

Standards for Assessment and Accreditation of Primary Medical Programs

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Acknowledgement of country



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

We acknowledge and pay our respects to the Traditional Custodians of all the lands on which the AMC works, and their ongoing connection to the land, water and sky.

The AMC acknowledges the past policies and practices that impact on the health and wellbeing of Aboriginal and/or Torres Strait Islander and Māori Peoples and commits to working together with communities to support healing and positive health outcomes.

The AMC is committed to improving outcomes for Aboriginal and/or Torres Strait Islander and Māori Peoples through its assessment and accreditation processes including equitable access to health services for First Nations Peoples.

We note that the language to refer to so many separate and diverse Nations is viewed differently, and wish to note that the language choices made in these standards referring to these many Nations are not intended to diminish the individual and unique identities of these Nations. We acknowledge these differences, and our shared knowledge and experience.

Accreditation in Australia and Aotearoa New Zealand



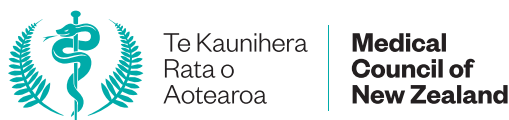
The purpose of the Medical Board of Australia (the Board) is to ensure that Australia's medical practitioners are suitably trained, qualified and safe to practise. The Board operates in accordance with the *Health Practitioner Regulation National Law* (the National Law), as in force in each state and 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 therefore 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.

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 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.

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Glossary

ABORIGINAL, TORRES STRAIT ISLANDER AND MĀORI

Aboriginal refers to the First People and Traditional Custodians of the Australian mainland and many of its islands, such as Tasmania, K'gari, Hinchinbrook Island, the Tiwi Islands, and Groote Eylandt, but excluding the Torres Strait Islands.

Torres Strait Islander refers to the First People and Traditional Custodians of the Torres Strait Islands.

Māori refers to the tangata whenua, or the Indigenous people of Aotearoa New Zealand.

ASSESSMENT

A systematic process for measuring and providing feedback on the student's progress or level of achievement, against defined criteria.

CLINICAL EXPERIENCE AND CLINICAL PLACEMENT

Clinical experience is time spent in a setting such as a community health or service facility, a general practice or a hospital, primarily in direct contact with patients and supervised by a clinical supervisor.

A **clinical placement** is a formal, planned period of clinical experience and learning.

An essential component of the medical program is a significant period of student contact with patients. This normally entails the equivalent of at least two years spent primarily in direct contact with patients, as well as personal contact with patients during other parts of the program.

Collectively, clinical placements are planned and structured to enable students to demonstrate the graduate outcomes across a range of clinical disciplines including medicine (and its specialties), women's health, child health, surgery (and its specialties), mental health and primary care.

CLINICAL SUPERVISOR

An appropriately qualified and trained health practitioner who guides the student's clinical experience and clinical training on behalf of the education provider. The supervisor's training and education role will be defined by the education provider, and may encompass educational, support and organisational functions.

COMMUNITY GROUPS WHO EXPERIENCE HEALTH INEQUITIES

Community groups who are more likely to experience unfair differences in health that result from differing distribution of resources and opportunities within society.

In both Australia and Aotearoa New Zealand, there are community groups that the Australian Medical Council (AMC) recognises as experiencing barriers to healthcare access and poorer health outcomes. These may include people:

- with disabilities
- from the LGBTQIA+ community
- from low socioeconomic backgrounds
- from migrant and/or refugee backgrounds and those whose first language is not English
- in rural communities.

Education providers are expected to partner with stakeholders and local communities to identify community groups experiencing health inequities in their context.

The health sector has specific obligations to Aboriginal and/or Torres Strait Islander people in Australia and Māori in Aotearoa New Zealand based on their commitment to cultural safety. In Aotearoa New Zealand, this extends to obligations under Te Tiriti o Waitangi. Therefore, Aboriginal and/or Torres Strait Islander and Māori people, communities and organisations are referred to separately from community groups who experience health inequities in this definition and in the standards.

CULTURAL SAFETY

There are three definitions of cultural safety which are relevant to these standards. The definition that should be applied depends on whether the standards are being applied in Australia or Aotearoa New Zealand and, in Australia, whether the relevant graduate outcome statement or standard for programs refers to Aboriginal and/or Torres Strait Islander people specifically or to all people. This latter consideration will be clear in the phrasing of the graduate outcome statement or standard for programs.

In Australia, the AMC has endorsed two definitions of cultural safety.

The first is a **general definition of cultural safety**, which is relevant when cultural safety is being referred to in a way that is not exclusive to Aboriginal and/or Torres Strait Islander people:

Cultural safety is based on the experience of the recipient of care, and involves the effective care of a person or family from another culture by a healthcare professional who has undertaken a process of reflection on their own cultural identity and recognises the impact their culture has on their own practice.

The second is the **National Registration and Accreditation Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy definition of cultural safety**. This definition is relevant when specifically referring to Aboriginal and/or Torres Strait Islander people:

"Cultural safety is determined by Aboriginal and Torres Strait Islander individuals, families and communities.

"Culturally safe [practice] is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism."¹

1. Australian Health Practitioner Regulation Agency and National Boards. [The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020–2025](#). Canberra: AHPRA, 2020: 9.

CULTURAL SAFETY (CONT.)

In Aotearoa New Zealand, AMC has endorsed the **Medical Council of New Zealand's definition of cultural safety**. This definition is relevant to all people and contexts:

Cultural safety is

"The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.

"The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.

"The awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities."

In addition, "cultural safety is of particular importance in the attainment of equitable health outcomes for Māori."²

EDUCATION PROVIDER

"A university; or a tertiary education institution, or another institution or organisation, that provides vocational training; or a specialist medical college or other health profession college."³

EQUITY GROUPS

Community groups that, due to differing distribution of resources and opportunities within society, are more likely to be under-represented as students in medical programs and/or to experience barriers to achieving their full academic potential.

In both Australia and Aotearoa New Zealand, there are equity groups that the AMC recognises as being under-represented in medicine and/or experiencing barriers to achieving their full academic potential. These may include people:

- with disabilities
- who are first in their family to attend university
- from the LGBTQIA+ community
- from low socioeconomic backgrounds
- from migrant and/or refugee backgrounds and those whose first language is not English
- with rural backgrounds.

Education providers are expected to partner with stakeholders and local communities to identify equity groups in their context.

The health sector has specific obligations to Aboriginal and/or Torres Strait Islander people in Australia and Māori in Aotearoa New Zealand based on their commitment to cultural safety. In Aotearoa New Zealand, this extends to obligations under Te Tiriti o Waitangi. Therefore, Aboriginal and/or Torres Strait Islander and Māori people, communities and organisations are referred to separately from applicants and students belonging to equity groups in this definition and in the standards.

EVALUATION

The set of policies and processes by which an education provider determines the extent to which its training and education functions are achieving their intended outcomes.

Continuous evaluation is an evaluation process which is regular, cyclical and systematic.

2. Medical Council of New Zealand. [Statement on cultural safety](#). Wellington: MCNZ, 2019: 2.

3. *Health Practitioner Regulation National Law (Qld)* s 5.

FLEXIBLE STUDY

Flexibility in how a medical program is structured and/or delivered.

Examples of flexible study may include part-time study, variation to study processes (such as return to study and flexible recognition of prior learning processes) in the context of students still meeting program attendance and completion requirements, and program outcomes. Flexible study may be provided to all students or to individual students through a transparent and fair process.

INTERN AND INTERNSHIP

An **intern** is:

- In Australia, a prevocational doctor in their first postgraduate year (PGY1) who holds provisional registration with the Medical Board of Australia.
- In Aotearoa New Zealand, a doctor who is undertaking prevocational medical training (the intern training programme), which spans the two years following registration with the Medical Council of New Zealand, including both postgraduate year 1 (PGY1) and postgraduate year 2 (PGY2).

Internship is:

- In Australia, the first year of generalist, work-based, clinical training. It is the first part of the prevocational training program, which is undertaken after graduation from an Australian medical program. The National Framework for Prevocational (PGY1 and PGY2) Medical Training sets national standards and requirements for prevocational training, including internship. Internship is also known as PGY1.
- In Aotearoa New Zealand, the prevocational training program which spans PGY1 and PGY2. Internship is commonly known as the intern training programme. The Medical Council of New Zealand sets accreditation standards and policy for the intern training programme.

A **prevocational training provider** is:

- In Australia, the organisation that provides supervised clinical practice, education and training to interns (PGY1) and prevocational doctors in their second postgraduate year (PGY2), and that is responsible for the standard of the prevocational training program. Providers may be a hospital, a community health facility, a general practice, or a combination of these.
- In Aotearoa New Zealand, an organisation that is accredited by the Medical Council of New Zealand to provide prevocational medical training and education to PGY1 and PGY2 doctors.

INTERPROFESSIONAL EDUCATION OR LEARNING AND COLLABORATIVE PRACTICE

The AMC uses the World Health Organization definition of interprofessional education as the basis for these definitions.

Interprofessional is between two or more professionals from two or more different professions.

Interprofessional education or interprofessional learning occurs when two or more students or professionals from two or more different professions "learn about, from and with each other to enable effective collaboration and improve health outcomes.

"**Professional** is an all-encompassing term that includes individuals with the knowledge and/or skills to contribute to the physical, mental and social wellbeing of a community.

"**Collaborative practice** occurs when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings."⁴

4. Health Professions Networks Nursing and Midwifery Human Resources for Health, World Health Organization. [Framework for Action on Interprofessional Education and Collaborative Practice](#). Geneva: WHO, 2010. (accessed May 2023).

LEADERSHIP AND FOLLOWERSHIP

Leadership is a role in which leaders influence, guide, motivate and inspire individuals, teams or organisations, aligning “strategy to establish direction for individuals and the systems in which they work.”⁵

Followership is “a relational role in which followers have the ability to influence leaders and contribute to the improvement and attainment of group and organisational objectives. It is primarily a hierarchically upwards influence.”⁶

LEVEL OF QUALIFICATION

Medical programs in Australia and Aotearoa New Zealand are diverse in duration, structure and in the qualification awarded by the education provider. Programs may lead to the award of an undergraduate (bachelor level) or postgraduate (master level) qualification or a combination of these. The AMC applies the approved accreditation standards to the assessment and accreditation of all programs of study that lead to registration in medicine.

MEDICAL PROGRAM

The curriculum, content/syllabus, assessment and training provided by an education provider that will lead to practice as an intern. The medical program leads to the award of a formal qualification.

MEDICAL PROGRAM OUTCOMES

The expected skills, knowledge and behaviours of medical students at different stages of the medical program and graduates of the program. These are specified in the medical program’s curriculum.

Medical schools will partner with stakeholders, including local communities, to contextualise medical program outcomes so they are relevant to community needs, readily translated into learning and assessment, and sequenced appropriately in the curriculum.

Outcomes of the medical program are the results of the medical program, which are measured by student competence in the knowledge, skills and behaviours specified in the medical program outcomes, with reference to the education provider’s purpose.

PARTNER AND PARTNERSHIP

A person or organisation that the medical program works with, considers the views of, and is responsive to, is a **partner**.

A **partnership** is a formal or informal association of partners.

Partnerships or partnering with patients comprises many different, interwoven practices – from communication and structured listening, through to shared decision making, self-management support and care planning – between a student, practitioner or interprofessional team and a patient. These practices will be consistent with relevant standards and codes in Australia⁷ and Aotearoa New Zealand.⁸

PERSON-CENTRED CARE

An approach that “treats each person respectfully as an individual human being, and not just as a condition to be treated. It involves seeking out and understanding what is important to the patient, their families, carers and support people, fostering trust and establishing mutual respect. It also means working together to share decisions and plan care.”⁹

5. Aggarwal R, Swanwick T. Clinical leadership development in postgraduate medical education and training: policy, strategy, and delivery in the UK National Health Service. *J Healthc Leadersh* 2015; 17: 109–122.

6. Carsten M, Uhl-Bien M, West B, et al. Exploring social constructions of followership: a qualitative study. *Leadership Quarterly* 2010; 21: 543–562.

7. Medical Board of Australia. *Good medical practice: a code of conduct for doctors in Australia*: Section 4.2 – Doctor-patient partnership. Australia: MBA, 2020: 8; and Australian Commission on Safety and Quality in Health Care. *Partnering with Consumers standard: Working in partnership with patients and colleagues*. 2nd ed. Sydney: ACSQHC, 2023.

8. Consistent with Medical Council of New Zealand. *Good Medical Practice: Working in partnership with patients and colleagues*. Wellington: MCNZ, 2021.

9. Australian Commission on Safety and Quality in Health Care. *Person-centred care*. ACSQHC website, 2023, accessed 17 May 2023.

PRE-INTERNSHIP PROGRAM

A designated clinical placement or set of clinical placements specifically designed to facilitate a safe transition to internship through consolidation and development of clinical knowledge and provision of strategies and skills relevant to internship. In Aotearoa New Zealand, the pre-internship program is commonly known as the trainee intern year.

STAKEHOLDERS

Individuals or groups who are affected by or can influence the medical program.¹⁰

This encompasses:

- people and groups internal to the education provider such as students and those contributing to the design and delivery of training and education functions, including but not limited to leadership, staff, supervisors and committees
- external partners who contribute directly to training and education, such as training sites
- other external people and groups with an interest in the process and outcomes of medical training and education, such as prevocational training providers, health consumers and their representatives, health workforce bodies, health jurisdictions, regulatory authorities, professional associations, Aboriginal and/or Torres Strait Islander and Māori people and organisations, and other health professions.

A **health consumer** “is a person who has used, or may potentially use, health services, or is a carer for a patient using health services.”

A “**health consumer representative** is a person who provides a consumer perspective, contributes consumer experiences, advocates for the interests of current and potential health service users, and takes part in decision-making processes.”¹¹

A **health jurisdiction** is an Australian state or territory health department or ministry, the Australian Government Department of Health and Aged Care or the New Zealand Ministry of Health.

A **training site** is an organisation, health service or facility at which the student undertakes clinical experiences and clinical placements.

SUSTAINABILITY

“Meeting the needs of the present without compromising” the future, particularly “the ability of future generations to meet their own needs.”¹²

Sustainability includes consideration of the environmental, social and economic impacts of decisions about medical programs. In particular, the contribution of these decisions to climate change will be considered.

10. National Health and Medical Research Council, *Guidelines for Guidelines: ‘Engaging stakeholders’*. NHMRC website, 2018, accessed 17 May 2023.

11. Australian Commission on Safety and Quality in Health Care, *FAQs about partnering with consumers in the NSQHS Standards*, ACSQHC website, 2023, accessed 17 May 2023.

12. Brundtland Commission, United Nations, *Report of the World Commission on Environment and Development: our common future*. New York City: UN, 1987.

Graduate outcome statements

The graduate outcome statements set out, at a high level, the knowledge, skills and behaviours required of medical students at the time of graduation from the **medical program**.

The statements provide the basis for medical program curricula and systems of **assessment**. The mechanism for integration of the statements in curricula and systems of assessment is described later in this document, in the **next section**.

The statements are set according to the level of training and experience that will have been gained by an entry-level practitioner. Graduates will not possess the clinical knowledge, **leadership** skills or advocacy skills of an experienced practitioner; however, they will need the foundation of knowledge, skills and behaviours to ensure a safe transition to supervised practice as **interns** in Australia¹³ and Aotearoa New Zealand.¹⁴

Medical students must learn and practise safely when acquiring the knowledge, skills and behaviours outlined in the statements. Delivering safe and high-quality health care is an overarching expectation on all students and practitioners, at all stages of training, in all healthcare settings, and in the medical programs developed by **education providers**. Accordingly, education providers, medical students and graduates of medical programs should take account of:

In Australia,

- the work of the Australian Commission on Safety and Quality in Health Care
- the National Safety and Quality Health Service (NSQHS) Standards
- the NSQHS Standards *User guide for Aboriginal and Torres Strait Islander health*.¹⁵

In Aotearoa New Zealand,

- the work of Te Tāhū Hauora – Health Quality & Safety Commission
- the Medical Council of New Zealand's *Statement on cultural safety*¹⁶
- obligations related to Te Tiriti o Waitangi.¹⁷

All doctors should practise according to standards of clinical and cultural competence and ethical conduct for doctors, including:

- in Australia, the Medical Board of Australia's, *Good medical practice: a code of conduct for doctors in Australia*¹⁸
- in Aotearoa New Zealand, the Medical Council of New Zealand's, *Good Medical Practice*.¹⁹

13. The prevocational outcome statements relevant to internship in Australia build on the graduate outcome statements. See Australian Medical Council. [Training and assessment requirements for prevocational \(PGY1 and PGY2\) training programs](#). Canberra: AMC, 2023: 9–20.

14. The 14 Learning Activities relevant to the intern training programme in Aotearoa New Zealand build on the graduate outcome statements. See Medical Council of New Zealand. [Prevocational – 14 Learning Activities](#). Wellington: MCNZ, 2019.

15. The Wardliparingga Aboriginal Research Unit of the South Australian Health and Medical Research Institute. [NSQHS Standards User guide for Aboriginal and Torres Strait Islander health](#). Sydney: ACSQHC, 2017.

16. Medical Council of New Zealand. [Statement on cultural safety](#). Wellington: MCNZ, 2019.

17. Te Whatu Ora – Health New Zealand recognises the five principles of Te Tiriti relevant to the health sector the principles, adapted from recommendations made by the Waitangi Tribunal. These principles are articulated in Ministry of Health. [Whakamaua: Māori Health Action Plan 2020–2025](#). Wellington: Ministry of Health, 2020.

18. Medical Board of Australia. [Good medical practice: a code of conduct for doctors in Australia](#). Australia: MBA, 2020.

19. Medical Council of New Zealand. [Good Medical Practice: Working in partnership with patients and colleagues](#). Wellington: MCNZ, 2021.

The graduate outcome statements are grouped into four domains as follows:

Medical Education

The graduate who provides person-centred care for patients, including applying safety skills, communicating appropriately and demonstrating competence in procedural skills. The graduate applies their knowledge and skills in diverse healthcare settings and to patients with diverse needs.

The graduate who partners with their patients and their families and carers when providing care. The graduate recognises that broader determinants of health have tangible effects on their patients and takes account of their context as well as broader systemic issues.



The graduate who provides care according to relevant standards of clinical and cultural competence and ethical conduct for doctors, as well as ethical and legal frameworks. Includes the importance of lifelong learning and teamwork.

The graduate who applies and expands their scientific and medical knowledge, including in research and clinical practice. The graduate conscientiously supports research as well as quality improvement and assurance approaches to enable continuous improvement.

Clinical Practice: the medical graduate as a practitioner

DOMAIN 1

Domain 1 describes the graduate as a practitioner who provides **person-centred care** for patients, across the stages of their patients' life, with supervision appropriate for **internship**. The graduate applies their knowledge and skills in diverse healthcare settings and with patients with diverse needs. The graduates also place first their patients' physical, emotional, social, economic, cultural and spiritual needs and their patients' geographic location, recognising that these can influence a patient's description of symptoms, presentation of illness, healthcare behaviours and access to health services or resources.

DOMAIN 1

On entry to professional practice, Australian and Aotearoa New Zealand graduates are able to:

- 1.1 Place the needs and safety of patients at the centre of the care process and apply safety skills including effective clinical handover, graded assertiveness, delegation and escalation, infection control and adverse event reporting.
- 1.2 Apply whole-person care principles in clinical practice, including considering a patient's physical, mental, developmental, emotional, social, economic, environmental, cultural and spiritual needs and their geographic location.
- 1.3 Practise sensitive and effective communication with patients and their families and carers that promotes rapport and elicits needs, concerns and preferences.
- 1.4 Demonstrate flexible, adaptive and effective communication that supports health literacy and the needs of patients and their families and carers.
- 1.5 Demonstrate **culturally safe** practice with ongoing critical reflection on their own knowledge, skills, attitudes, bias, practice behaviours and power differentials to deliver safe, accessible and responsive health care free of racism and discrimination.
- 1.6 Demonstrate empathic communication with patients and their families and carers through respect for **Aboriginal and/or Torres Strait Islander** and **Māori** knowledges of wellbeing, Aboriginal and/or Torres Strait Islander and Māori healthcare models, and obligations to Aboriginal and/or Torres Strait Islander and Māori people when providing culturally safe care. In Aotearoa New Zealand, the obligations to Māori people include those under Te Tiriti o Waitangi.
- 1.7 Integrate knowledge of the health issues and diseases that affect Aboriginal and/or Torres Strait Islander and Māori patients across medical disciplines when providing culturally safe care.
- 1.8 Elicit an accurate, structured medical history from the patient and, when relevant, from families and carers or other sources, including family, social, occupational, lifestyle and environmental features.
- 1.9 Demonstrate competence in relevant and accurate physical and mental state examinations.
- 1.10 Integrate and interpret findings from the history and examination to make an initial assessment, including a relevant differential diagnosis and a summary of the patient's mental and physical health.
- 1.11 Provide accessible information on options, rationales, costs, risks, harms and benefits of health interventions to enable patients and their families and carers to make fully informed choices about the management of their health.
- 1.12 Demonstrate the ability to adapt management proposals to the needs and communication requirements of patients and their families and carers.
- 1.13 Apply scientific knowledge and clinical skills to care for patients across their lifespan, including as children, adolescents and ageing people, and patients in pregnancy and childbirth.
- 1.14 Demonstrate competence in the procedural skills required for internship.
- 1.15 Select, justify, request and interpret common investigations, with due regard to the pathological basis of disease and the efficacy, safety and **sustainability** of these investigations.
- 1.16 Work within the **interprofessional** team to identify and justify management options, based on evidence, access to resources and services, and on the patient's needs and preferences.
- 1.17 Prescribe and, when relevant, administer medications safely, appropriately, effectively, sustainably and in line with quality and safety frameworks and clinical guidelines.
- 1.18 Prescribe and, when relevant, administer other therapeutic agents including fluid, electrolytes, blood products and inhalational agents safely and in line with quality and safety frameworks and clinical guidelines.

DOMAIN 1

- 1.19** Record, transmit and manage patient data accurately and confidentially.
- 1.20** Recognise, assess and respond to deteriorating and critically unwell patients who need immediate care, including those with physical, mental or cognitive condition deterioration, communicating critical information and escalating care as required.
- 1.21** Demonstrate competence in emergency and life support procedures.
- 1.22** Apply preventive health approaches, such as screening and lifestyle advice, including to support the ongoing management of chronic conditions.
- 1.23** Apply the principles of quality care for patients at the end of their lives, avoiding unnecessary investigations or treatment, aligning care with patient values and preferences, and ensuring physical comfort including pain relief, psychosocial support and other components of palliative care.
- 1.24** Demonstrate digital health literacy and capability in supporting patients and their families and carers to use technology for promoting wellbeing and managing health concerns.

Professionalism and Leadership: the medical graduate as a professional and leader

DOMAIN 2

Domain 2 describes the graduate as a practitioner who provides care to all patients according to *Good medical practice: a code of conduct for doctors in Australia*²⁰ and standards of clinical and cultural competence and ethical conduct for doctors, as relevant to the location of their medical education and practice. The graduate also demonstrates understanding of the ethical and legal frameworks relevant to their workplace, and has both knowledge of professional standards, and the ability and aptitude to always practise within them. This includes reflecting on their practice, recognising their own limits and committing to life-long learning. The graduate applies the principles of **leadership** and effective teamwork in **interprofessional** teams and contributes to supportive working and learning environments for all healthcare professionals.

20. Medical Board of Australia. [Good medical practice: a code of conduct for doctors in Australia](#). Australia: MBA, 2020.

DOMAIN 2

On entry to professional practice, Australian and Aotearoa New Zealand graduates are able to:

- 2.1** Display ethical and professional behaviours including integrity, compassion, self-awareness, empathy, discretion and respect for all.
- 2.2** Apply the principles of professional leadership, **followership** and teamwork in health care by providing care within interprofessional healthcare teams.
- 2.3** Demonstrate an understanding of the ethical dimensions of medical practice, and explain the main ethical frameworks used in clinical decision making.
- 2.4** Communicate effectively with patients, their families and carers and other healthcare professionals regarding the options and implications of ethical issues related to patient care.
- 2.5** Recognise the complexity and uncertainty inherent in the health care of diverse patients and be aware of the limits of their own expertise.
- 2.6** Engage with the interprofessional team to optimise patient outcomes, particularly to manage complexity and uncertainty.
- 2.7** Demonstrate awareness of professional limitations and actively monitor and address personal wellbeing, fatigue, health and safety to support self-care and patient care. This includes seeking support when needed and following the relevant advice of a trusted health professional.
- 2.8** Manage their time, education and training demands and show ability to prioritise workload to manage patient outcomes and health service functions.
- 2.9** Respect the boundaries that define professional and therapeutic relationships in clinical practice.
- 2.10** Explain the options available when personal values or beliefs may influence patient care, including the obligation to effectively refer patients to another practitioner.
- 2.11** Describe and show respect for the roles and expertise of healthcare and other professionals.
- 2.12** Demonstrate the ability to learn and work **collaboratively** as a member of an interprofessional team.
- 2.13** Demonstrate lifelong learning behaviours, including seeking feedback on, reflecting on and evaluating their own professional practice.
- 2.14** Seek, reflect on and use feedback in critically evaluating their own professional practice to improve the **cultural** and clinical safety of their practice for colleagues, patients and their families and carers.
- 2.15** Describe and apply the legal responsibilities of health professionals, including but not limited to:
- implementing a human rights-based approach to health
 - accepting a duty of care to patients and colleagues
 - maintaining privacy and confidentiality
 - completing records, certificates and other documents
 - using digital health technology
 - undertaking informed consent processes
 - managing financial and other conflicts of interest
 - applying mandatory reporting mechanisms.
- 2.16** Apply the principles of effective near-peer teaching, appraising and assessing.
- 2.17** Contribute to psychosocially safe and supportive working and learning environments, including adhering to and enacting their responsibilities under bullying, harassment, racism and discrimination policies and processes.
- 2.18** Critically evaluate their own professional practice in the context of health system structures and processes to contribute to culturally safe health environments, with particular awareness of **Aboriginal and/or Torres Strait Islander and Māori** communities.

Health and Society: the medical graduate as a health advocate

DOMAIN 3

Domain 3 describes the graduate as a practitioner who recognises the diverse needs of patients in communities across Australia and Aotearoa New Zealand, understands the underlying social and environmental determinants of health, and can apply strategies that address **health inequities** for individual patients, communities and populations. The graduate is committed to health advocacy to improve access and outcomes for individual patients, and to influence system-level change in a socially accountable and environmentally **sustainable** manner.

DOMAIN 3

On entry to professional practice, Australian and Aotearoa New Zealand graduates are able to:

- 3.1 Describe differences in healthcare access, healthcare delivery and patient experiences across diverse hospitals and community health settings in metropolitan, rural and remote areas.
- 3.2 Identify the social, cultural, personal, physical and environmental determinants of health for individuals and communities, including factors related to the ongoing impacts of climate change.
- 3.3 Describe the ongoing impact of colonisation, intergenerational trauma and racism on the health and wellbeing of **Aboriginal and/or Torres Strait Islander and Māori** people.
- 3.4 Describe the systemic and clinician implicit and explicit biases in the health system that impact on healthcare access, experience, quality and safety for Aboriginal and/or Torres Strait Islander and Māori people. This includes understanding current evidence around all forms of racism as a determinant of health and how racism establishes and sustains inequities in health.
- 3.5 Describe the structural barriers to accessing healthcare services and apply strategies to increase the inclusivity of these services for **community groups who experience health inequities** and Aboriginal and/or Torres Strait Islander and Māori communities by **partnering** with those groups.
- 3.6 Apply health advocacy skills by partnering with patients and their families and carers, and/or communities to define and highlight healthcare issues, particularly health inequities and sustainability.
- 3.7 Explain, select and apply common population health screening, disease prevention and health promotion approaches in public health.
- 3.8 Describe how incorporating health technologies in clinical practice can both improve patient experiences and outcomes and present risks, particularly for community groups who experience health inequities and for Aboriginal and/or Torres Strait Islander and Māori communities.
- 3.9 Describe a systems approach to improving the quality, safety, sustainability and inclusivity of health care.
- 3.10 Describe the principles of sustainable and equitable allocation of finite resources to meet the needs of individuals and communities now and in the future, and the roles and relationships between health agencies, disability agencies and services in resource allocation.
- 3.11 Describe Aboriginal and/or Torres Strait Islander and Māori holistic concepts of wellbeing and Aboriginal and/or Torres Strait Islander and Māori health models, including programs and Aboriginal and/or Torres Strait Islander and Māori specific **interprofessional** healthcare teams that can enhance patient health outcomes.
- 3.12 Describe global health issues and determinants of health and disease, including their relevance to healthcare delivery in Australia and Aotearoa New Zealand, the broader Western Pacific region and in a globalised world.

Science and Scholarship: the medical graduate as a scientist and scholar

DOMAIN 4

Domain 4 describes the graduate as a practitioner who is committed to expanding their scientific knowledge and who evaluates and applies evidence to their clinical practice. The graduate recognises that research, along with quality improvement and assurance approaches, underpins continuous improvement of clinical practice and the broader healthcare system, and conscientiously supports these activities.

DOMAIN 4

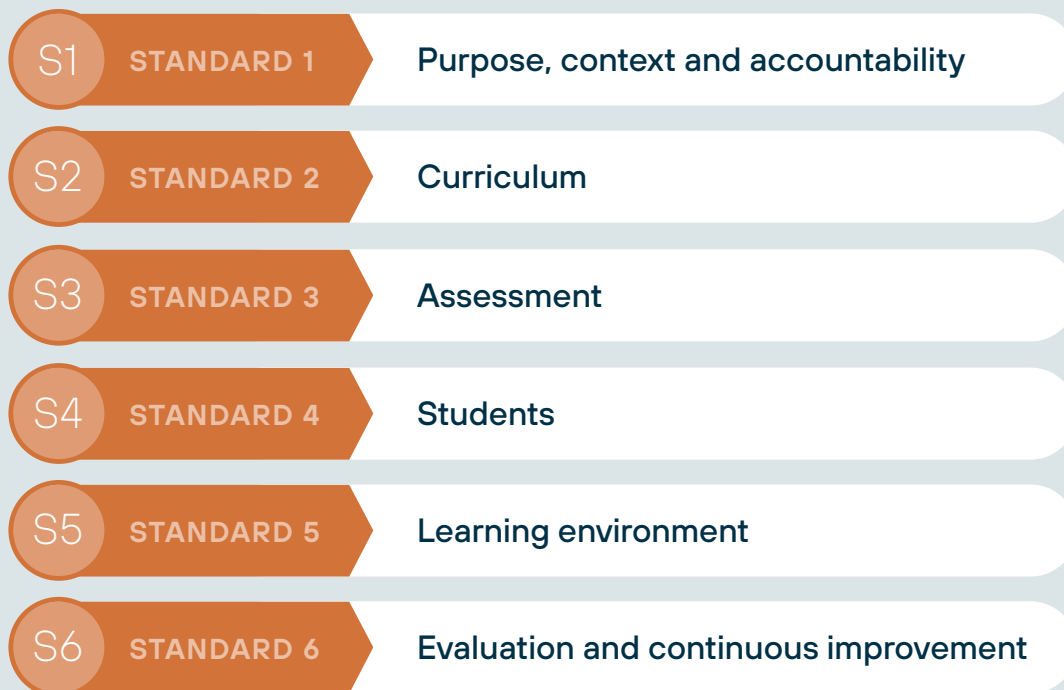
On entry to professional practice, Australian and Aotearoa New Zealand graduates are able to:

- 4.1** Apply biological, clinical, social, behavioural and planetary health²¹ sciences and informatics in health care.
- 4.4** Describe the aetiology, pathology, clinical features, natural history and prognosis of common and important conditions at all stages of life.
- 4.2** Apply core medical and scientific knowledge to populations and health systems, including understanding how clinical decisions for individuals influence health equity and system **sustainability**.
- 4.5** Access, critically appraise and apply evidence from medical and scientific literature.
- 4.3** Describe **Aboriginal and/or Torres Strait Islander and Māori** knowledges of wellbeing and models of health care, including community and sociocultural strengths. Describe best practice approaches that lead to improved and sustained positive Aboriginal and/or Torres Strait Islander and Māori health and wellbeing outcomes.
- 4.6** Apply scientific methods to formulate relevant research questions and identify applicable study designs.
- 4.7** Comply with relevant quality and safety frameworks, legislation and clinical guidelines, including health professionals' responsibilities for quality assurance and quality improvement.

21. 'Planetary health is the achievement of the highest attainable standard of health, wellbeing, and equity worldwide through judicious attention to the human systems—political, economic, and social—that shape the future of humanity and the Earth's natural systems that define the safe environmental limits within which humanity can flourish. Put simply, planetary health is the health of human civilisation and the state of the natural systems on which it depends.' Whitmee S, Haines A, Beyrer C, et al. Safeguarding human health in the Anthropocene epoch: report of The Rockefeller Foundation–Lancet Commission on planetary health. *Lancet*. 2015 Nov 14;386(10007):1973–2028.

Accreditation standards for medical education providers and their programs of study

The standards are structured as follows:



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.

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.

S1 Purpose, context and accountability

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.

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.

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.

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.

S2 Curriculum

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**.

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.

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.

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.

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.

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.

S4 Students

4.3 Professionalism and fitness to practise

- 4.3.1 The medical education provider implements policies and timely procedures for managing medical students with an impairment when their impairment raises concerns about their fitness to practise medicine or their ability to interact with patients, including in a culturally safe way.
- 4.3.2 The medical education provider implements policies and timely procedures for identifying, managing and/or supporting medical students whose professional behaviour raises concerns about their fitness to practise medicine or their ability to interact with patients, including in a culturally safe way.

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.

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.

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.

S5 Learning environment

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.

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.

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.

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.

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 student performance in relation to student characteristics and shares these data with 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.

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.