of patient engagement in curriculum planning towards more structural engagement in curriculum and teaching design, assessment and evaluation, and to expand its partnerships with patients to promote safe, high-quality care in learning and teaching methods. The School may wish to explore how the current Community Advisory Working Party can contribute constructively to this development in its recommendation to the new School Committee, which is being formed.

The School recognises the ongoing need to revise and update resources to accurately reflect contemporary patient populations and evolving approaches to patient care. To support curriculum and content design, the School has adopted the APA Bias-Free Language Guide and conducts annual reviews of communication and clinical skills scenarios to ensure inclusive language. In recent years, additional material on LGBTIQ+ and Aboriginal and/or Torres Strait Islander health has been incorporated into PBL cases and other teaching and learning methods.

Opportunities to learn about needs of differing community groups and Aboriginal and/or Torres Strait Islander communities

There is evidence that students can learn about engaging with various community groups, including Aboriginal and/or Torres Strait Islander communities, at different stages of the program. The opportunity to apply learning in face-to-face experiences should be purposefully incorporated into the clinical year curriculum to ensure that all students undertake this experiential learning.

Engaging with community groups

The curriculum has been structured to enable students to critically assess social determinants of health. It also supports evaluation of how health systems, models of care and patient-centred approaches may be adapted to improve equity, accessibility and cultural responsiveness for priority populations. Through PBL cases, students are offered meaningful opportunities to investigate the various dimensions of these inequities within clinical and contextual frameworks. PBL cases are deliberately aligned with domain-specific learning and teaching activities throughout the week, fostering an integrated and practical understanding. Population groups are identified through national policy frameworks, including those by the Australian Institute of Health and Welfare.

In Years 1 and 2, students attend local immersion programs that build on curriculum content; Fremantle students in the Wheatbelt, Western Australia; Sydney students in Lithgow, New South Wales; and KCRMT students in Derby, Western Australia. The Wheatbelt Medical Student Immersion Program, where students live with local communities and experience rural living firsthand, was valued by many students. Sydney students are offered exposure to rural living, Aboriginal and/or Torres Strait Islander cultures and healthcare environments on a two-day immersion trip to Lithgow. Planned community rotations in the national MD program should further enhance students' learning experiences.

Aboriginal and/or Torres Strait Islander communities

In the foundation Years 1 and 2, PBL cases include Aboriginal and/or Torres Strait Islander patients and contexts. There are strong learning examples in IHM-led lectures, tutorials and workshops on a broad range of topics such as:

- working with Aboriginal health professionals
- racism in health and health care
- social and emotional wellbeing of Aboriginal People
- Aboriginal environment health
- ethics of research in Aboriginal health

Experiential activities supplement structured learning and teaching activities, and external guest speakers are invited to share expertise on specific topics. The Cultural Immersion Day at the Sydney campus, held at the Australian Museum, was highlighted as an exemplary program that supports students in increasing their knowledge and understanding of Aboriginal and/or Torres Strait Islander culture, history, and health and wellbeing issues.

In Years 3 and 4, students attend weekly back-to-base days, during which they do not undertake clinical placements but instead attend a teaching or learning session at their local campus or clinical school, some of which cover Aboriginal and/or Torres Strait Islander health broadly. Back-to-base days are run locally, so the student experience of this exposure can vary. The team heard about valuable and effective local teaching sessions at some back-to-base programs. In clinical environments, exposure to engaging with Aboriginal and/or Torres Strait Islander patients appears to be incidental in both metropolitan and rural/remote settings. This is further discussed under Standard 5.4.

The team sees integrating academic learning about Aboriginal and/or Torres Strait Islander health into clinical practice as a key development area. Although there are some positive examples, more work is needed to include Aboriginal and/or Torres Strait Islander knowledge systems and address systemic disadvantage, power imbalances and historical injustices in teaching.

Culturally safe learning and teaching, informed by Aboriginal and/or Torres Strait Islander knowledge systems

The team heard that awareness of, and responsibility for, advancing Aboriginal and/or Torres Strait Islander health equity vary across campuses, clinical placements and learning activities. This variability suggests that culturally safe practice and health equity are not yet fully embedded as a shared institutional responsibility. This is further compounded by evidence of 'othering' in some learning environments, raising significant concerns about colonial load and cultural safety. Importantly, the School's commitment to culturally safe learning and teaching is not yet matched by sufficient resourcing, structural authority, or accountability mechanisms, limiting its ability to deliver sustained change, as discussed in Standard 1.

The team heard of instances in which Aboriginal and/or Torres Strait Islander students were asked, or implicitly expected, to lead or contribute to the education of their peers during teaching sessions, including in supported learning contexts. Reliance on Aboriginal and/or Torres Strait Islander students to explain or teach content risks placing an inappropriate cultural and emotional burden on them and may undermine culturally safe learning environments. While students may choose to share personal or culturally informed perspectives, the School should ensure that teaching staff and students understand that this is neither an expectation nor a responsibility of Aboriginal and/or Torres Strait Islander students.

The School is encouraged to systematically embed a strengths-based approach throughout the program that is developed by or with community members from groups who experience health inequity to ensure it is respectful, inclusive, and representative of their voices and experiences. The team heard examples of language used in some environments that did not support self-determination or culturally safe teaching. Attention should be paid to language that may 'other' certain groups, or not reflect language used by communities themselves. Language should sufficiently acknowledge community strengths and the broader systemic factors influencing health outcomes.

The importance of aligning the School's understanding, resourcing, and application of cultural safety in the teaching and learning environment cannot be understated, and it is an urgent priority for attention and development. This correlates with the need to ensure cultural safety training for staff, clinical supervisors and students, as discussed in Standard 5.4.

Interprofessional education opportunities

The School provides a robust interprofessional education (IPE) curriculum with strong collaboration between health disciplines. The team was impressed by the breadth of opportunities accessible to all students, as well as the localised initiatives that the School actively promotes. Examples continuing in the national MD program curriculum include the following:

- In Year 2, there is a structured small group tutorial in which MD students work collaboratively with either psychology (in Fremantle and Sydney) or nursing (in Broome) students on a patient care scenario.
- Year 2 Sydney students participate in Rural Trauma Week with paramedicine students from the University of Tasmania to explore the assessment and management of trauma in a rural context. This engages the local communities in Sydney, the Blue Mountains and Lithgow, even using local high school drama students as actors.
- In Years 3 and 4, students participate in an activity called the Game of Greater Good with physiotherapy students. The online activity simulates healthcare resource allocation in various budget and resource contexts. The activity is supported by expert panellists, and in the national MD program, the activity will have local context embedded at each campus.

Current modifications to support the local context and learning outcomes include the immersion programs in the Wheatbelt, Derby and Lithgow, as well as varying exposure and engagement with co-located health professional students for learning and teaching.

Both students and staff value these opportunities, which are actively promoted. The team found that access to IPE experiences varies among students, and greater consistency could improve the experience for all. To promote fairness across the cohort, the School has an opportunity to better document and monitor these activities to support equitable distribution and to enable students to better explore areas of interest, as discussed in Standard 2.2.10.

Development of clinical skills

Through the CCP domain, students learn, develop and practise procedural and clinical skills, which are clearly described across the four years of the program. Several credentialled skills are also included and formally assessed in clinical simulation suites. These either contribute to continuous assessment marks or serve as hurdle assessments prior to clinical placements. Clinicians across the clinical footprint were complimentary of students' skills and competencies during their supervision, and their 'work readiness' upon graduation. In part, this is due to students being exposed to a broad range of real-world clinical and community settings, preparing them for practice. There was a general sentiment that the transition between Years 2 and 3 was challenging; however, this is not unusual. Data from 2024 student surveys indicated that over 70% of students at both the Fremantle and Sydney campuses felt prepared to apply clinical skills during their clinical placements, while over 10% responded neutrally. The School responded practically to this feedback by increasing student access to clinical rooms and equipment to practise skills in their own time and improve their confidence. There was some appetite for early clinical exposure in Years 1 and 2 to improve transition to clinical placement.

Experiential learning

The School is committed to ensuring that students have a wide range of experiential learning opportunities in metropolitan, regional, rural and remote settings, engaging with a variety of health and community providers. The rural clinical schools in New South Wales and Victoria and the Riverina Regional Training Hub in rural New South Wales are noted for their very active presence in their respective communities. Examples include:

- NSW Farmers Conference participation: Year 1 and 2 medical students partner with the Rural Adversity Mental Health Program to deliver a public health screening service
- cultural capability initiatives: partnerships with Aboriginal and/or Torres Strait Islander leaders in the Murrumbidgee Local Health District to develop and deliver cultural capability training
- health needs assessments in Lithgow: collaborative projects with Nepean Blue Mountains Local Health District, Nepean Blue Mountains Primary Health Network, Lithgow City Council and Aboriginal and/or Torres Strait Islander leaders to produce reference reports on the health of the Lithgow community and the local Traditional Owners. These reports directly inform regional planning, including for the Lithgow Emerging Economy Project and the Lithgow Workforce Project.

The primary care program was highlighted as an excellent learning experience. General practice is longitudinally integrated throughout all years of the program, with early exposure integrated into the PBL curriculum and progressively increasing clinical exposure. Rural generalist exposure is structurally integrated into the curriculum, and educational leads have aligned educational resources with the Royal Australian College of General Practitioners to ensure a smooth transition to general practice training for graduates. The team was impressed by the dedication of the general practice discipline teams at both Fremantle and Sydney, and their demonstrated commitment to positive general practice learning experiences. The Sydney general practice discipline team reported a lack of oversight of placement quality, and both teams reported a lack of necessary staffing resources to effectively deliver their vision of the program; this is discussed further in Standard 5.

The School has strong relationships with several private hospital providers, with evidence demonstrating that these placements provide positive and supportive learning experiences for students. These placement partners had differing policies for allowing access for students to patient notes and history. The School recognises that private hospital settings may limit exposure to certain learning opportunities, particularly complex cases and care for populations experiencing health inequities, and accordingly seeks to provide a mix of private and public placements. However, it was not clear to the team how this balance is assured in practice. A documented policy or process to ensure diversity across private and public placements would further mitigate this risk.

With the implementation of the national MD program from 2027, the School plans to enhance learning experiences and ensure a good balance of placements in public and private settings (see Figure 3).

Clinical placements: 2027	
Year 1	General community placements: drug and alcohol, general practice, residential care
Year 2	General community placements: radiology, general practice, primary care clinics, rehabilitation services
Year 3	General medicine: acute care and clinics Surgery: acute care and clinics Obstetrics and gynaecology: acute care and clinics General practice and community mental health placement Upon application: Rural Clinical School of Western Australia/rural clinical schools in New South Wales and Victoria
Year 4	General medicine: acute care and clinics Surgery (including ear, nose and throat and musculoskeletal): acute care and clinics Psychiatry: acute care and community clinics General practice: regional and metropolitan Critical care: acute care Pre-internship placements Electives (metropolitan, rural, remote or overseas placements)

Figure 3: Example of planned clinical placements for the national MD program in 2027

Pre-internship program

The School is working to strengthen graduates' readiness for the workforce by creating a dedicated preparation for internship program. Currently, the pre-internship phase is being developed with input from consultations and has not been finalised yet. It will be important that systems to evaluate the program's effectiveness are included once it's in place. Some students can access place-based programs, such as those offered in Western Australian hospitals, where they are assigned to a hospital matched to their internship, helping them transition smoothly.

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.

Assessment system

The School has a comprehensive, University-aligned assessment framework documented through policy, course outlines and guidance on the LMS. Course outlines detail assessment types, weightings and progression rules, with rubrics and instructions available on Blackboard. Assessment uses a range of methods—including objective structured clinical examinations (OSCEs), workplace-based assessments (WBAs), written exams and group tasks—to assess knowledge, skills and professional behaviours. Transparency is supported through early publication of requirements and targeted assessment information sessions for students.

In 2026, the University revised its Assessment in Higher Education and Enabling Coursework Programs policy, and the School adheres to these updates.

The team did not identify evidence that the assessment strategy was informed by research nor reached an understanding of how evaluation data informed assessment design decisions, although the assessment system is consistent with standard practice. The School's submission identified items relating to feedback and assessment in the 2024 student experience survey that performed below expectations. Further work is required to demonstrate and structure how research and evaluation inform the assessment program.

The School provided an outline of the National Assessment Program due to be fully operationalised in 2027. This includes a plan to commence work on assessment design for the pre-internship program in April 2026. Progress has been made regarding aligning the Sydney campus with the Fremantle campus semester one summative exams. Further, OSCE formats, including timing and rubrics, have been developed along with an update to the course outline progression rules. The OSCE was run in Broome for the first time in 2025 with no reported problems. Currently, Sydney uses multiple choice questions (MCQs) and short-answer questions (SAQs), while Fremantle uses MCQs and case-based exams (CBEs); the plan is to move towards a consolidated national exam format. The team notes that further work is planned to develop standard setting for synchronous written exams across multiple time zones and to align exam formats for both the foundation and clinical years for 2027.

Currently, Board of Examiners (BOE) meetings are held independently at each campus, with Broome sharing processes with Fremantle. The BOE makes the final decision on which students meet or do not meet the required standards for each curriculum year. This structure will remain in place when the program moves towards a National School of Medicine. Prior to the BOE meeting, the leadership team meet to identify

student issues and special accommodations. Student assessments are reviewed holistically, including OSCE performance and examiner feedback, the sequence in which the student completed stations, and results from other assessments. For example, if a student scores just below the expected standard in the end-of-year OSCE but demonstrated satisfactory performance across other assessment components, they would likely be permitted to progress or be offered a supplementary assessment rather than being failed outright.

Student progression

Assessment across the four-year program is designed to enable students to demonstrate progression towards graduate outcomes, including professional behaviours, and is aligned with course learning outcomes through a combination of continuous assessment, OSCEs and written examinations. Progression decisions are made holistically by the BOE using evidence from multiple assessment methods.

Professional behaviours are also assessed longitudinally using WBAs, end-of-rotation supervisor reports, OSCE performance (including simulated patient feedback), and professional practice portfolios. Students also receive feedback from tutors and clinical educators during the foundation years, which supports reflective practice and the formation of professional identity.

Assessment of professionalism currently varies across campuses; this will be unified, including plans to introduce a reflective practice program across the four years of the national MD program.

A tiered process is used to manage professionalism concerns, ranging from feedback and monitoring for minor issues to escalation to senior academic staff or formal disciplinary processes for serious breaches, in accordance with the Code of Conduct.

Assessment blueprinting

Blueprinting is conducted separately on each campus, with plans to move to a nationally cohesive approach in 2027. This process involves collaboration between the assessment leadership team and the IHM domain leads to ensure suitable integration. Program-level blueprinting connects assessment practices with the School's graduate outcomes, while year-level plans are developed annually at the course level to guarantee proper sampling of learning outcomes, content areas and assessment weighting.

At the time of the accreditation, the assessment system was not yet fully aligned with AMC graduate outcomes across the program. Although assessments are mapped to AMC outcome domains, they are not comprehensively mapped to all specific AMC graduate outcomes, nor do they cover the various assessment modalities across knowledge, clinical skills, professionalism and broader graduate capabilities. Additionally, the team did not receive an assessment blueprint for each stage of the program. Some students viewed the assessment program as lacking a holistic approach, with niche topics tested rather than common conditions—possibly because students lacked an adequate, transparent blueprint.

The School is transitioning towards a national blueprinting approach, with national templates planned for implementation from 2027. The National Head of Assessment will oversee blueprint development in collaboration with domain leads. The School anticipates some gaps may be identified when unifying each campus blueprint; however, it is committed to ensuring assessment is comprehensive of competencies. It will be important to communicate these changes to students to ensure they understand that they may be assessed on content from any year of the program.

As the program transitions to the national MD curriculum, the School should provide evidence of a systematic approach and a program-level blueprint across all four years of the program that clearly maps assessment to learning outcomes and to all the AMC graduate outcomes. This should include evidence of a consistent approach to calibration and moderation across the program sites.

Assessment methods

The School uses an appropriate range of assessment formats to reduce reliance on single assessment modalities, thereby enhancing reliability and validity. Assessment formats include MCQs, CBEs, OSCEs, written tasks and WBAs. CBEs incorporate sequential unfolding scenarios designed to simulate clinical reasoning and reduce cueing. The School provides staff training in item writing and maintains style guides for consistency. The School also describes evolving responses to artificial intelligence (AI) risks, including

assessment redesign, use of plagiarism and AI detection tools, and implementation of controlled writing platforms such as Cadmus.

At present, about 75% of assessment is concentrated on the intersection of basic and clinical sciences with CCP, while the remaining 25% covers IHM, public health, PPD, and medical research and innovation. In the first year of the foundation program, assessments are intentionally weighted 30/70. About 20% of students do not pass the mid-year exams; however, this failure rate typically decreases by the end-of-year exams because students receive time and support to improve. In the second foundation year, assessments shift to a 40/60 weighting. Many students view the mid-year exams during foundation years as valuable checkpoints for receiving feedback on their academic progress.

Assessment weighting has incorporated student feedback in the pre-clinical years. Students noted that in-course assessment tasks have relatively low weighting and require a disproportionate time to complete. The assessment team recognised the challenge of balancing assessment burden and weighting. Some students felt that the heavy weighting of summative exams made it difficult to accurately benchmark their progress throughout the year.

During the clinical years, the team found that some students struggled with the high-stakes nature of summative exams. Assessments are organised by discipline, requiring students to pass each rotation separately. Students noted inconsistencies in the marking of mini-clinical evaluation exercises (mini-CEXs) and WBAs, which posed challenges during the clinical years: instructions for mini-CEXs were described as unclear and difficult to standardise, and students reported that there was no rubric for WBAs in MEDI6300 and MEDI6400.

Mini-CEX assessments are graded, and the team heard numerous students reporting intentionally selecting assessors whom they believed may provide more favourable marks. Program staff have observed that this practice leads students to complete more mini-CEXs, as only a selection is ultimately submitted for assessment. While increased exposure and practice can be advantageous, some students have raised concerns about the inherent variability of this approach. The 2024 National Quality Report also highlighted the use of mini-CEX as a summative assessment as an area warranting attention. The School may wish to explore strategies to address these issues. Transitioning the mini-CEX to a pass/fail format rather than using graded scores may offer a solution.

Standard setting

The School uses established standard-setting approaches, including borderline regression for OSCEs. This approach incorporates global ratings and station scores and is supported by examiner calibration and standardised instructions. The School states that this method accounts for examiner and simulated patient variation. The School uses the Cohen method for computer-based exams, which it considers a more equitable approach for the cohort than methods like Angoff.

The School reports using item analysis and post-exam review processes to identify poorly performing items and support continuous improvement of assessment quality. Reported approaches to calibration of assessments were inconsistent across sites, particularly in the clinical years and in primary care rotations. General practice supervisors reported different degrees of orientation to assessments. Some, for example, described watching a video and then benchmarking against each other to support their understanding of third-year students' expectations, while students reported that others lacked familiarity with the assessment forms. Inconsistencies were noted in the year-level orientation materials provided for supervisors; this is discussed further in Standard 5.

Assessment of Aboriginal and/or Torres Strait Islander health and culturally safe practice

The School has taken some initial steps towards improving assessment of the topic of Aboriginal and/or Torres Strait Islander health, including a requirement for all exam questions referencing Aboriginal and/or Torres Strait Islander patients to be reviewed and accepted by the IHM team, blueprinting of all foundation years exam content with the involvement of IHM staff, and the inclusion of personal student reflection and presentation assessments.

While these developments are acknowledged, assessment of Aboriginal and/or Torres Strait Islander health and culturally safe practice is not yet fully integrated across the program. There is very little deliberate or planned assessment of this content in the clinical years, which is of significant concern given that applied clinical contexts are where culturally safe practice must ultimately be demonstrated. The current approach appears to focus on cultural awareness rather than culturally safe practice, and the paucity of assessment in clinical years means there is no evidence that students are being consistently assessed on the application of culturally safe practice in real or simulated clinical settings.

Furthermore, while Aboriginal and/or Torres Strait Islander health experts are consulted in some assessment processes—for example, writing CBE questions—they do not yet appear to hold appropriate authority over assessment design. The School has indicated that this content will be assessed through continuous assessment, CBEs and OSCEs. The School needs to demonstrate evidence that assessment in this domain is implemented systematically and consistently across all campuses and year levels, and that its design is led by Aboriginal and/or Torres Strait Islander health experts.

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.

Assessment feedback

The School describes a range of feedback mechanisms, including WBAs, OSCEs, supervisors and portfolio reviews. Feedback is intended to support reflection and professional development across the program. Students can access their assessment results via Blackboard. The team notes that feedback processes are being aligned nationally, and new feedback templates are under development, which will include the provision of percentage scores, visual analogue scales, and individual scores for OSCE stations and each written CBE.

Students are offered optional formative exams with feedback. In clinical years, eMedici is provided to students for final-year and end-of-block exams through ExamSoft. There is some inconsistency in the provision of mock OSCE practice noted by students across clinical schools—notably Broome students, who report fewer opportunities for practice before exams, as well as some rural clinical schools.

Students from the Sydney campus highlighted the program's responsiveness to their needs for more detailed feedback on mid-semester exams, noting the inclusion of quartiles and domains, and plans to improve feedback on summative exams in the second year, including domain and individual OSCE station performance. Some students reported delays of up to two months for feedback on summative written exams, which the School should address.

Performance improvement

The School describes early identification of concerns through multiple assessment data sources and feedback processes, with escalation through academic leadership structures. Students remark, however, that those achieving just above the pass standard (e.g. 50–55%) can be overlooked when it comes to additional feedback.

With increasing international student enrolments, the School has increased staffing at the Sydney campus and identified specific staff at the Fremantle campus who can provide international students with additional support, including meetings with academic staff, counselling, study groups and the PASS program.

The team observed inconsistencies in the provision of support for students identified as academically at risk. Aboriginal and/or Torres Strait Islander students perceived a lack of targeted educational support, which presented a significant obstacle to their academic achievement; this matter is explored in greater detail under

Standard 4. Additionally, the team was informed of excessive delays in processing special consideration applications and noted variability in staff understanding regarding the implementation of special consideration policies.

The School must ensure consistent and proactive identification and support of students at academic risk, standardised timing and processes for special consideration applications, and uniform implementation of relevant policy across all student cohorts.

Staff feedback

The School reports that it provides staff with cohort-level performance data, including exam item analysis and performance reports. These are shared with discipline and domain leads to inform teaching and assessment review. The team heard that cohort performance is received variably by hospital and general practice supervisors, some of whom indicated this would be of interest to them.

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.

Regular review of assessment system

The School demonstrates a commitment to assessment quality through multiple quality assurance processes, including benchmarking through the Australian Medical Schools Assessment Collaboration, student evaluation processes and formal quality reporting cycles. These processes feed into continuous improvement and are reviewed through School and University governance structures, with University-level academic integrity policies, including specific responses to AI use, providing additional oversight.

There remains a need to more explicitly align review and evaluation processes with the principles of equity, ensuring that fairness and flexibility are foregrounded alongside validity and reliability in ongoing assessment review. The School should embed a systematic approach to evaluation and continuous improvement that explicitly addresses the effectiveness, fairness, flexibility, equity, validity, reliability and fitness for purpose of all assessment methods and processes. Recognising that small numbers in some cohorts may risk inadvertent identification of individual students, the School evaluation team recognises there is an opportunity to more systematically evaluate assessment performance, particularly for student groups at risk of inequity.

Managing variations in assessment practice and processes

The team found that differences in assessment practices and processes across teaching sites were reasonably managed, but learning outcomes, expectations and assessment burdens appear to be comparable. With the move to the national MD program, there are plans to further align assessment processes—in particular, the move to nationally coordinated OSCEs will need to be monitored.

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.

Student cohort

The School manages growth in the program by ensuring student intakes remain aligned with available academic, clinical and support resources. Domestic enrolment capacity is largely constrained by federally mandated Commonwealth supported places (CSPs); as a result, planned growth over the next five years is focused on a gradual and controlled increase in international student. Ten CSPs were reallocated from Fremantle to support the KCRMT expansion. Growth has been deliberately limited, determined by program capacity rather than institutional revenue pressures.

The School continues to assess opportunities to apply for additional CSPs offered by the Australian Government in consultation with University senior management and with careful consideration of facilities and resourcing. The School was successful in obtaining 10 additional CSPs for 2026 from the Stream A grant funding and have applied for an additional five CSPs in Fremantle and five CSPs in Sydney from Stream B grant funding.

To support international student growth, additional full-time equivalent (FTE) staff have been allocated at the Sydney and Fremantle campuses. There were some instances in which resources and support for international students felt informal, unplanned or inadequately prepared. As this cohort continues to grow, more organised and dedicated resources will be needed to ensure proper and sustainable support.

Support measures for student cohorts, domestic and international, should be informed by strategically collected data on cohort composition across campuses, with particular focus on diversity/equity group measures. Any additional academic and professional staff roles should provide ongoing monitoring and early intervention for students at risk of academic difficulty, consistent with Standards 3.2.2 and 4.2.2.

Kimberley Centre for Remote Medical Training

In 2025, the Fremantle program enrolled 27 students across Years 1 and 2 to the KCRMT. The limited availability of RCSWA clinical placements in the Kimberley to support Years 3 and 4 is a major constraint. There are only 21 fourth-year RCSWA places across all Western Australian medical schools, and there is no sustainable funding stream for increasing fourth-year RCSWA placements. KCRMT students are guaranteed placements in RCSWA. Remaining RCSWA placements not allocated to KCRMT are competitive with Curtin and UWA students—meaning it may become unlikely for non-KCRMT students to get RCSWA placements. Consequently, it is not currently feasible for all KCRMT students to complete their clinical years in the Kimberley region. The program has been advertised as end-to-end rural, rather than end-to-end in the Kimberley region, however it was clear to the team that this was not fully understood by all KCRMT students, and there remained significant anxiety about having to relocate for clinical years.

This issue is particularly urgent for students local to Broome, for whom a temporary relocation to complete required placements would significantly impact their ability to continue the degree. Students expressed anxiety about this prospect and immediate action is needed to develop and implement a clear and sustainable clinical placement strategy for Years 3 and 4 in consultation with students.

The School also needs to implement ongoing monitoring and improvement of program resourcing, particularly clinical placements, noting that the School does not intend to expand this cohort beyond 40 places (10 per year level).

Students reported generally positive educational experiences within the KCRMT program, with some issues related to anonymous reporting discussed later in Standard 4.2.

Selection policies

The School has defined the nature of its student cohort through specified categories and requirements for prospective program applicants, as shown in Figure 4 below.

Applicant Category	Requirements
Metropolitan	• Must meet GEMSAS (Graduate Entry Medical School Admissions System) minimum requirements. • Submit KCRMT application to UNDA. • Personal statement, CV/resume and successful interview(s).
Rural/regional	• Residency of at least five consecutive or 10 cumulative years in rural/regional areas per the Modified Monash Model. • Submit GEMSAS application with Fremantle preference, confirmation of rurality and KCRMT application directly to UNDA. • Personal statement, CV/resume and successful interview(s).
Kimberley/Pilbara	• Residency in Kimberley or Pilbara for at least five consecutive or 10 cumulative years. • Completion of a minimum three-year full-time undergraduate degree with a GPA ≥ 5.0 within the past 10 years (exceptions apply with recent tertiary study). • Personal statement, CV/resume and successful interview(s). • Applications submitted directly to UNDA; applicants wishing to be considered for Sydney or Fremantle must apply via GEMSAS and meet its entry criteria.
Indigenous	• Must identify as Aboriginal and/or Torres Strait Islander, provide proof of Aboriginality, and meet academic and application requirements similar to Kimberley/Pilbara applicants.

Figure 4: Applicant categories and requirements for selection into the UNDA MD program

Top graduates who commenced UNDA's Bachelor of Biomedical Science degree from 2024 may be eligible for the priority pathway available at both the Fremantle and Sydney campuses. The first priority pathway cohort into the program will be available from the 2027 intake. From 2026, 10 positions are identified for Aboriginal and/or Torres Strait Islander students and 10 rural-origin students. These positions are not capped.

There is a commitment to ensuring students are recruited from rural backgrounds, with bonus points assigned for identified rurality upon general application. Bonus points are also assigned for Western Australian residency and higher degree by research completion. These initiatives are part of the national MD program general entry requirement. Aboriginal and/or Torres Strait Islander applicants receive a customised admissions process developed in partnership with the IHM team. This process waives Graduate Medical School Admissions Test (GAMSAT) requirements, offers flexible Grade Point Average (GPA) standards, and involves IHM staff in selection decisions, including applying contextual judgement during interviews. The

KCRMT intake also prioritises Aboriginal and/or Torres Strait Islander and rural applicants, aiming for a minimum of 15% Indigenous enrolment to reflect the population of the Kimberley and Pilbara.

The outcomes of the recent recruitment of Aboriginal and/or Torres Strait Islander students indicate significant room for improvement. Of the eight offers made in the latest cycle, only one was accepted across the entire program, and the overall numbers of admissions has declined over a three-year period. The School's leadership team has recognised the decline in early-year enrolments but did not provide a detailed analysis of potential causes, such as financial barriers, perceptions of cultural safety, geographic challenges, competing offers from other institutions, or evidence of structured review and responsive adjustments.

There is an opportunity for the School to enhance monitoring and analysis of student characteristics relative to selection and performance, which could lead to a better understanding of the reasons behind this decline, as discussed further in Standard 6. The team did not identify an overarching strategy or targets for each applicant category, and the School may wish to refine this, along with work related to capacity building or resourcing.

Recruitment of Aboriginal and/or Torres Strait Islander students

The recruitment of Aboriginal and/or Torres Strait Islander students is supported by a tiered model that incorporates academic oversight, culturally informed pastoral care, and liaison with the University's central Aboriginal and/or Torres Strait Islander support services. An example of this support was provided to the team about a student who received coordinated and structured support, including engagement with the IHM team, academic tutoring, mentoring and a formalised study plan. Staff identified relational continuity and early engagement as key strengths.

At the Fremantle campus, year coordinators described strong collaboration with Aboriginal and/or Torres Strait Islander student support officers, including proactive communication regarding cultural obligations such as Sorry Business, consideration of feasibility on a case-by-case basis, and appropriate briefing of academic staff on cultural context. Targeted Aboriginal and/or Torres Strait Islander student support roles are also in place at the Sydney campus, including a designated Aboriginal and/or Torres Strait Islander student support officer for medicine. Despite these strengths, there are still gaps in the consistency and cultural safety of the support provided to students admitted through targeted access schemes. Some students have indicated that certain aspects of support did not feel culturally safe, such as perceived breaches of confidentiality. These challenges are further exacerbated by limited staffing capacity within the IHM domain, as referenced under Standard 1.

While the School's overarching pastoral wellbeing framework is effective for most students (see Standard 4.2), there is a lack of targeted, culturally appropriate interventions to enhance retention outcomes for these cohorts. Additionally, most clinical sites, including KCRMT, lack dedicated Aboriginal and/or Torres Strait Islander student support officers, limiting access to culturally relevant support in distributed training settings. This shortfall does not align with the program's stated objective of strengthening the Aboriginal and/or Torres Strait Islander medical workforce. The School also needs to consider specific support for students in end-to-end rural programs (i.e. KCRMT) or undertaking Year 3 in RCSWA, as their needs would differ from those of other students.

These concerns highlight the School's need to balance open collegial support for all students by all staff with the need to ensure clearly communicated confidentiality boundaries and role distinctions among staff involved in student support. In addition, there is clearly no articulated or coordinated strategy focused on the retention of students from equity groups, particularly Aboriginal and/or Torres Strait Islander students. The formation of the Health Equity and Community Engagement Working Party should enhance recruitment, retention and support strategies for students from equity groups; however, this should not replace consultation with current and/or former students on how support can be improved.

Inclusion of students with disabilities

The School collaborates with the University's Access and Inclusion team to support students requiring reasonable adjustments. Learning access plans (LAPs) are generally applied consistently in written assessments. However, variability remains in their implementation across clinical and practical settings. In

OSCEs, additional time is not typically provided; instead, examiners are briefed on required adjustments and alternative approaches, such as verbalisation of manoeuvres, which are permitted where appropriate. While early identification processes and special consideration arrangements support students experiencing health-related impacts, the student submission identified inconsistencies in LAP implementation, unsuitable examination environments and limited flexibility for alternative attendance at some sites. These findings indicate the need to ensure reasonable adjustment provisions are applied consistently across the academic and clinical contexts, with improved operation clarity, particularly during the transition to the National School of Medicine.

Selection and admission processes

The School adheres to the University's Admission and Credit policy to assure selection processes are transparent, structured, and centrally coordinated through Graduate Entry Medical Schools Admission System (GEMSAS) and internal mechanisms. CSPs are allocated based on interview performance, followed by Bonded Medical Places and full-fee positions. International applicants are subject to equivalent assessment processes, including English language requirements where applicable. IHM staff contribute to the assessment of Aboriginal and/or Torres Strait Islander applicants, and planned reforms include formalising GPA flexibility. While these processes are appropriate, further review of eligibility criteria for financial support services could be considered to ensure equitable access for students admitted through targeted pathways.

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.

Student wellbeing and inclusion strategy

As discussed in Standard 4.1, the School adheres to a multi-tiered system of support for students in the national MD program. There is a strong emphasis on pastoral care as a core component of its wellbeing approach, and the team observed many positive examples in practice. Heads of Clinical Schools, hospital

coordinators and associated staff were consistently described as knowing their students well and being trusted and valued by the majority of students.

Central support is provided by campus-based Student Matters coordinators, linked to central University services, and dedicated international student leads at each campus. Support services are introduced during orientation at each year level, with relevant resources accessible via Blackboard. Students may access up to 12 psychology sessions through the University, while reasonable adjustment processes are managed by the Access and Inclusion team.

The leadership team described regular engagement with students through meetings with student societies, monthly year-representative forums and town halls involving senior staff. Student representatives confirmed frequent and constructive engagement with senior leadership and noted a positive cultural shift under the current Dean. Students across multiple sites similarly described leadership as more visible, responsive and accessible than in previous years, representing a genuine and commendable improvement.

The wellbeing strategy is driven by a culture of relationship building, which is a strength, but also presents challenges and risks, particularly for students from equity groups who may require more tailored or proactive support. A greater focus on contextualising pastoral care for these cohorts, alongside more systematic and anticipatory wellbeing strategies—such as cultural safety audits that identify emerging issues rather than relying on student self-disclosure—would strengthen the overall framework, with potential to leverage existing evaluation mechanisms and frameworks for this purpose.

Student support

Students have access to a range of support services for their academic and personal needs, including counselling, Student Matters coordinators, Access and Inclusion advisors, respect officers (full-time in Fremantle and Sydney; 0.4 FTE in Broome), chaplaincy, and the 'Sonder' app for safety tracking in placement settings. In addition, financial hardship grants are available through central University funds each year, and resources on bulk-billing psychologists and general practitioners are circulated.

Student performance in in-course assessment, mid-year examinations and end-of-year examinations is closely monitored with the National Head of Assessment meeting weekly with foundation and clinical year heads to review emerging concerns. Approximately 10% of students engage in structured academic support conversations annually, while students who are unsuccessful in mid-year examinations are contacted directly and provided with tailored feedback. Repeating students receive formal study plans and monthly review meetings with senior academic staff. This monitoring system is integrated with progression governance through the BOE and appears responsive and functional.

When wellbeing support functions well, students report strong experiences, particularly with campus-based coordinators and the School's Student Matters team. In addition, Heads of Clinical Schools and hospital coordinators were identified as sources of valued pastoral support for students on clinical placements. In Broome, students specifically identified the absence of in-person counselling as a significant gap, outlining the benefit of introducing a wellbeing contact person who is not concurrently involved in academic functions and has clear, separate reporting lines.

Managing conflicts of interest

Students can disclose health or personal information through Student Matters coordinators or Access and Inclusion staff. The Student Matters team outlined clear confidentiality guidelines for handling this information, noting that escalation without consent only happens when risk levels are exceeded. However, students have varying understanding of role boundaries, especially where staff previously provided psychological support but now are in different roles that do not have the same confidentiality requirements. This has caused some students to mistrust the confidentiality of support and clinical staff. Although procedures comply with policy standards, students' understanding varies and should be clarified through transparent communication about what is confidential and the appropriate escalation steps based on the support needed. Further discussion about the need for confidential mechanisms for student support is considered under Standard 4.2.7.

Access to financial support

Students report that financial support has become less accessible. Hardship grants, which are normally up to \$1000 per annum, have become harder to obtain due to changes in eligibility criteria. Students based in Broome reported significant hardship, as off-campus accommodation costs exceeded or approached Centrelink allowances, with local employment limited and campus-specific financial support mechanisms minimal. There is also an opportunity for the School to improve communication with students regarding financial resources and fee changes.

Academic support

While there are existing mechanisms, the team identified significant concerns about equity in academic support. Students perceived a reduction in tailored, culturally aware tutoring provided specifically for Aboriginal and/or Torres Strait Islander students. This perception caused distress for students and was interpreted as a sign of reduced institutional commitment to equity-based support. Since recruitment goals focus on increasing Aboriginal and/or Torres Strait Islander student participation, amending dedicated academic support arrangements should be carefully reviewed and current student concerns consulted. The concerns raised by students should be supported with an appropriate response by the School to facilitate their academic success.

The School provides structured mechanisms for leave of absence and extension of enrolment beyond the standard six-year maximum, with a seventh year approvable where necessary. Repeating students receive formal written approval and structured monthly progress meetings with senior academic staff. Students are encouraged to communicate early regarding leave needs, and administrative tracking is centralised through University systems.

Progression decisions are made by the BOE, and Student Matters staff do not participate in decision making regarding progression outcomes. Prior to formal meetings, preparatory discussions occur among the Dean, Deputy Heads and the National Head of Assessment to identify students with accommodations or complex circumstances. The structural separation appears appropriate at a policy level; however, the Dean's close involvement in both pastoral support functions and progression decisions creates an overlapping role that may, in practice, undermine the separation principles outlined between staff involved in either academic progression decisions or student support.

Concerns raised by students around such potential conflicts of interest should be addressed. Current practice should be re-examined to ensure students perceive a clear separation between academic and pastoral functions. This is particularly pertinent for students with impairment or fitness-to-practice concerns, who would benefit from clearly documented policy and processes that ensure seeking support carries no influence on academic outcomes. In addition, for small cohort sizes, such as the Broome campus, the overlap among roles of support staff, teaching staff and decision-making personnel is structurally unavoidable. Therefore, the Professional Practice and Fitness to Practice policy requires revisions to explicitly separate these roles in documentation and ensure that this is understood by all staff and students.

Reporting of bullying, harassment and racism

The University has formal policies to address bullying, harassment, racism and discrimination, with Respect Officers on each campus and escalation pathways within the School involving Heads of Years and the Dean. Policies include confidential procedures for addressing grievances raised by students, and a student's appeals process. University Student Grievance Officers are available to students should they wish to raise concerns about any aspect of their UNDA experience. Information on how to raise a concern, grievance or appeal is publicly available on the [University website](#).

The University has also adopted a no-tolerance approach to racism and is participating in a national survey on the prevalence of racism in Australian universities, conducted by the Australian National University on behalf of the Australian Human Rights Commission. The survey findings will inform the Commission's subsequent report, which will have impact on Australian universities at large.

The School's Student Matters team described processes for informal discussion, withdrawal from placements where necessary, and escalation to University-level structures. The School and MSAND published a Student

Support Pathways document that was developed in 2023 that provides a step-by-step guide for students to identify and navigate support systems for various concerns applicable to their specific situation.

Despite the presence of established University structures and the School's professed commitment to student wellbeing, the team expressed concern that students frequently demonstrated limited awareness, confidence or understanding of the procedures for reporting bullying, harassment, racism and discrimination. The following reasons were cited by students:

- Students preferred to approach student society representatives rather than use formal reporting pathways. This appeared to reflect a combination of limited awareness of reporting processes, frequent turnover of support staff with delayed communication to students when roles changed, and a broader lack of trust or confidence in the safety and effectiveness of existing reporting mechanisms.
- Students felt very uneasy about reporting complaints, citing previous experiences where complaints were handled in unsafe ways.
- Students believed reporting incidents would be futile, as they anticipated no changes would occur. These observations suggest that a lack of reporting should not be interpreted by the School as indicating a lack of a problem.
- There is perception that there is no confidential, safe pathway to escalate a complaint within the School.

The team noted that several students withdrew their complaints due to apprehensions regarding their identities being linked to formal reports. Access to confidential reporting is especially significant for KCRMT and students in rural clinical placements, where smaller cohorts increase the need for robust measures to safeguard anonymity when raising concerns. Instances of formal complaint submissions were perceived as lacking consistent follow-up and substantive action, with student societies highlighting inadequate protection and confidentiality for affected students at KCRMT. These societies also identified delays in response time as a contributing factor undermining students' trust in existing reporting procedures.

The team considers a reluctance to report and escalate incidents of bullying, harassment, racism and discrimination a significant risk, especially for students from equity groups or those based in rural and remote areas, where the ability to seek supportive or appropriate assistance may be limited. Given the School's targets for the medical program, it is important that the development of safe reporting mechanisms, with associated addressing of student perceptions, be prioritised to ensure student safety in all campuses and program years.

While it is positive that the School can collaborate with student societies on matters of student wellbeing and reporting, and should continue to do so, student societies should not be relied upon as a primary source for identifying, escalating and responding to student concerns or issues. Improving the visibility of student societies in governance, as discussed in Standard 1, should support swifter identification and resolution of issues directly impacting students.

There is a significant gap between policy structures and student confidence that needs focused attention at all of UNDA's national MD program campuses. The School must urgently create and roll out a structured system for students to report bullying and harassment that is safe, accessible and confidential, distinct from academic reporting and informal pastoral care mechanisms. Students should also have a clear understanding of how these mechanisms connect with broader University grievance reporting processes, and ensure these options are clearly and regularly communicated to both current and incoming students. When designing and implementing these systems, it is essential to consider the specific needs of students from equity groups.

4.3 Professionalism and fitness to practice

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| 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. |
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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.
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Impairment matters are managed in alignment with University regulations, with matters escalating to the Dean and, where required, to external committees that include student representation when impairment raises concerns regarding fitness to practice. Students may be withdrawn from placements pending review, and examples were provided that demonstrated structured intervention plans incorporating mentoring and additional learning activities.

While the operational approach appears functional, the policy framework requires development in several respects. As outlined in Standard 4.2, the current Professional Practice and Fitness to Practise policy does not clearly account for staff that may be involved in both student support and decisions regarding a student's ongoing enrolment and progression. Such conflicts of interest should be explicitly addressed in policy and resolved through governance reform. The Professional Practice and Fitness to Practise policy and associated governance structures must be updated as a priority to ensure that student support mechanisms are operationally separated from decision-making processes about academic progression.

Professional behaviour is assessed longitudinally through PPD domain assessments, WBA forms and rotation evaluations. Unsatisfactory professionalism indicators trigger review by Heads of Clinical Years and may escalate to the BOE. Multiple streams of learning, such as clinical debriefing and PBL, enable early identification of students who may require support in culturally safe practice and professionalism.

Students reported that access to staff for support was hierarchically flat, with students feeling comfortable to approach a range of staff members, including year coordinators and the Dean, for various concerns. This culture of accessibility and support is a genuine strength of the School and is affirmed by students across a range of sites.

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.
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Students are indemnified through Marsh Pty Ltd under the 10-23 Newline Australia University Combined Liability Insurance policy.

STANDARD 5: Learning environment

5.1 Facilities	
5.1.1	The medical education provider has the educational facilities and infrastructure to deliver the medical program and achieve the medical program outcomes.
5.1.2	Students and staff have access to safe and well-maintained physical facilities in all learning and teaching sites. The sites support the achievement of both the medical program outcomes and student and staff wellbeing, particularly for students and staff with additional needs.
5.1.3	The medical education provider works with training sites and other partners to provide or facilitate access to amenities that support learning and wellbeing for students on clinical placements. This includes accommodation near placement settings that require students to be away from their usual residence.
5.1.4	The medical education provider uses technologies effectively to support the medical program's learning, teaching, assessment and research.
5.1.5	The medical education provider ensures students have equitable access to the clinical and educational application software and digital health technologies to facilitate their learning and prepare them for practice.
5.1.6	Information services available to students and staff, including library and reference resources and support staff, are adequate to meet learning, teaching and research needs in all learning sites.

The School has a broad geographical footprint across Australia. Years 1 and 2 are delivered at the UNDA campuses in Fremantle, Sydney and Broome. Years 3 and 4 are delivered across multiple teaching hospitals and general practices in Perth as well as through placements across Western Australia via the RCSWA for Fremantle and Broome students. Sydney students undertake their placements and across a range of clinical schools and general practices in New South Wales and Victoria. The team visited sites across the broad footprint of the program and found that students and staff generally have access to safe, well-maintained facilities and infrastructure across all learning and teaching sites.

At most sites, the School facilitates access to amenities and accommodation where necessary. Accommodation is available on-site at the Broome campus for Years 1 and 2 students. Clinical schools in regional and rural areas in New South Wales and Victoria provide suitable accommodation for students, and some of the Sydney-based clinical schools offer temporary accommodation for students finishing late shifts, which is a valued amenity. Students reported that wi-fi access in rural and remote locations can be variable, particularly in Broome.

The team was satisfied with the information technology (IT) services available to students and staff. The School has appropriate technologies in place to support learning, teaching, assessment and research. A cybersecurity incident in 2025 raised some concerns; however, both the School and the broader University appear to have managed the response appropriately. There remain some areas for improvement, including the lack of online assessment forms and limited student access to REDCap (a survey and database software), which pose barriers to research activities. The School is currently transitioning its LMS to Blackboard Ultra, which could improve students' IT and learning experiences.

At most sites, students were able to access the clinical and educational software required for their learning. However, at one site, the team was advised that students did not have individual login credentials and were instead using other clinicians' credentials to access medical records. This arrangement raises potential legal and governance concerns. The School should work with placement providers to clarify these arrangements and ensure they are compliant with relevant legal and regulatory requirements.

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.

Academic staffing

The School demonstrates a commitment to ensuring adequate academic staffing to cover the scope of the medical program and its delivery. Several gaps were identified in some disciplines:

- As discussed in Standards 1.3 and 1.4, gaps remain for Aboriginal and/or Torres Strait Islander academic staff, particularly at senior levels, which need to be urgently addressed.
- In the general practice discipline, staff across both the Fremantle and Sydney campuses were passionate and highly competent, yet many were observed to be operating beyond their expected capacity; additional FTE was identified as necessary to sustain program delivery.

The team observed that slow central recruitment procedures was cited as a structural barrier preventing the School from obtaining resources in a timely manner. The University, Faculty and School will need to collaborate closely to identify and reduce barriers to recruitment to ensure the national MD program is appropriately resourced.

Professional staffing

The professional staff within the medical program demonstrate a strong dedication to supporting program operations. There is a School Manager overseeing all campuses, and the team believes that the current organisational structure effectively meets the program's requirements. Staff members have indicated that they receive sufficient support from the School. While the School recognises the need for additional staff at the Broome campus, it is currently making good use of resources from the Majorlin Institute, co-located with the KCRMT, as a temporary solution until long-term staffing arrangements are established.

The team was particularly impressed by hospital coordinators and clinical school administrative staff, who are highly valued by clinicians, academic staff and students as essential points of contact and support, and who play a central role in the day-to-day functioning of the program. Numerous professional staff, clinical site personnel and stakeholders who interacted with the team showed enthusiasm for collaborating with the School and expressed strong support for its current trajectory.

Aboriginal and/or Torres Strait Islander recruitment and expertise

The University is currently updating its 2024–2026 Aboriginal and Torres Strait Islander employment strategy. The appointment of an Aboriginal and Torres Strait Islander Employment Advisor who meets regularly with the Dean is a welcome and positive step. However, current Aboriginal and/or Torres Strait Islander staffing levels within the medical program are insufficient to deliver the level of education and support required by the program and students.

The team noted that several positions remain unfilled, partly due to prolonged recruitment processes. Although the School is undertaking efforts to address these vacancies, the team did not identify a clearly articulated or strategic approach to recruiting and retaining Aboriginal and/or Torres Strait Islander staff that aligns with the specific needs and context of the medical program. This issue is particularly significant given the existing gaps in the teaching and learning of IHM curriculum content, as referenced in Standard 2. Without a comprehensive and sustainable recruitment and succession plan, there is an ongoing risk of insufficient expertise needed to develop, implement and continuously enhance IHM domain curriculum and assessment, as well as to provide culturally safe medical education. Furthermore, the shortage of Aboriginal and/or Torres Strait Islander academic staff, along with limited representation in senior governance levels (Standard 1.3), hampers the full utilisation of existing expertise in managing the program.

Recruitment, support and training of patients and community members

The program relies on dedicated simulated and volunteer patients to support student learning, skill instruction and clinical exams. However, recruitment, engagement and support processes lack the formalisation needed for consistency, safety and equity. These gaps are particularly notable in the context of summative assessments, where robust training and quality assurance of simulated patient performance in OSCEs are essential. With the introduction of the National School of Medicine and MD program, it is important to adopt structured strategies for recruiting, training and supporting simulated or volunteer patients and community members across its footprint.

Having formal recruitment, support and training processes works well alongside approaches that actively involve community groups in rural/remote settings or facing health inequities, such as Aboriginal and/or Torres Strait Islander communities. Aspects of formalisation should include written agreements that outline the mutual obligations and responsibilities of both parties, including any forms of remuneration, structured orientation or training processes, procedures for managing adverse events that may arise during learning and teaching activities, and the provision of safe environments for patients and community members. Protecting the physical and emotional wellbeing of patients and community members, especially those who are vulnerable, is vital. It is also crucial to prioritise culturally safe environments for Aboriginal and/or Torres Strait Islander participants, particularly in simulated clinical settings.

Staff indemnification

Staff are indemnified through Marsh Pty Ltd under the 10-23 Newline Australia University Combined Liability Insurance policy.

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.
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University-wide policies regarding the appointment and advancement of academic staff provide a reliable and uniform framework for overseeing personnel involved in teaching, research and service. At the time of the assessment, no significant inconsistencies in the application were identified across campuses beyond the need for improvement in the coordination of research and scholarship activities, as noted in Standard 2.2. Staff engaged in research across the School's footprint, including at clinical schools, expressed interest in a more coherent approach to research, with more administrative coordination and support provided.

Appointment and promotion policies for Aboriginal and/or Torres Strait Islander staff

A key issue identified pertains to the appointment and promotion processes for Aboriginal and/or Torres Strait Islander academic staff. Existing policies may not fully recognise the wide range of expertise that is crucial and valuable in this context, including cultural knowledge, community engagement and lived experience. Although there is support at the School level for acknowledging Aboriginal and/or Torres Strait Islander knowledge in hiring decisions, institutional emphasis on formal western academic qualifications constrains the implementation of more culturally inclusive recruitment and promotion practices.

The team was unable to identify evidence of a culturally safe framework for evaluating the success of Aboriginal and/or Torres Strait Islander staff. Establishing such a system should be considered a priority and undertaken through authentic consultation with Aboriginal and/or Torres Strait Islander staff, ensuring it is relevant, respectful and encompasses the full scope of their contributions to the program.

Appraisal and development

The University has structured systems to ensure staff engage in ongoing performance appraisal and development on an annual basis. Review of adjunct positions is supported through communication with the Dean. The School has strengthened its reappointment processes with formal reviews by the School's National Executive Committee, and positions must be nominated for a staff member to be considered.

Evaluation and development practices have been established in several clinical schools, where systematic approaches are effectively reinforced through collaborative teamwork. Due to the broad scope of the National School, variations in implementation may occur across different sites; this underscores an opportunity to improve communication and promote greater consistency in appraisal processes.

Professional development

The University has a professional development policy that gives staff financial support to attend conferences and relevant courses to support their professional development. The University and the School appear to be supportive of staff who wish to access development opportunities. The team heard Aboriginal and/or Torres Strait Islander staff have been supported to participate in events such as the Australian Indigenous Doctors' Association Conference. Aboriginal and/or Torres Strait Islander staff expressed feeling valued and supported by School leaders, which is an encouraging foundation to build upon.

Presently, however, structured professional development opportunities appear limited, highlighting the potential to create pathways for training and mentoring for Aboriginal and/or Torres Strait Islander staff across the program, School and University. Expanding these opportunities would support the growth and connectivity among Aboriginal and/or Torres Strait Islander staff and help build a more connected and sustainable workforce in the School.

Training in cultural safety

The University requires staff to complete online modules that offer a basic introduction to Aboriginal and/or Torres Strait Islander Peoples and cultures. The School also provides cultural awareness training for all academic, professional and clinical staff across each campus. However, these modules do not specifically cover health care, and there is limited information about further education and training opportunities for students beyond curriculum content related to the IHM domain.

It is crucial for the School to distinguish between cultural awareness training and cultural safety training. Culturally safe practice requires health practitioners to engage in continual critical reflection on their knowledge, skills, attitudes, behaviours and power dynamics, ensuring that health care is provided in a manner that is safe, accessible, responsive and free from racism. The team noted that there is still a need to ensure staff, clinical supervisors and students undergo relevant cultural safety training, as evidence of culturally safe practices within the program remains limited.

The School must ensure that the development or assessment of all cultural safety training undertaken by staff, students and clinical supervisors is aligned with the National Registration and Accreditation Scheme, as defined by Ahpra (Australian Health Practitioner Regulation Agency), and meets an equivalent standard. Additionally, it is imperative to implement effective mechanisms that support ongoing education in cultural safety beyond the initial training phase.

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 School has formal relationships with health service partners across Western Australia, New South Wales and Victoria, including with relevant health departments, private healthcare providers and general practice clinics. These partnerships appear to be effective, and students generally expressed satisfaction with their clinical learning experiences.

Many students may interact with Aboriginal and/or Torres Strait Islander patients during clinical placements at major tertiary hospitals in Western Australia and New South Wales, yet these encounters are not always formally acknowledged or recognised, representing a gap in clinical education. A common misconception is that interactions with Aboriginal and/or Torres Strait Islander patients are more common in rural or remote areas, even though the Australian Institute of Health and Welfare reports that most Aboriginal and/or Torres Strait Islander People live in urban and regional settings. There can also be a misconception that Aboriginal and/or Torres Strait Islander People predominantly use Aboriginal health services compared to conventional health services.

To ensure students can provide clinical and culturally safe health care to Aboriginal and/or Torres Strait Islander patients, structured systems are needed to guarantee that all students obtain relevant experience prior to graduation. There are opportunities for the School develop mutually beneficial relationships with Aboriginal health units/liaison officers, Aboriginal community controlled health organisations, Aboriginal medical services and related health units in both urban and rural settings to ensure that students have adequate opportunities to deliver health care to Aboriginal and/or Torres Strait Islander communities. There are some positive examples of this, such as the partnership with Derbarl Yerrigan in East Perth, which could be improved on and expanded across the entire program to ensure students in all campuses obtain equivalent experience and education. Additional education for students on culturally safe ways to engage with patients and teaching on the importance of identification of Aboriginal and/or Torres Strait Islander patients would also be valuable.

Engagement with co-located health professions

Engagement with co-located health profession education providers is variable. There are examples of extremely positive relationships with some co-located medical schools:

- Advancements in collaboration between medical schools in Wagga Wagga appeared particularly effective, where shared staffing arrangements and the implementation of a common timetable across

the three medical schools have significantly improved relationships and thus the clinical experience for students.

- The RCSWA is an innovative model of collaboration between the three Western Australian medical schools, which is steered by collegial relationships among the three Deans.

Relationships with other health profession education providers appeared less developed, particularly where adequate formal structures and communication channels had not been well established. Strategic and active engagement with co-located medical schools needs to be maintained and standardised across all campuses to ensure positive relationships and collaboration on clinical facilities and teaching capacity are more uniform and consistent.

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.

Students' experiences in clinical placements are led by dedicated Heads of Clinical Schools and hospital coordinators across Australia, providing a strong and geographically distributed supervision framework. The team noted some concerns around informal supervision orientation practices. In particular, the use of locum workforce as supervisors introduces an element of variability that is difficult to control centrally. While this is not currently a significant issue at any site, the presence of locums in rural and remote sites will continue to increase, and the School could be more proactive in managing how these locum doctors can effectively supervise students. The School should monitor whether this significantly impacts student experience and take action if so.

Orientation and access to training

Evidence indicates variability in orientation and access to ongoing training for clinical supervisors, particularly in primary care settings. Currently, orientation is conducted informally, resulting in inconsistent access to training opportunities for clinicians and supervisors across different sites. While there are exemplary instances of supervisor orientation, these appear to be based on individual relationships rather than systematic processes, which may result in vulnerability to key person dependency. Although resources such as the Clinical Supervisor Information sheet exist, awareness of these materials—particularly among primary care supervisors—appears to be limited. Students highlighted how their experiences with primary care learning and teaching varied, demonstrating this inconsistency. Formalising the orientation process for clinical supervisors and improving the visibility of training opportunities available to clinicians is critical as the national MD program is implemented, as there will be key areas of change, particularly around culturally safe practice. It is essential to communicate changes to learning objectives and required outcomes clearly to clinical supervisors from the outset, while also anticipating the necessary training to support their ability to deliver on program objectives effectively.

Clinical supervisor performance

The informal relationships between the School and clinical placement providers appear to function effectively in practice. The School has an existing evaluation system that collects feedback from Heads of

Clinical Schools in Sydney and hospital coordinators in Fremantle, as well as tri-annual student evaluations, which provide a foundation for performance monitoring. Clinical supervisors are monitored through information channelled via clinical coordinators and escalated as needed, although there is variability and inconsistency across sites. Clinical supervisors have expressed that regular, constructive feedback on their performance would be beneficial to their development.

Allocated teaching time

Staff appear to have adequate time allocated for teaching within clinical service requirements, and no concerns were raised regarding this issue during the assessment. The balance between teaching and clinical service demands appears to be achieved effectively. It was not clear to the team how this balance is achieved or maintained, nor whether the School plays a proactive role in working with health services to ensure teaching time is protected. The absence of a documented process makes it difficult to assess sustainability or replicate success across sites. Documenting processes for working with health services to allocate and protect staff teaching time to ensure transparency, consistency and sustainability across all placement sites may safeguard this success in the future.

Definition of responsibilities

The responsibilities of hospital and community practitioners who contribute to delivering the program appear to have been defined by the School. It is less clear whether the School's reciprocal responsibilities to its practitioners are communicated in a manner that is visible and accessible to practitioners themselves. Clarity in this area would support the partnership between the School and its placement providers.

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.

There is a well-developed, nationally coordinated evaluation structure. This is overseen by the NQC, which replaced previous campus-based committees, to ensure a national approach.

There is a clearly articulated evaluation framework that is used to guide data synthesis, identify information gaps and inform further data collection. Multiple data sources are integrated into review processes. Quality officers collate and synthesise information before presentation to leadership. The NQC produces an annual quality report distributed to students, discipline leads and other stakeholders. Course outlines communicate to students what changes have occurred in response to feedback ('closing the loop').

There are regular student evaluations via standard course and rotation evaluation forms. End-of-clinical-rotation reports are anonymous and shared with Heads of Clinical Schools, discipline leads and other relevant stakeholders. These reports provide a comprehensive overview of key trends in student feedback, specifically addressing the quality of clinical teaching, placement experiences and overall preparedness for clinical practice. The School acknowledges that response rates are lower than desired and encourages consideration of mechanisms to improve them.

The annual Federation of Rural Medical Educators (FRAME) survey gathers feedback from final-year students after rural placements and has been managed by the Rural Clinical School since 2021. It captures attitudes and career aspirations of students, with universities using both individual and national data to benchmark and improve rural education programs.

Discipline-specific evaluation data are provided to discipline leads, who are then required to review findings, meet with Prevocational Advisory Committee (PreVAC) staff, and report outcomes and improvement actions back to the School. Clinical supervisors are monitored through information channelled via clinical coordinators and escalated as needed, although there is variability and inconsistency across sites. There are ongoing meetings with hospitals regarding pre-internship program quality and alignment. Heads of Clinical Years meet regularly with PreVAC partners to support site-level quality improvement. Strategic meetings are held between the Dean and Chief Medical Officers across states to maintain alignment.

Engagement with stakeholders in evaluation

Community feedback from post-immersion evaluations—including the Derby immersion program, KCRMT Year 2 and Rural Trauma Week—has shaped the refinement of immersion experiences, the Community Stakeholder Plan, and the work of the Community Engagement Working Party. Work is ongoing to establish a procedure that allows community groups to provide comprehensive input on broader program aspects. Clinician engagement is facilitated through clinical site networks, with feedback systematically directed to the NQC. From 2027, there is a plan for Heads of Clinical Years to meet with supervisors to gather structured feedback about graduate preparedness, and the AMC looks forward to the School providing more

information on this plan's implementation, particularly if there are any interactions with the finalisation of the pre-internship program discussed in Standard 2.3.9.

Engagement of Aboriginal and/or Torres Strait Islander staff in evaluation

Staff members are empowered to initiate evaluations using a formal request process, thereby ensuring their perspectives are meaningfully included. Evaluations can be customised for individual projects, following a collaborative methodology that prioritises Aboriginal and/or Torres Strait Islander leadership and partnership, consistent with the commitment to stakeholder engagement and alignment with IHM leadership.

Issues related to cultural safety are initially reviewed by quality assurance managers and, following established protocols, escalated to the IHM team. Prior references in the standards above highlight the significance of Aboriginal and/or Torres Strait Islander oversight in fostering culturally safe environments. The team notes that cultural safety with regard to Aboriginal and/or Torres Strait Islander People can only be determined by Aboriginal and/or Torres Strait Islander People. Attention to this should be given when triaging issues related to cultural safety to ensure Aboriginal and/or Torres Strait Islander Peoples are involved in this process.

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.

Monitoring student and cohort outcomes

Student and graduate cohorts, including those identified by entry pathways, are analysed, with appropriate consideration given to sample size limitations. Trend analysis is performed regardless of these constraints. Graduate preparedness is to be monitored, and structured graduate supervisor feedback will be implemented in 2027. Engagement in national benchmarking activities continues, encompassing the Medical Schools Outcomes Database, Quality Indicators for Learning and Teaching Graduate Outcomes Survey, FRAME survey and Australasian Collaboration for Clinical Assessment in Medicine, with further initiatives under consideration.

Notwithstanding that small numbers in some cohorts may risk inadvertent identification of individual students, the School evaluation team recognises there is an opportunity to more systematically evaluate assessment performance, particularly for student groups at risk of inequity.

Use of outcomes data for improvement

Evaluation findings are synthesised and reviewed collaboratively by quality officers and senior leadership, including the Deputy Heads of School. The NQC frequently analyses trends and is responsible for escalating systemic issues as they emerge. Discipline leads must review and address evaluation outcomes, with results from discipline lead meetings with PreVAC subsequently conveyed to School leadership. Hospital-level discussions inform ongoing refinement of the pre-internship program, while strategic meetings with Chief Medical Officers support greater consistency across jurisdictions. Notably, evaluation of Years 3 and 4 in Broome has not yet occurred, and this process should be monitored going forward.

The School evaluates student performance to improve selection, curriculum and support. Ongoing monitoring via exams provides insight into cohort differences and guides updates to assessment and admissions. For example, as of 2026, rural and metropolitan applicants must submit GAMSAT and Casper scores, have completed a Bachelor degree, and meet the GEMSAS GPA requirements. Student feedback has led to fewer live lectures, more recorded options and enhanced IT resources. The national curriculum now limits face-to-face teaching to 20 hours weekly, allowing for more independent study.

Continued efforts are underway to enhance the systematic analysis of cohort performance. While relevant data are available, further work is required to fully integrate these findings into ongoing improvement processes. To support continuous quality enhancement, outcomes should be routinely reported to the appropriate committees, including those overseeing student selection, curriculum development and student support.

Evaluation of outcomes for students from equity groups

The Assessment team monitors the progression of Aboriginal and/or Torres Strait Islander students, especially during the foundation years and the first year, and provides academic referrals as needed, with culturally appropriate support from Aboriginal and/or Torres Strait Islander staff. From 2026, targeted surveys will be introduced to gather feedback on support service awareness, access and experiences, guiding evidence-based improvements. Survey analysis and evaluations of cultural learning activities are done collaboratively with relevant teams, including the IHM team, to ensure resources remain responsive, inclusive and culturally appropriate across campuses.

The School recognises that recruitment to vacant positions, such as Aboriginal and/or Torres Strait Islander support staff, is essential for providing culturally appropriate support and resources to facilitate student progress and wellbeing, as discussed in Standard 5.2.3.

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.

Reporting mechanisms

The National Quality Report, compiled by the Quality Assurance team, collates and synthesises information derived from quality assurance activities to support strategic planning, program benchmarking and key program outcomes for the National School of Medicine. It is presented to the School’s Executive Committee, published for staff, and shared with student leadership via the student societies to promote transparency and engagement. Discipline-specific outcomes are communicated to discipline leads for targeted improvements. Course outlines are updated to reflect feedback-driven changes, while significant concerns from clinical supervisors are escalated to Heads of School for high-level action.

This structured process ensures regular and comprehensive dissemination of information, supporting ongoing quality assurance and continuous development across the program. The approach directly aligns with earlier commentary on the need for systematic analysis and integration of cohort performance outcomes (see Standard 6.2.3) and reporting student progress to relevant committees.

Closing the loop and transparency

End-of-rotation reports and benchmarking data are regularly shared with key stakeholders, including Heads of Clinical Schools and hospital coordinators, as outlined in Standard 6.1. There is some variability, with some general practice supervisors reporting they did not receive these reports. In 2025, an Action Plan template was added to end-of-rotation reports to allow stakeholders to formally address findings, propose improvement initiatives and record related discussions. This approach fosters two-way feedback and

accountability between stakeholders and the program. All School evaluation reports are accessible to staff on the Quality Resources team site, providing up-to-date data that support transparency and informed decisions. Documenting changes made in response to feedback further reinforces transparency, as highlighted in earlier standards about closing the loop and maintaining stakeholder engagement.

Appendices

Appendix 1: Accreditation in Australia and Aotearoa New Zealand

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

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

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

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

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

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

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

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

Appendix 2: Membership of the 2026 AMC Assessment Team

Name	Role
Professor Tim Wilkinson (Chair) MBChB (Otago), PhD (Otago), MClEd (UNSW), FRACP, MD (Otago), FRCP (London), FANZAHPE, FAMEE	Deputy Dean & Professor of Medicine and Medical Education, University of Otago, Christchurch Consultant Geriatrician, Burwood Hospital, Christchurch
Professor Sarah Chalmers (Deputy Chair) BSc (Hons), PGDipEd, MBBS, FRACGP, FACRRM	Senior Rural Generalist, Deputy Director of Medical Services Public and Primary Health Care, Top End Health Services (NT Health)
Mr Karl Briscoe MPH, GradCertPSM, AdvDipPHC, DipPracMgt	Chief Executive Officer, National Aboriginal and Torres Strait Islander Health Worker Association
Associate Professor Leonie Griffiths MBBS, MClEd, DRANZCOG, FRACGP, GAICD	MD Course Director, Melbourne Medical School, University of Melbourne
Dr Harry Luu BMedSc, MD	Medical Intern, Metro South Health (Queensland Health)
Associate Professor Nicole Mercer BN, RN, GAICD	Associate Head of School, Indigenous Strategy, School of Medicine, Deakin University
Professor Imogen Mitchell AM BSc(Hons), MBBS, SFHEA, PhD, FRCP, FRACP, FCICM	Executive Director, Education, Research and Academic Partnerships, Canberra Health Service & Australian National University
Dr Shyamsundar Muthuramalingam BTech, MS, PhD	Director of Clinical Research, Barossa Hills Fleurieu Local Health Network
Juliana Simon	Head of Accreditation Assessments, Australian Medical Council
Melissa Johnson	Cultural Strategic Facilitator, Indigenous Policy and Programs, Australian Medical Council
Ciara O'Sullivan	Policy and Programs Officer, Accreditation Assessments, Australian Medical Council
Esther Jurkowicz	Program Lead, Accreditation Assessments, Australian Medical Council

Appendix 3: Summary of the 2026 AMC Assessment Team's Accreditation Program

Meetings	Roles engaged with
Monday 23 February 2026	
University of Notre Dame Australia, Fremantle Campus	
Welcome to Country	Senior Lecturer, Indigenous Health and Medicine Domain Head of Domain, Indigenous Health and Medicine Domain Aboriginal Student Support Officer, Indigenous Health and Medicine Domain Dean, National School of Medicine Deputy Head of School of Medicine, Fremantle National Head, Student Matters, Selection & Pathways Quality Assurance Coordinator, School of Medicine MSAND President and Vice Presidents
Overview of the Week	Dean, National School of Medicine Deputy Head of School, Fremantle Deputy Head of School, Sydney
Governance and Medical Program Management	Dean, National School of Medicine Deputy Head of School, Fremantle Deputy Head of School, Sydney National Head of Medical Education and Innovation National Head of Student Matters, Selection and Pathways National Head of Rural Clinical Schools
Furthering Aboriginal and/or Torres Strait Islander Health Equity	Associate Professor, Indigenous Health and Medicine, Fremantle Senior Lecturer, Indigenous Health and Medicine, Fremantle Student Support Office, Indigenous Health and Medicine, Fremantle Manager, Indigenous Education Indigenous Employment Advisor National Head of Student Matters, Selection & Pathways Public Health Domain, Sydney
Community Engagement – Wheatbelt Program	Rural Health West Representative Wheatbelt East Regional Organisation of Councils Representative Wheatbelt and Beyond Youth Mentoring Host Family Representatives
Closed Session – Aboriginal and/or Torres Strait Islander Staff	Associate Professor, Indigenous Health and Medicine Senior Lecturer, Indigenous Health and Medicine Student Support Officer, Indigenous Health and Medicine, Fremantle
Student Society MSAND Representatives	MSAND President MSAND Executive Team MSAND Year Reps

Meetings	Roles engaged with
	Fremantle Students across Year 1 & Year 2
Curriculum and Outcomes	National Head of Medical Education and Innovation Associate Professors of Medical Education PBL Project Lead Public Health Academics Medical Education Development Officer Medical Education, Senior Lecturer
Aboriginal and/or Torres Strait Islander Community Stakeholders	Associate Professor, Indigenous Health and Medicine, Fremantle Senior Lecturer, Indigenous Health and Medicine, Fremantle Student Support Office, Indigenous Health and Medicine, Fremantle Adjunct, School of Medicine Dean, Indigenous Engagement, Curtin UWA Aboriginal School of Medicine Staff Director of Aboriginal Health Workers, East Metro Health Service Aboriginal Liaison Office Aboriginal Health Director, East Metro Health Service
Tour of Facilities	Foundation Years Tutor Senior Lecturer, School of Medicine
Research in the Program	National Head of Research Strategy & Operations, School of Medicine Associate Professor, General Practice Research and Medical Research and Innovation Domain Chair of Digital Health and Telemedicine Head of General Practice and Primary Care Research Senior Lecturer, Senior Research Fellow
Aboriginal and/or Torres Strait Islander Students	Aboriginal and/or Torres Strait Islander Students
Tuesday 24 February 2026 University of Notre Dame Australia, Fremantle Campus	
Partnerships with Communities and Engagement with Stakeholders	Chair of School of Medicine External Advisory Board CEO, St John of God Subiaco Hospital
Faculty executive, Budgets and financial sustainability	Executive Dean of Faculty School Manager Faculty Manager Finance Business Partner Associate Director of Finance Dean, National School of Medicine
Teaching and Learning	Head of Foundation Years Head of Clinical Years National Head of Medical Education

Meetings	Roles engaged with
	PBL Tutors Clinical Skills Tutors Discipline Leads
Monitoring and Evaluation	Deputy Head of School, Fremantle Quality Assurance Coordinator, Fremantle Quality Assurance Coordinator, Sydney National Quality Manager
Assessment Strategy	National Head of Assessment Head of Clinical Years, Fremantle Head of Clinical Year, Sydney National Head of Medical Education and Innovation Head of Domain, Indigenous Health and Medicine Domain Assessment Coordinator
Admissions and Selection	National Head of Student Matters, Selection and Pathways Director of Admissions National Manager, Admissions Manager, International Student Recruitments and Admissions Biomedicine Pathways, Associate Director, Learning & Teaching Acting Associate Dean, Learning and Teaching
Assessment in Practice	National Head of Assessment Deputy Head of School, Fremantle PBL Project Lead
Student Wellbeing	National Head of Student Matters, Selection and Pathways Director, Student Engagement and Success Course Coordinators Student Matter Coordinators National Manager of Student Wellbeing Access and Inclusion Lead
Primary Care Clinical Supervisors	Primary Care Clinical Supervisor Representatives
Primary Care Lead and Education Team	GP Discipline Lead GP Clinical Placement Coordinator
Co-located School – Curtin Medical School	Dean, Curtin Medical School
Tuesday 24 February 2026 St John of God Hospital	
Clinical Site Leadership	Hospital Coordinator Site Administrator
Clinical Supervisors	SJOG Clinical Supervisors
Students	Students and alumni on placement

Meetings	Roles engaged with
Hospital Executive	CEO Medical Director Director of Postgraduate Medical Education
Wednesday 25 February 2026 Fiona Stanley Hospital	
Hospital/Site Executive	Chief Executive Executive Director, Fiona Stanley Fremantle Hospital Group
Clinical Site Leadership	UNDA Clinical Site Lead/Hospital Coordinator UNDA/Fiona Stanley Hospital Site Administrator UNDA Head of Clinical Years UNDA Clinical Placements Officer
Clinical Placement Supervision and Strategy	Clinical Site Lead/Hospital Coordinator Medical Education Unit Representative Fiona Stanley Hospital Medical Education Officer Medical Education Registrar
Students	Students and alumni on placement
Clinical Supervisors	Department Lead, ENT Department Lead, Emergency Department Lead, General Medicine Paediatrics consultant UNDA Surgery Mentor
Aboriginal Liaison Office	Aboriginal Liaison Officer
Tour of Facilities	Clinical Site Lead/Hospital Coordinator Hospital Site Administrator Head of Clinical Years
Virtual Meeting with Other Hospitals	Clinical Site Lead/Hospital Coordinator, Hollywood Private Hospital Department Lead, Anaesthetics, Sir Charles Gairdner Hospital Clinical Site Lead/Hospital Coordinator, Armadale Hospital
Wednesday 25 February 2026 University of Notre Dame Australia, Fremantle Campus	
Interprofessional Learning	Representatives from School of Health Sciences
State/Territory Health Department	Chief Medical Officer, WA Health
Rural Clinical School WA (RCSWA)	Head of School, RCSWA Co-Deputy Director, RCSWA Operations Manager
Co-located School – University of Western Australia (UWA) Medical School	Dean, UWA Medical School

Meetings	Roles engaged with
Thursday 26 February 2026	
University of Notre Dame Australia, Kimberley Centre for Remote Medical Training (KCRMT)	
Facilities Tour	Administration Coordinator Coordinator, Chaplaincy Head of Foundation Years Director, Majarlin Kimberley Centre for Remote Health
Site Leadership	Dean, National School of Medicine National Head of Rural Clinical Schools Acting Head of KCRMT Head of Foundation Years Coordinator, Chaplaincy
Aboriginal and/or Torres Strait Islander Staff	Student Support and Outreach Officer Cultural Security Officer Senior Administration Officer, Majarlin Senior Lecturer, Indigenous Health Medicine
Academic Staff	Acting Head of KCRMT Head of Foundation Years Senior Lecturer, Indigenous Health Medicine PBL Tutors
Evaluation of KCRMT	Deputy Head of School, Fremantle Rural Research Coordinator Quality Assurance Coordinator, Fremantle
Friday 27 February 2026	
University of Notre Dame Australia, Kimberley Centre for Remote Medical Training (KCRMT)	
Community stakeholders	Kimberley-Pilbara Training Hub Rural Flying Doctor Service Kimberley Mental Health and Drug Service Broome Aboriginal Medical Service Kimberley Health Professional Network: Rural Health West Rural Clinical Schools Western Australian Country Health Service Nyamba Buru Yawuru
Students	KCRMT Students
Friday 27 February 2026	
Broome Hospital	
Rural Clinical School Western Australia, Broome Leads	RCSWA Broome Leads RCSWA Regional Hub Representative
Clinical Leadership, Broome Hospital	Senior Medical Officer Medical Education Officer

Meetings	Roles engaged with
Monday 2 March 2026	
Blue Mountains Planetary Health Centre, Katoomba	
Welcome to Country and Smoking Ceremony	Cultural Interpreter for NSW National Parks NSW National Parks Guide Dean, National School of Medicine Head of Ballarat Clinical School National Head of Rural Clinical Schools Professor of Population and Planetary Health Public Health Medicine Specialist Trainee
Rural and Indigenous Immersion Trip	Senior Lead, Planetary Health Initiative, Blue Mountains City Council Professor of Population and Planetary Health Public Health Medicine Specialist Trainee Foundation Year Tutor Head of Ballarat Clinical School National Head of Rural Clinical Schools
Monday 2 March 2026	
Lithgow Rural Clinical School	
Introduction to Lithgow Rural Clinical School	Professor of Public Health Professor of Population and Planetary Health Dean, National School of Medicine National Head of Rural Clinical Schools Head of Ballarat Clinical School Rural Research Coordinator and Epidemiologist Public Health Medicine Specialist Trainee Foundation Year Tutor Executive Officer Senior Administration Officer and Student Coordinator Administration Officer Community Member
Lithgow RCS Clinical Staff	Professor of Public Health National Head of Rural Clinical Schools Head of Ballarat Clinical School Rural Research Coordinator and Epidemiologist Professor of Population and Planetary Health Public Health Medicine Specialist Trainee Foundation Years Tutor Clinical Discipline Leads
Community Advisory Board	Community Advisory Board Representatives

Meetings	Roles engaged with
Monday 2 March 2026	
Virtual meetings – Co-located Schools	
Co-Located School –University of Sydney	Dean, Sydney Medical School
Co-located School – University of New South Wales	Vice Dean UNSW Medicine and Health and Head of School of Clinical Medicine Head of St Vincent’s Healthcare Clinical Campus Director of Medical Education, UNSW Medical Education
Co-located School – Deakin University	Dean, Deakin Medical School Deputy Course Director Deputy Course Director Clinical Education Lead Clinical Education Lead (Geelong-Barwon) Associate Head of School of Medicine (International and Partnerships)
Co-located School – Charles Sturt University	Interim Dean, School of Rural Medicine
Co-located School – Western Sydney University	Deputy Dean, School of Medicine Associate Dean, School of Medicine
Tuesday 3 March 2026	
Lithgow Rural Clinical School	
Students	Year 4 UNDA Students
Professional Staff	Executive Officer Senior Administration Officer and Student Coordinator Administration Officer
Local Primary Care Supervisors	Primary Care Supervisor Representatives
Partnerships with health organisations and the local Lithgow council	Nepean Blue Mountains PHN Representative Nepean Blue Mountains Local Health District Representative Professor of Population and Planetary Health Head of Ballarat Clinical School Professor of Public Health Public Health Medicine Specialist Trainee National Head of Rural Clinical Schools
Tuesday 3 March 2026	
Virtual Meetings – Clinical Schools	
Ballarat and Melbourne Clinical Schools	Head of Ballarat Clinical School and Acting Head of Melbourne Clinical School Senior Administrative Officer (Ballarat) Senior Administrative Officer (Melbourne)
Wagga Wagga Clinical School	Head of Wagga Wagga Clinical School

Meetings	Roles engaged with
	Student Coordinator and Senior Administration Officer (Wagga Wagga)
Hawkesbury Clinical School	Head of Hawkesbury Clinical School
Students	Melbourne, Ballarat, Wagga Wagga, and Hawkesbury Students
Admin, Clinical and Professional Staff	Clinical Placements Coordinator Foundation Years Administration Assistant Administration Officer (Hawkesbury) Senior Administrative Officer (Melbourne) Senior Administrative Officer (Ballarat) Senior Administrative Officer (Wagga)
University of Wollongong	Dean, Graduate School of Medicine
Aboriginal and/or Torres Strait Islander Stakeholders	Australian Museum Program Team
Wednesday 4 March 2026 University of Notre Dame Australia, Darlinghurst Campus	
Vice Chancellor	UNDA Vice Chancellor
Local Community Stakeholders	Volunteer Simulated Patients Executive Officer, Kidsafe NSW
Standard 2 Curriculum	Clinical Domain Heads
Foundation Years Team	Head of Foundation Years Deputy Head of Foundation Years PBL Tutors
Students	Medical Association of Notre Dame Sydney Student Representatives
Aboriginal and/or Torres Strait Islander Students	Aboriginal and/or Torres Strait Islander Students
Primary Care Education Team	Discipline Head of General Practice Discipline Leader of General Practice
Primary Care Supervisors	Primary Care Supervisor Representatives
Postgraduate Medical Council of Western Australia	Chair, Postgraduate Medical Council of Western Australia
Wednesday 4 March 2026 St Vincent's Hospital	
Hospital Site Executive	Chief Executive Officer Chief Medical Officer Director of Allied Health Chief Operating Officer
Clinical Site Leadership	Acting Head of Clinical School Administration Officer

Meetings	Roles engaged with
Medical Education Unit and Clinical Supervisors	Clinical Supervisors
Students	Students on placement
Wednesday 4 March 2026 Auburn Clinical School	
Hospital Site Executive	Acting Chief Executive, Western Sydney LHD Executive Director Quality & Safety, Western Sydney LHD Director of Education Western Sydney LHD Director of Medical Services, Auburn Hospital
Clinical Site Leadership	Head of Clinical School Administrative Officer (Auburn)
Medical Education Unit and Clinical Supervisors	Director of Prevocational Training Clinical Discipline Leads Clinical Supervisors
Students	Students on placement
Thursday 5 March 2026 University of Notre Dame Australia, Darlinghurst Campus	
Governance and Staffing	School Manager Faculty Manager Deputy Head of School, Fremantle Deputy Head of School, Sydney Manager, Organisational Development Senior HR Business Partner
Facility Tour: Darlinghurst campus	Head of Foundation Years Clinical Skills Laboratory Manager
Professionalism in the MD Program	Dean, National School of Medicine Deputy Head of School, Fremantle Deputy Head of School, Sydney National Head of Student Matters, Selection and Pathways
Friday 6 March 2026 University of Notre Dame Australia, Darlinghurst Campus	
Final Debrief	Dean, National School of Medicine Deputy Head of School, Fremantle Deputy Head of School, Sydney National Head of Medical Education and Innovation National Head of Student Matters, Selection and Pathways National Head of Rural Clinical Schools

Appendix 4: Glossary of Acronyms, Abbreviations and Terms

Term	Definition
AI	Artificial intelligence
AMC	Australian Medical Council
AQF	Australian Qualification Framework
Blackboard	The University's learning management system
BOE	Board of Examiners
Casper	An open-response situational judgment test that measures aspects of your social intelligence and professionalism
CBEs	Case-based exams
CCP	Communication and clinical practice
CLO	Course learning outcome
CSPs	Commonwealth supported places
eMedici	Medical exam preparation for Australian doctors and students
FRAME	Federation of Rural Medical Educators
FTE	Full-time equivalent
GAMSAT	Graduate Medical School Admissions Test
GEMSAS	Graduate Entry Medical Schools Admission System
GP	General practice
GPA	Grade Point Average
IHM	Indigenous Health and Medicine
IPE	Interprofessional education
IT	Information technology
KCRMT	Kimberley Centre for Remote Medicine Training
LAPs	Learning access plans
LMS	Learning management system
MANDUS	Medical Association of Notre Dame University Sydney (Sydney-based)
MBBS	Bachelor of Medicine/Bachelor of Surgery
MCQs	Multiple choice questions
MD	Doctor of Medicine
Mini-CEXs	Mini-clinical evaluation exercise
MSAND	Medical Students' Association of Notre Dame (Freemantle-based)
National Law	Health Practitioner Regulation National Law
NQC	National Quality Committee

Term	Definition
OSCE	Objective structured clinical examinations
PASS	Peer Assisted Study Sessions
PBL	Problem-based learning
PPD	Personal and professional development
PreVAC	Prevocational Advisory Committee
RCSWA	Rural Clinical School of Western Australia
SAQs	Short-answer questions
The Cohen method	A data-driven standard-setting approach used in education
UNDA; the University	University of Notre Dame Australia
UWA	University of Western Australia
WBAs	Workplace-based assessments

