

10th August 2026

Mrs Lillian Fenner

Policy and Governance Officer, Medical School Accreditation
Australian Medical Council



Dear Lillian,

On 2 March 2026, the Adelaide Medical Students' Society (AMSS) received an invitation from the Australian Medical Council (AMC) to provide a student report evaluating the performance of the Adelaide University Medical School. This report has been prepared in accordance with the AMC standards for accreditation and offers a comprehensive assessment from the student viewpoint.

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The AMSS, as the peak representative body for medical students at Adelaide Medical School, recognises the importance of the AMC accreditation process and values the opportunity to represent the views and experiences of the student cohort. The AMSS appreciates the AMC's ongoing commitment to incorporating student perspectives into the accreditation process.

As with previous student submissions, the AMSS has invested significant effort in developing an evidence-based report addressing the core AMC accreditation standards. This year's report is informed by 362 student survey responses, providing a broad representation of student experiences across the medical program.

The AMSS calls on the AMC to carefully consider the substantial body of student data presented in this submission and, where appropriate, support action to ensure the Adelaide Medical School continues to meet the high standards expected of medical education in Australia. This submission should, however, be considered within the context of its limitations. While student opinion alone cannot determine the structure or direction of the medical program, students are key stakeholders whose experiences provide valuable insight into the program's strengths and, importantly, areas requiring further improvement.

The survey was designed to gather student-specific feedback on the key strengths of the MBBS (Year 6) and BMD (Years 1–5) programs, overall course satisfaction, and areas requiring improvement. This year, several areas of strength were identified across the medical program, alongside areas where students indicated further improvement is required.

Strengths of the Adelaide University medical program identified in this year's AMC student submission include a broad range of clinical experiences across the lifespan, clinical disciplines, and metropolitan, rural and community settings; strong clinical supervision and increasing opportunities for student involvement in patient care; and positive education regarding Aboriginal and Torres Strait Islander health and culturally safe care.

In comparison, key areas requiring attention and improvement moving forward include limited opportunities for electives and studies of choice within the current BMD curriculum; ongoing concerns regarding disability support, reasonable adjustments and flexible study arrangements; inconsistent actioning of, and communication regarding, student feedback; and inadequate educational facilities, study spaces and dedicated student spaces.

Finally, we would like to acknowledge the contributions of the other students who were involved in the creation of this submission, as listed below:

- Shawn Mbewe (Year 3 BMD Student, AMSS Early Clinical Education Officer): consulted for drafting.
- Isabella Gallomario (Year 3 BMD Student, AMSS Sponsorship Officer): consulted for drafting.
- Allegra Kleinig (Year 3 BMD Student, AMSS Engagement Officer): consulted for drafting.

We sincerely thank the AMC for the opportunity to submit this report and would be happy to provide any additional information if required.

We thank you for your time and consideration. Please do not hesitate to contact us with any questions or queries.

Warm Regards,

Miss Annie Fewster

Vice President (Education)

Adelaide Medical Students' Society



Mr Kashyapchandra Avadhani

President

Adelaide Medical Students' Society



1. Glossary / List of Abbreviations

Below is a comprehensive list of key acronyms and abbreviations used throughout this report, with their respective definitions.

1.1 Degree and Program Structure

AMC	Australian Medical Council
AMSS	Adelaide Medical Students' Society
AMS	Adelaide Medical School
MBBS	Bachelor of Medicine / Bachelor of Surgery Degree
BMD	Bachelor of Medical Studies / Doctor of Medicine Degree
MBBS Students	Refers to students currently enrolled in MBBS Degree <i>In 2026, this includes Year 6 of the medical program</i>
BMD Students	Refers to medical students currently enrolled in the BMD Degree <i>In 2026, this includes Years 1–5 of the medical program</i>
ARCS	Adelaide Rural Clinical School
Faculty	Throughout this report, the term <i>Faculty</i> reflects the terminology commonly used by students when referring to the medical program's senior academic staff, including the Dean of Medicine, Director of Medical Education, Dean of Clinical Years (Years 4–6), and BMS Program Director (Years 1–3). These roles form the leadership team of the Adelaide University (AU) School of Medicine (SoM).

1.2 Teaching Components

SBL	Scenario Based Learning <i>Years 1–3 students work through clinical cases to integrate knowledge of anatomy, physiology, pathology, diagnostic reasoning and management.</i>
ClinPrac	Clinical Practice, also referred to as MedPrac <i>Years 1–3 classes where students develop and practise clinical skills through simulated patients and clinical scenarios in structured teaching sessions.</i>

1.3 Clinical Placements (includes Year 3–6)

1.3.1 BMD Program (Year 1–5)

TCS Year 3 BMD	Transition to Clinical Students <i>During Semester 1, Year 3 students undertake one supervised placement day per</i>
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	<i>week at an allocated general practice as part of TCS. In Semester 2, students attend an additional day of clinical placement in hospital. However, as the AMC survey was released and closed before Semester 2 commenced, this report reflects students' experiences in general practice only.</i>
WCH Year 5 BMD	Refers to Women's and Children's Health Includes Obstetrics and Gynaecology (O&G) and Paediatrics and Child Health <i>Includes Clinical Placement and Formal Teaching</i>
HCC Year 5 BMD	Refers to Health Care Continuum Includes General Practice, Geriatrics, and Anaesthetics, Pain and Intensive Care <i>Includes Clinical Placement and Formal Teaching</i>

1.3.2 MBBS Program (Year 6)

TTIP	Transition To Internship (Part 1) A semester-based Year 6 course designed to prepare students for internship through three six-week clinical rotations in Medicine, Surgery, and Emergency. <i>Includes Clinical Placement and Formal Teaching</i>
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1.4 Assessments

DAQ	Data Analysis Questionnaire <i>A written assessment format used in Years 1–3 of the medical program, assessing students' ability to interpret, analyse, and apply clinical data to medical scenarios.</i>
OSCE	Objective Structured Clinical Examination <i>At Adelaide Medical School, OSCEs are now undertaken by Year 3 students at the end of the academic year and by Year 4 and Year 5 students at the conclusion of each semester.</i>
MCQ	Multiple Choice Questionnaire

1.5 Building / Locations

AHMS	Adelaide Health and Medical Sciences Building
RAH	Royal Adelaide Hospital
TQEH	The Queen Elizabeth Hospital
LMH	Lyell McEwin Hospital

2. Methods

2.1 Survey Design

2.1.1 Question Development and Structure

The survey included a combination of core questions that were common across all year levels and year-specific questions tailored to the curriculum and learning experiences of each cohort (Years 1–6, including both BMD and MBBS students). Survey questions were developed, reviewed, and approved by student representatives prior to distribution. The AMC standards included in the survey were selected based on feedback received through AMSS communication channels and the findings of the 2025 AMC student submission. This enabled previously identified issues to be re-evaluated while continuing to capture student perspectives on key strengths and areas for improvement. In 2026, Standards 2 and 6 were the primary focus.

Students responded to survey statements using a five-point Likert scale (1–5), with a “cannot answer” option available where appropriate. At the conclusion of each AMC standard section, students were invited to provide optional free-text comments to further explain their responses or provide additional qualitative feedback. For Standard 2, an additional targeted free-text question was included: *“Are there any additional opportunities you would like to further support the development of your clinical skills?”* For all other sections, students were invited to elaborate on their responses through the general prompt: *“Please elaborate on your responses above, if you wish.”*

2.1.2 Survey Distribution and Participation

Respondents completed the survey according to the year level they are expected to complete in 2026. Participation was promoted to all students enrolled in the Adelaide Medical School medical program in 2026 through AMSS communication channels. To encourage engagement, the AMSS again offered a pizza lunch to the year level achieving the highest survey response rate, continuing an initiative first introduced in 2025. To minimise duplicate responses, students were required to sign in with a Google account, limiting survey completion to one response per participant.

2.1.3 2026 Specific Curriculum Considerations

The 2026 academic year marked the first implementation of the Year 5 BMD curriculum. The revised Year 5 curriculum consists of two major components: the Women’s and Children’s Health semester, which remained broadly consistent with the previous MBBS program, and the newly restructured Health Care Continuum (HCC) course. Although the core clinical disciplines within the HCC were retained from the MBBS program, including general practice, geriatrics, anaesthetics, pain and intensive care, the structure and delivery of these components were revised. The two elective blocks previously undertaken in Year 5 of the MBBS program were removed, enabling greater time to be allocated to general practice and community-based medical disciplines, with increased emphasis on the health and wellbeing needs of Aboriginal and Torres Strait Islander peoples and other priority populations.

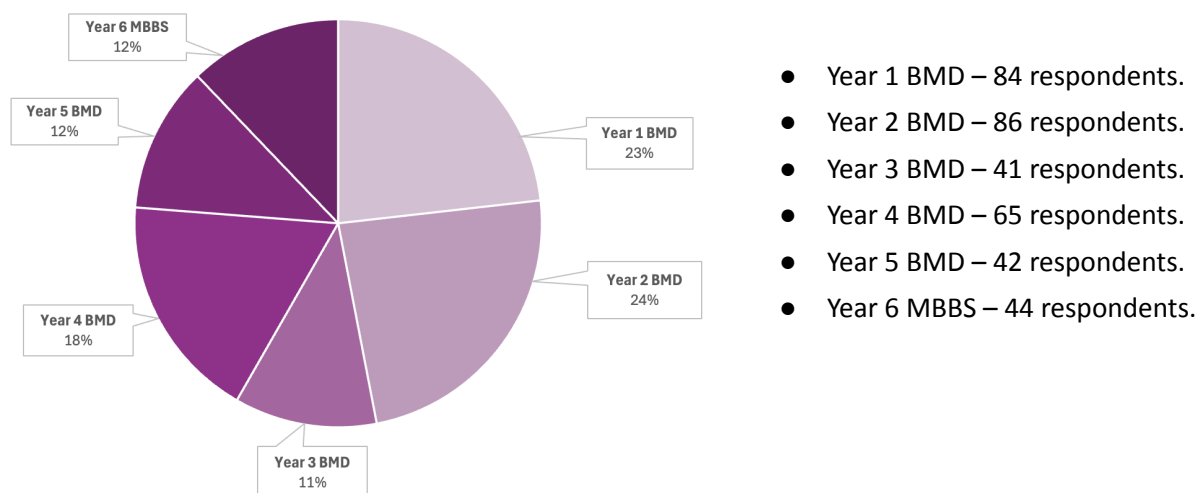
For further context, Year 5 students undertake one of three curriculum pathways: metropolitan semester-based rotations within Adelaide local health networks; the Aarhus University exchange program, in which students complete the Women’s and Children’s Health semester in Denmark before returning to Adelaide to undertake the HCC course; or the integrated year-long ARCS program. Unlike the metropolitan and exchange pathways, the ARCS program delivers the Year 5 curriculum longitudinally across regional South Australia, with specific placement structures varying between rural sites.

Given this curriculum transition, evaluating students’ experiences of the revised Year 5 program, particularly the HCC course, was a specific focus of the 2026 survey. Year 5 students were therefore asked to identify the Semester 1 course they had completed. This enabled responses to be analysed according to curriculum pathway, allowing any identified strengths or concerns to be attributed to particular components of the revised Year 5 curriculum rather than the Year 5 program as a whole.

2.2 Demographics

This report is based on responses from 362 medical students. Respondents included students across all year levels of the BMD and MBBS cohorts, with the distribution of responses presented in Figure 1.

Figure 1: Respondents by year level



The most recent enrolment data available indicate that the Adelaide Medical School cohort comprised 1,031 students at the end of 2025. As current 2026 enrollment figures were not available at the time of analysis, this value has been used as an approximate denominator. While the composition of the cohort will have changed with graduating students and new enrolments, it is reasonable to assume that the overall cohort size has remained broadly similar. On this basis, the 362 completed AMC surveys represent an estimated response rate of approximately 35.1% of the Adelaide Medical School student cohort in 2026. This provides a substantial sample from which to evaluate student perspectives across the program.

Respondents provided demographic information relating to Aboriginal and/or Torres Strait Islander identification, disability identification, and LGBTQI+ identification. Cohort-level characteristics are presented to provide context for interpreting survey findings across the medical program.

Year 1 Cohort (n = 84): Two respondents (2.4%) identified as Aboriginal and/or Torres Strait Islander, while one respondent (1.2%) preferred not to say. Four respondents (4.8%) identified as living with a disability, and nine respondents (10.7%) identified as LGBTQI+.

Year 2 Cohort (n = 86): One respondent (1.2%) identified as Aboriginal and/or Torres Strait Islander, while one respondent (1.2%) preferred not to disclose this information. Two respondents (2.3%) identified as living with a disability, and one respondent (1.2%) preferred not to disclose. Six respondents (7.0%) identified as LGBTQI+ and three (3.5%) preferred not to disclose this information.

Year 3 Cohort (n = 41): No respondents (0%) identified as Aboriginal and/or Torres Strait Islander. One respondent (2.4%) identified as living with a disability. Four respondents (9.8%) identified as LGBTQI+, while one respondent (2.4%) preferred not to disclose this information.

Year 4 Cohort (n = 65): No respondents (0%) identified as Aboriginal and/or Torres Strait Islander, while one respondent (1.5%) preferred not to disclose this information. Five respondents (7.7%) identified as living with a disability, with one respondent (1.5%) preferring not to say. Eight respondents (12.3%) identified as LGBTQI+, and two respondents (3.1%) preferred not to disclose this information.

Year 5 Cohort (n = 42): One respondent (2.4%) identified as Aboriginal and/or Torres Strait Islander. No respondents (0%) identified as living with a disability. Six respondents (14.3%) identified as LGBTQI+, and one respondent (2.4%) preferred not to disclose this information.

Of the 42 Year 5 respondents, students were completing their clinical training across a range of learning contexts. Eight respondents were undertaking the longitudinal ARCS Rural program. Twelve respondents were completing the Health Care Continuum (HCC) semester, which was hosted for the first time in 2026. Twenty respondents were metropolitan-based students completing the Women's and Children's Health (WCH) rotation, while two respondents were completing their placement in Denmark. Where applicable, responses for specific AMC Standards were analysed comparatively across the four groups.

Year 6 Cohort (n = 44): One respondent (2.3%) identified as Aboriginal and/or Torres Strait Islander and one respondent (2.3%) preferred not to disclose this information. Two respondents (4.5%) identified as living with a disability, and one respondent (2.3%) preferred not to say. Four respondents (9.1%) identified as LGBTQI+, and one respondent (2.3%) preferred not to disclose this information.

2.3 Data Interpretation

There were no incomplete survey responses requiring exclusion from the analysis. Both the mode and mean were used to interpret responses to five-point Likert scale items. Responses were categorised according to the following criteria:

- Positive response: Mode > 3 AND Mean > 3.5
- Negative response: Mode < 3 AND Mean < 2.5
- Equivocal response: Mode = 3 OR $2.5 \leq \text{Mean} \leq 3.5$

2.4 Data Presentation

Likert scale responses are presented using the following format (example below):

Mode: 4 [40.1%] | Mean: 3.75 | Range: 1 to 5 | n = 362 from 362 responses.

2.5 Limitations

2.5.1 Methods Used

The use of a five-point Likert scale introduces several methodological limitations. While Likert scales provide an efficient means of quantifying student perceptions, they do not capture the reasoning underlying respondents' choices. Although an optional free-text section was included to provide additional context, completion was not mandatory, limiting the qualitative information available to support interpretation of the quantitative findings.

The repeated use of Likert-scale questions throughout the survey, combined with the overall survey length, may also have contributed to response fatigue, potentially resulting in less considered or less consistent responses. Furthermore, fixed response options may oversimplify complex educational experiences. For example, a neutral response may reflect a balance of both positive and negative experiences rather than genuine neutrality, which cannot be distinguished without accompanying qualitative feedback.

2.5.2 Student Opinion

This survey, and by extension this student submission, is intended to reflect the views of the majority of respondents regarding various aspects of the medical program. However, students' perceptions of their educational experiences are inherently subjective and are influenced by individual expectations, prior experiences, and personal interpretations of what constitutes a high-quality learning environment.

As with all self-reported surveys, responses may also be influenced by recall bias and differences in how respondents interpret survey questions and response categories. Consequently, findings should be interpreted as students' perceptions of the program rather than objective measures of educational quality.

2.5.3 Survey Timing

The survey was open from 4 June 2026 to 14 July 2026, allowing students to reflect on their Semester 1 experiences. Although some students had commenced Semester 2 by the time the survey closed, responses were collected before a meaningful proportion of Semester 2 teaching or clinical placements had been completed. Consequently, the findings should be interpreted as reflecting students' Semester 1 experiences.

Compared with last year's survey, which closed in April, the 2026 survey provides a more representative evaluation of students' Semester 1 experiences. Students across all year levels (including both MD and MBBS cohorts) had completed a full semester of teaching and associated assessments prior to completing the survey, including MCQs and/or OSCEs where applicable. As the timing of the 2025 survey was identified as a significant limitation in the previous AMC student submission, ensuring students had the opportunity to provide feedback informed by a complete semester of study was of key importance in this 2026 AMC student submission. This allowed for more meaningful evaluation of teaching, assessment, and feedback experiences, particularly for Year 1 and Year 2 students, whose experiences were less fully captured in the previous survey.

The 2026 academic year also coincided with the merger of the University of Adelaide and the University of South Australia to form Adelaide University. Consequently, some responses may reflect transitional administrative, organisational, or technological challenges associated with the institutional merger rather than the quality of the medical program or its alignment with Australian Medical Council (AMC) accreditation standards. This context should therefore be considered when interpreting the survey findings.

2.5.4 Response Rate

A total of 362 responses were received, representing an estimated 35.1% of the 1,031 students enrolled in the Adelaide Medical School. This response rate is comparable to that achieved in the 2025 survey, which received 460 responses (approximately 45% of enrolled students), and represents a substantial increase from the 169 responses received in the 2024 survey.

While a higher response rate would further reduce the potential for selection bias, achieving substantially greater participation in a survey of this length is likely to be challenging. Nevertheless, the number of responses obtained provides a substantial sample of the Adelaide Medical School student body.

Where findings are presented as representing the overall student cohort, it can be assumed that no meaningful differences were identified between year-level responses unless otherwise stated. Although the survey does not capture the perspectives of every student, the response rate and broad representation across all year levels provide a reasonably representative overview of student opinion. A higher response rate, ideally exceeding 40%, would further strengthen the representativeness and comprehensiveness of the findings.

2.5.5 Selection Bias

Selection bias is an inherent limitation of voluntary student surveys. Students with particularly positive or negative experiences may be more likely to participate, while those who are generally satisfied or disengaged may be less inclined to respond. Although a response rate of approximately 35% cannot

eliminate this bias, the large number of respondents and representation across all year levels reduces the likelihood that the findings are substantially influenced by volunteer bias.

A further potential source of selection bias relates to question selection. Owing to practical constraints, it was not feasible to address every Australian Medical Council (AMC) accreditation standard within a single survey. Consequently, some aspects of the medical program may not have been explored in the same depth as others. To mitigate this limitation, respondents were provided with an optional free-text section to raise additional issues or comments not specifically addressed by the survey questions.

2.5.6 Cohort Data Comparison

Comparisons between year levels should be interpreted with caution, as students at different stages of the medical program undertake a progressive curriculum with distinct learning objectives, assessment formats, clinical exposure, and educational experiences. Consequently, differences in survey responses may reflect variations in educational context rather than differences in program quality.

Similarly, clinical placement experiences are inherently variable, with students allocated to different clinical sites, supervisors, healthcare settings, patient populations, and learning opportunities. Consequently, responses relating to clinical education may reflect individual placement experiences in addition to the overall quality of the placement program.

2.5.7 Central Tendency Bias

The extensive use of Likert-scale questions introduces the potential for central tendency bias, whereby respondents preferentially select neutral or moderate response options rather than the extremes of the scale. This may result in an overrepresentation of equivocal responses and reduce the apparent strength of both positive and negative opinions. Consequently, areas of particularly high satisfaction or significant concern may be understated, potentially limiting the survey's ability to identify issues requiring priority attention.

Standard 1: Purpose, Context and Accountability

Purpose (Standard 1.1.3)

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.

Methodology:

The following statements were tailored to each year level to reflect students' stage of training while assessing the same underlying concept: their confidence that the medical program is developing the knowledge, skills, and preparedness required for progression towards safe and effective internship practice.

Students were asked to rate their level of agreement based on the following statements:

Years 1–3:

- *The medical program is helping me develop the knowledge and skills expected at my current stage of training.*

Years 4 and 5:

- *At this stage of my training, I feel the medical program is preparing me to practice safely and effectively under supervision as an intern.*

Year 6:

- *I feel confident in my ability to practice safely and effectively as an intern in Australia next year based on my training so far.*

All Students:

- *The medical program provides a strong foundation for lifelong learning and future training in any branch of medicine I choose to pursue.*

Data:

All Students:

Overall, students agreed that the medical program is preparing them to practise safely and effectively for their current stage of training (Mode: 4 [50.8%] | Mean: 4.24 | Range: 1 to 5 | n = 362 responses). The response from Year 6 MBBS students is particularly positive given this cohort is approaching internship within six months (Mode: 4 [54.5%] | Mean: 4.25 | Range: 2 to 5 | n = 44 responses). These findings suggest that final-year students generally perceive themselves as prepared for the transition to supervised practice as an intern. Students also agreed that the medical program provides a strong foundation for lifelong learning and further training across any branch of medicine they may choose to pursue (Mode: 4 [47.2%] | Mean: 4.09 | Range: 1 to 5 | n = 362 responses).

Governance (Standard 1.3.4)

1.3.4 – Students are supported to participate in the governance and decision making of their program through documented processes that require their representation.

Methodology:

Students across all years were asked to rate their level of agreement with the following statements:

My opinions and insights about the medical program,

- *Are supported and/or encouraged by the University.*
- *Can be communicated through to the decision makers/organisers of the medical program.*
- *Are acted upon appropriately by these decision makers/organisers.*
- *Have the potential to make meaningful changes to the program.*

I feel comfortable raising feedback about the medical program with relevant University staff and/or decision makers.

Students are appropriately represented in decisions about the medical program.

Data:

Globally, students agreed that their opinions and insights about the medical program are supported and encouraged by the University (Mode 4 [43.0%] | Mean: 3.71 | Range: 1 to 5 | n = 358 responses). However, perceptions differed by year level, with Years 1–3 reporting positive views (Mean: 3.92, 4.18 and 3.56 respectively), compared with equivocal responses from Years 4–6 (Mean: 3.38, 3.50 and 3.27 respectively).

Students also agreed that their opinions and insights can be communicated to decision-makers and organisers of the medical program (Mode 4 [49.0%] | Mean: 3.93 | Range: 1 to 5 | n = 359 responses), and that they are comfortable raising feedback with relevant University staff (Mode: 4 [42.5%] | Mean: 3.76 | Range: 1 to 5 | n = 362 responses). Students were similarly positive that they are appropriately represented in decisions about the medical program (Mode: 4 [39.2%] | Mean: 3.61 | Range: 1 to 5 | n = 362 responses), and that their opinions and insights have the potential to create meaningful change (Mode: 4 [42.4%] | Mean: 3.60 | Range: 1 to 5 | n = 354 responses).

However, a clear difference emerged when students were asked whether the feedback they provide is acted upon. While Year 1 (Mode: 4 [34.2%] | Mean: 3.67 | Range: 1 to 5 | n = 79 responses) and Year 2 (Mode: 4 [43.4%] | Mean: 4.10 | Range: 2 to 5 | n = 83 responses) demonstrated positive responses, perceptions among the senior cohorts (Years 3–6) were equivocal:

- Year 3 – Mode: 3 [41.5%] | Mean: 3.32 | Range: 1 to 5 | n = 41 responses.
- Year 4 – Mode: 3 [42.9%] | Mean: 3.30 | Range: 1 to 5 | n = 63 responses.
- Year 5 – Mode: 4 [35.7%] | Mean: 3.12 | Range: 1 to 5 | n = 42 responses.
- Year 6 – Mode: 3 and 4 [34.1% each] | Mean: 3.21 | Range: 1 to 5 | n = 44 responses.

Overall, students appear comfortable providing feedback and believe they can communicate their views and contribute to decision-making. The key concern is whether students see evidence that their feedback leads to meaningful action. The consistent shift from positive responses in Years 1–2 to equivocal responses from Year 3 onwards is particularly important, as Year 3 marks the transition into the clinical component of the program. Greater transparency around how feedback is considered and acted upon may therefore be warranted. Students would benefit from clearer University-led communication about changes resulting from their feedback, including where feedback cannot be implemented and the reasons for this.

Open Text Responses (Standards 1.1.3 and 1.3.4):

The free-text responses aligned with the quantitative findings, demonstrating positive perceptions of existing feedback mechanisms, particularly those facilitated through the AMSS. One Year 3 student described the *“education feedback system between the AMSS and University”* as *“excellent,”* adding that *“our course coordinators listen to us and try to make changes based on [our] feedback.”* Similarly, a final-year student emphasised how this *“well-set up forum”* provides *“students with the opportunity to speak directly to the Faculty.”*

However, students identified concerns regarding the transparency and effectiveness of the feedback process. One Year 3 student commented that *“feedback is encouraged but not applied,”* while another noted that *“there is always a rationale behind these choices, perhaps they could be [explained] to the group.”* Multiple students suggested a centralised *“update system of changes being implemented”* to provide greater visibility of feedback outcomes.

Students also described the process of achieving meaningful change as lengthy and, at times, difficult. A Year 4 student noted that previous advocacy outcomes, such as the elective component of the Year MBD course, were *“hard-won and required a lot of work from the AMSS,”* while a Year 6 student reflected that although *“we can have our voices heard and influence the course,”* attempts to do require *“a lengthy process to make any meaningful change.”* This was perceived to place an additional burden on student advocacy representatives, with one student reporting that *“those in these advocacy positions are met with resistance. This causes burnout,”* and another describing *“an unsafe environment for us to speak up.”*

Overall, students value opportunities to contribute to the development of the medical program and recognise instances where feedback has been taken on board and used to inform changes. Greater transparency around how feedback is considered, what changes result, and why suggestions may not be implemented would strengthen confidence in the process. Similar feedback and concerns are also reflected under Standard 6.

Purpose and Governance (Standard 1.1.4 and 1.3.5)

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.

1.3.5 – 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.

Methodology:

The following set of questions were specifically intended to capture the experiences and perspectives of Aboriginal and/or Torres Strait Islander students. Students who identify as Aboriginal and Torres Strait Islander were asked to rate their level of agreement with the following:

As an Aboriginal and/or Torres Strait Islander student, I feel Aboriginal and/or Torres Strait Islander peoples and perspectives are meaningfully represented in:

- *Teaching and learning activities.*
- *Student representation and advocacy.*
- *Decision-making about the medical program.*
- *Academic and clinical teaching staff.*
- *Governance roles within the medical program.*
- *Student support services.*

Data:

As described above, five respondents identified as Aboriginal and/or Torres Strait Islander, this included two from Year 1 and one each from Years 2, 5 and 6. No respondents were from Years 3 or 4. It is important to acknowledge the small sample size.

Overall, respondents reported positive perceptions of Aboriginal and/or Torres Strait Islander representation within the medical program. This included representation in teaching and learning activities (Mode: 5 [40.0%] | Mean: 4.60 | Range: 4 to 5 | n = 5 responses), student representation and advocacy (Mode: 4 [80.0%] | Mean: 4.20 | Range: 4 to 5 | n = 5 responses), decision-making (Mode: 4 [60.0%] | Mean: 4.40 | Range: 4 to 5 | n = 5 responses), and among academic and clinical teaching staff (Mode: 4 [60.0%] | Mean: 4.0 | Range: 3 to 5 | n = 5 responses).

Respondents also reported very positive perceptions of Aboriginal and/or Torres Strait Islander student support services (Mode: 5 [80.0%] | Mean: 4.8 | Range: 4 to 5 | n = 5 responses). Comparatively, perceptions of Aboriginal and/or Torres Strait Islander representation within governance roles of the medical program were slightly less positive, although they remained favourable overall (Mode: 3 and 4 [40.0% each] | Mean: 3.8 | Range: 3 to 5 | n = 5 responses).

Open Text Responses (Standards 1.1.4 and 1.3.5):

No open-text responses were received from Aboriginal and/or Torres Strait Islander students for this Standard.

Standard 2: Curriculum

Medical Program Outcomes and Structure (Standard 2.1.2)

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.

Methodology:

Students across all year levels were asked to evaluate the consistency and comparability of their learning and supervisory experiences across different learning contexts. This included assessing whether their learning experiences, clinical supervision, and placement opportunities were comparable in quality to those of their peers within the same year level and across different placement sites.

Students undertaking full-time clinical placements (Years 4–6) were also asked to assess whether the learning environments and available resources adequately supported their clinical learning and progression through the program. Within the Year 5 cohort, responses were further compared across the four placement contexts: ARCS Rural, metropolitan HCC, metropolitan WCH, and Denmark.

Year 1:

- *I feel my learning experiences and supervision are comparable in quality to those of my peers across the program (e.g., in SBL and ClinPrac).*

Year 2:

- *I feel my learning experiences and supervision are comparable in quality to those of my peers across the program (e.g., in SBL and ClinPrac).*

Year 3:

- *My learning and supervisory experiences during GP placement are of comparable quality to those of my peers at different placement sites.*

Year 4:

- *My learning and supervisory experiences during Year 4 clinical placement are of comparable quality to those of my peers at different placement sites.*

Year 5:

- *My learning and supervisory experiences during Year 5 are of comparable quality to those of my peers across different placement types and sites.*

Year 6:

- *My learning and supervisory experiences during Year 6 are of comparable quality to those of my peers across different placement types and sites.*

As students in Years 4–6 undertake full-time clinical placements, these cohorts were also asked to rate their level of agreement with the following statement:

Years 4–6:

- *My clinical placement(s) provide the resources needed to support my learning and achievement of outcomes in each rotation.*

Data (Includes Open Text Responses for this Standard):

All Students:

Students generally agreed that the quality of their learning and supervisory experiences was comparable across different learning contexts, including simulation-based learning in Years 1–2 and clinical placements in Years 3–6 (Mode: 4 [43.9%] | Mean: 3.91 | Range: 1–5 | n = 362 responses).

Year 1:

Year 1 BMD students strongly agreed that the quality of their learning experiences were comparable across ClinPrac and SBL classes (Mode: 4 [35.7%] | Mean: 4.31 | Range: 2 to 5 | n = 84 responses).

Year 2:

This positive perception continued into Year 2, with BMD students agreeing that the quality of their ClinPrac and SBL experiences were comparable across the cohort (Mode: 4 [46.5%] | Mean: 4.28 | Range: 2 to 5 | n = 86 responses).

Year 3:

Year 3 BMD students were equivocal regarding whether their GP placement experiences were fair and comparable in quality to those of their peers (Mode: 3 and 4 [26.8% each] | Mean: 3.15 | Range: 1 to 5 | n = 41 responses). The split mode and comparatively lower mean indicate variation in students' experiences across GP placements, which was also evident in the qualitative feedback.

One student commented that the *“quality of placement experiences seems to be quite varied,”* describing peers having *“limited patient interactions”* and perceiving these differences in clinical exposure as *“unfair.”* Other respondents highlighted limited opportunities for hands-on clinical practice, with one student noting they were *“not receiving a lot of practice taking histories and undertaking exams,”* which had made it *“difficult... to continue to develop [their] skills”* and left them feeling *“underprepared for [their] OSCE.”*

While third year GP placements provide valuable clinical learning opportunities, variability between placement sites may be influencing students' perceptions of preparedness and confidence. Ensuring greater consistency across placement sites may support more equitable learning outcomes for Year 3 students and help facilitate a smoother transition into full-time clinical placement.

Year 4:

Year 4 BMD students generally agreed that the quality of their learning and supervision was comparable to that experienced by their peers across different clinical placement sites (Mode: 4 [50.8%] | Mean: 3.55 | Range: 1 to 5 | n = 65 responses).

Year 5:

Globally, Year 5 BMD students, across metropolitan (WCH and HCC), rural and Denmark placements, agreed that their placement experiences were of comparable quality to their peers (Mode: 4 [50.8%] | Mean: 3.74 | Range: 2 to 5 | n = 42 responses).

Year 5 responses were analysed by course. Students undertaking the WCH semester, including metropolitan and Denmark placements, and those participating in the rural program generally agreed that their placement experiences were comparable in quality. In contrast, Year 5 students who had recently completed the HCC course expressed equivocal views regarding whether their placement experiences were of a comparable standard to those of their peers (Mode: 4 [58.3%] | Mean: 3.33 | Range: 2 to 4 | n = 12 responses). Given that HCC is a newly introduced course, these findings warrant targeted review of placement experiences to identify the factors contributing to variation and ensure that students are provided with consistent and comparable learning opportunities as the course develops.

Year 6:

Year 6 students generally agreed that their placement experiences were comparable in quality to those of their peers (Mode: 4 [50.0%] | Mean: 3.80 | Range: 1 to 5 | n = 44 responses).

Years 4–6:

Students across Years 4–6 generally agreed that the clinical placement environments in each Semester 1 rotation provided the resources necessary to support their learning and achievement of the intended learning outcomes (Mode: 4 [49.0%] | Mean: 3.66 | Range: 1 to 5 | n = 151 responses).

Curriculum Design (Standard 2.2.1 and 2.2.6)

2.2.1 – There is purposeful curriculum design based on a coherent set of educational principles and the nature of clinical practice.

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.

Methodology:

The TTIP semester is the primary Year 6 course designed to prepare final-year students for internship by consolidating and integrating the knowledge, clinical skills, and professional behaviours developed throughout the medical program. These questions were included to evaluate students' perceptions of how effectively the TTIP curriculum supports their transition to practice as junior doctors.

Only Year 6 students who completed TTIP Part 1 during Semester 1 were eligible to respond. Students who completed their elective semester first had not yet undertaken TTIP Part 1 and were therefore excluded from this section.

Eligible students were asked to rate their level of agreement with the following statements:

The TTIP curriculum:

- *Is clearly and purposefully structured to prepare me for internship.*
- *Contains teaching content that is relevant, consistent, and of high quality.*
- *Provides a clear bridge between medical school learning and working as a junior doctor.*
- *Actively prepares me to perform the tasks and apply the knowledge expected of a junior doctor.*
- *Supports me to integrate the knowledge, skills, and professional behaviours I have developed throughout medical school into clinical practice.*

Students were also provided with the opportunity to provide open-text feedback: *If you have any specific feedback about the TTIP course, please elaborate on your responses below.*

Data:

Of the 44 Year 6 MBBS respondents, 21 had completed TTIP Part 1 during Semester 1 and subsequently provided responses to the following questions. These students generally agreed that TTIP was clearly and purposefully structured to support their transition to internship (Mode: 4 [76.2%] | Mean: 4.14 | Range: 3 to 5 | n = 21 responses) and that the curriculum content was relevant, consistent, and of high quality (Mode: 4 [52.4%] | Mean: 4.19 | Range: 3 to 5 | n = 21 responses).

These students also agreed that TTIP provided a clear bridge between medical school learning and junior doctor practice (Mode: 4 [52.4%] Mean: 4.29 | Range: 3 to 5 | n = 21 responses), prepared them to perform expected clinical tasks and apply relevant knowledge (Mode: 4 [47.6%] | Mean: 4.19 | Range: 2 to 5 | n = 21 responses), and supported integration of clinical skills and professional behaviours (Mode: 4 [52.4%] | Mean: 4.29 | Range 3 to 5 | n = 21 responses).

Open Text Responses (Standards 2.2.1 and 2.2.6):

Qualitative feedback from Year 6 students indicated that the practical components of the TTIP course were highly valued, particularly the simulation sessions and short-call activities. Students consistently described these sessions as authentic, engaging, and effective preparation for internship, with one student commenting that the *“TTIP Simulation sessions are excellent preparation for internship next year!”* Another noted that *“all of the simulation was excellent, such as the short calls.”*

Building on this positive feedback, Year 6 students expressed a desire for greater emphasis on these practical learning experiences. Several respondents suggested increasing the number of simulation and short-call sessions, particularly earlier in the semester, would be particularly helpful, with one student

noting that this would allow students to apply the acquired *“knowledge and skills on placement and improve effectively throughout the semester.”*

In contrast, Year 6 students described many TTIP lectures as “not engaging or helpful.” This suggests an opportunity to review the lecture content to ensure it is clinically relevant, high-quality, and closely aligned with the practical responsibilities of junior doctors. Some students also felt that the reflective assignments “didn’t really add” or contribute meaningfully to their transition to internship. There may therefore be scope to review these assessments and ensure they are meaningful, relevant, and focused on practical aspects of internship.

Curriculum Design (Standard 2.2.5)

2.2.5 – There is alignment between the medical program outcomes, learning and teaching methods, and assessments.

Methodology:

The following questions were asked of Year 1–5 students only, as these cohorts undertake graded summative assessments, including written examinations (e.g., DAQ, MCQ) and/or clinical assessments (e.g., OSCEs). Eligible students were asked to rate their level of agreement with the following statements:

- *The teaching methods used in the program support me to achieve the intended learning outcomes.*
- *The content I am assessed on adequately reflects what is taught in my medical program and the learning outcomes supplied.*

Data:

Year 1–5:

Overall, BMD students agreed that the teaching methods used in the medical program supported them to achieve the intended learning outcomes (Mode: 4 [40.5%] | Mean: 3.70 | Range: 1 to 5 | n = 318 responses). Perceptions of assessment alignment, however, varied by year level. Years 1, 2 and 5 agreed that assessments reflected course content and learning outcomes, while Years 3 and 4 were equivocal.

- Year 3 – Mode: 3 and 4 [41.5% each] | Mean: 3.37 | Range: 1 to 5 | n = 41 responses.
- Year 4 – Mode: 3 [49.2%] | Mean: 3.4 | Range: 1 to 5 | n = 65 responses.

Curriculum Design (Standard 2.2.10)

2.2.10 – There are opportunities for students to pursue studies of choice that promote breadth and variety of experience.

Methodology:

All students (Years 1–6) were asked to rate their level of agreement based on the following statements:

- *The program provides meaningful opportunities for me to broaden my learning experiences through studies of choice.*

- *The medical program encourages a variety and breadth of learning that I am satisfied with.*
- *I have adequate opportunities to pursue areas of personal interest within the medical program.*

In the 2025 AMC student submission, opportunities to pursue areas of individual interest through electives or other studies of choice were identified as a key area of concern. Students across all year levels expressed equivocal views regarding opportunities for individualised learning, with BMD students particularly indicating that they had insufficient opportunities to pursue areas of study of their choice.

This area was therefore retained as a focus in 2026 to assess whether student perceptions had changed following ongoing curriculum developments, including the planned introduction of the Year 6 BMD course in 2027, and to monitor progress against previously identified concerns. From a curriculum perspective, MBBS students have historically had multiple opportunities to undertake elective placements, including in Years 4, 5 (for metropolitan-based students), and 6. In comparison, the BMD curriculum does not currently include elective blocks in Years 4 or 5; however, the planned Year 6 BMD curriculum includes one dedicated 4-week elective block.

Data:

Students across Years 1–6 generally agreed that the medical program provides meaningful opportunities to broaden their learning through studies of choice (Mode: 4 [38.4%] | Mean: 3.61 | Range: 1 to 5 | n = 362 responses). However, perceptions varied by year level. While students in BMD Years 1–3 and MBBS Year 6 generally agreed, responses from the clinical-year BMD cohorts were less positive:

- Year 4 – Mode: 4 [30.8%] | Mean: 3.02 | Range: 1 to 5 | n = 65 responses.
- Year 5 – Mode: 4 [40.5%] | Mean: 3.14 | Range: 1 to 5 | n = 42 responses.

Encouragingly, students across all year levels agreed that the medical program provides a broad and varied range of learning experiences that meet their expectations (Mode: 4 [50.3%] | Mean: 3.95 | Range: 1 to 5 | n = 362 responses). However, this should be distinguished from opportunities for students to shape their learning according to their individual interests.

When specifically asked whether they had adequate opportunities to pursue areas of personal interest within the medical program, students across the cohort were equivocal (Mode: 4 [31.2%] | Mean: 3.43 | Range: 1 to 5 | n = 362 responses). This was particularly evident in Years 3–5:

- Year 3 – Mode: 2 and 3 [29.3% each] | Mean: 3.07 | Range: 1 to 5 | n = 41 responses.
- Year 4 – Mode: 3 [30.8%] | Mean: 2.83 | Range: 1 to 5 | n = 65 responses.
- Year 5 – Mode: 3 [28.6%] | Mean: 2.52 | Range: 1 to 5 | n = 42 responses.

In contrast, the Year 6 MBBS cohort were in agreement that they had adequate opportunities to explore areas of personal interest within their course (Mode: 4 [45.5%] | Mean: 3.95 | Range: 1 to 5 | n = 42 responses). Taken together, these findings suggest that while students recognise the breadth of learning experiences available within the program, they have fewer opportunities to shape their own learning

around their individual interests and future career goals. This is particularly evident in Years 3–5 of the BMD, where perceptions were less favourable despite these being the most important stages for elective and self-directed learning.

Open Text Responses (Standards 2.2.10):

Qualitative feedback strongly reinforced the quantitative findings, particularly the lower levels of agreement among Years 3–5 regarding opportunities to pursue areas of personal interest. BMD students consistently identified limited opportunities for elective, interstate and international experiences. One Year 3 student described electives as *“an integral part of discovering areas of medicine that are not routinely offered otherwise in medical school,”* noting that these experiences are designed to *“open doors and lead to interests that have the potential to impact [someone’s] entire medical career.”* This concern was particularly evident among clinical-year students, who described the fixed structure of clinical rotations across Years 4–6 as limiting their ability to explore specialties outside their allocated placements. Year 4 students identified that areas such as *“ophthalmology, ENT, neurosurgery”* remain unexplored and commented that it would be valuable to experience the *“day to day and work culture of such departments.”*

Year 5 students similarly advocated to *“re-open scope for more electives in 4–6th year.”* One student noted that elective opportunities had been *“replaced by more GP rotations,”* despite GP exposure already increasing in Year 3 with the transition from the MBBS to BMD. Students also identified areas such as tropical health as valuable opportunities for elective learning, with one stating that *“the ability to do selectives in Australia’s north would be valuable.”* While the planned four-week Year 6 BMD elective was recognised as a valuable component of the course, students questioned whether a single elective provides sufficient opportunity to explore specialties not encountered through pre-arranged rotations. One student noted that it *“doesn’t really give us the chance to try and test specialties which we aren’t exposed to,”* identifying areas including *“neurology, radiology, ophthalmology, dermatology and genetics.”*

Importantly, Year 6 MBBS students, who had greater elective opportunities earlier in their course, also emphasised that these opportunities should not be concentrated solely in the final year. One final-year respondent urged the program to *“continue to ensure students in more junior years also have sufficient elective opportunities, not just in final year.”*

Collectively, the quantitative and qualitative findings demonstrate that the concern is not a lack of breadth within the curriculum, but limited opportunities for students to choose and pursue areas of individual interest. This is consistent with the concerns identified in the 2025 AMC student submission and suggests that the introduction of a Year 6 elective alone may not fully address students’ desire for greater flexibility and choice throughout the clinical years. Given the lower perceptions among Years 3–5, there remains an opportunity to strengthen elective opportunities earlier in the BMD curriculum.

Learning and Teaching (Standards 2.3.4 and 2.3.5)

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.*

Methodology:

To ensure relevance to students' stage of training, each year level was asked to rate their level of agreement with statements tailored to their curriculum and clinical experience:

Year 1:

- *I have had sufficient time and involvement with patients and/or simulations in a supervised setting to develop and practise my clinical skills.*

Year 2:

- *I have had sufficient time and involvement with patients and/or simulations in a supervised setting to develop and practise my clinical skills.*
- *I feel prepared and confident in my clinical skills before starting clinical placements next year.*

Year 3:

- *Entering the clinical environment this year, I feel I have had sufficient time and involvement with patients and/or simulations in a supervised setting to develop and practice my clinical skills.*
- *I feel prepared and confident with my clinical skills before starting full-time clinical placement next year.*

Year 4:

- *Prior to attending full time clinical placement this year, I had developed and practiced the necessary clinical and procedural skills to a level where I could safely apply them in a clinical environment.*
- *I have had sufficient supervised involvement with patients to develop my clinical skills to the required level for my stage of training.*
- *I have had increasing levels of participation in clinical care as I proceed through the medical program.*

Years 5 and 6:

- *I have had sufficient supervised involvement with patients to develop my clinical skills to the required level for my stage of training.*
- *I have had increasing levels of participation in clinical care as I proceed through the medical program.*

Students were also provided with the opportunity to provide open-text feedback: *"Are there any additional opportunities you would like to further support the development of your clinical skills?"*

Data (Includes Open Text Responses for this Standard):

Year 1:

Year 1 BMD students strongly agreed that they had sufficient time and involvement with patients and/or simulations in supervised settings to develop and practise their clinical skills (Mode: 5 [53.6%] | Mean: 4.27 | Range: 2 to 5 | n = 84 responses).

Qualitative feedback strongly reinforced the value of these learning experiences. One Year 1 respondent described clinical practice as *“the most effective learning activity.”* Students’ suggestions focused not on the quality of these sessions, but on increasing the frequency and distribution of opportunities to participate. Several students requested *“more simulated encounters per week,”* noting that currently *“only two people get the opportunity to perform an exam/history”* during each session. Students also suggested incorporating simulated patients with relevant past medical history, allowing them to *“assess people with already diagnosed issues”* and develop a practical understanding of how symptoms *“look/feel/sound like”* in practice. Overall, this feedback demonstrates strong student endorsement of authentic, hands-on learning with practical suggestions for further strengthening these already highly valued experiences.

Year 2:

Year 2 respondents also strongly agreed that they had sufficient opportunities to engage with simulated patients to develop and refine their clinical skills (Mode: 4 [57.0%] | Mean: 4.24 | Range: 1 to 5 | n = 86 responses). They also agreed that they felt prepared and confident in these skills prior to commencing placement at general practice and hospital sites next year (Mode: 4 [38.4%] | Mean: 3.76 | Range: 1 to 5 | n = 86 responses).

Year 2 students also identified opportunities to further support their transition into third-year clinical placement. Suggestions included additional clinically focused teaching on *“common GP presentations and problems,”* as well as a *“pharmacology overview of key medications”* relevant to Year 2 and 3 scope of practice. Other respondents highlighted concerns regarding the *“over reliance of video lectures instead of in person lectures or more interactive class styles.”* Greater use of face-to-face teaching, including lectures as well as workshops, could better support learning and retention of clinically relevant content.

Year 3:

Year 3 students expressed equivocal views regarding whether they had sufficient time and involvement with patients and/or simulations to practise their clinical skills (Mode: 4 [39.0%] | Mean: 3.46 | Range: 1 to 5 | n = 41 responses). Similarly, this cohort was equivocal regarding whether they felt prepared and confident in their clinical skills before commencing full-time hospital-based placement next year (Mode: 3 [39.0%] | Mean: 2.98 | Range: 1 to 5 | n = 41 responses).

In the open-text responses, Year 3 students described a *“significant reduction in opportunities to practice [their] clinical skills,”* noting that weekly simulation from Year 2 had been reduced to *“just one simulation*

session for the entire semester.” Other students highlighted limited opportunities to practise history-taking and physical examination during GP placements, with some reporting feeling “underprepared” for clinical assessments such as the end-of-year OSCE. Students also described the removal of regular mock-patient clinical practice in Year 3 as *“a real loss in reinforcing our skills,”* and called for *“more simulation sessions”* and *“more clinically-focused workshops.”* Taken together, this feedback highlights an opportunity to review the frequency, consistency and structure of clinical skills practice available to Year 3 students. Taken together, this feedback highlights an opportunity to review the frequency, consistency and structure of clinical skills practice available to Year 3 students.

Year 4:

Year 4 students were equivocal regarding whether they had developed and practised the necessary clinical and procedural skills prior to commencing full-time clinical placement (Mode: 4 [41.5%] | Mean: 3.48 | Range: 1 to 5 | n = 65 responses). However, by Year 4, students were positive that they had sufficient opportunities for supervised patient involvement to support the continued development of their clinical skills (Mode: 4 [55.4%] | Mean: 3.89 | Range: 1 to 5 | n = 65 responses) and that their involvement in patient care increased appropriately with training (Mode: 4 [47.7%] | Mean: 4.17 | Range: 2 to 5 | n = 65 responses).

While students valued the clinical exposure gained through placement, the open-text responses indicated that additional structured opportunities to practise clinical skills both before commencing full-time placement and throughout Year 4 would strengthen clinical confidence. Respondents requested *“more simulation sessions”* and *“regular practical and procedural workshops”* particularly for *“venepuncture, cannulation, intra-muscular and subcutaneous injections and indwelling urinary catheterisation.”* These comments were underpinned by strong recognition of the value of face-to-face, practical teaching. One student wrote *“learning from in-person sessions improves our clinical skills,”* describing this as the *“most important aspect to a degree as hands-on as medicine.”*

Year 5:

Year 5 students were positive that they received appropriate supervision to support their clinical development (Mode: 4 [61.9%] | Mean: 4.10 | Range: 3 to 5 | n = 42 responses) and that their involvement in patient care increased appropriately with their skills and stage of training (Mode: 4 [54.8%] | Mean: 4.10 | Range: 2 to 5 | n = 42 responses).

Many Year 5 BMD students supported extending the structured simulated-patient teaching used in Years 1–3 into Years 4–6. Students noted that *“protected clinical teaching with clinicians”* can be difficult to access consistently during placements. Continuing simulated-patient teaching into the senior years could provide more consistent opportunities for direct supervision and student-specific feedback, while complementing clinical learning gained through placements.

It is important to acknowledge that the Year 5 WCH semester was particularly well regarded, with one student describing their Paediatrics, Obstetrics and Gynaecology placements as *“easily the best out of medical school”* and reporting being *“extremely satisfied”* with the quality of teaching and clinical supervision provided. The structure and delivery of this course may therefore provide a useful model for identifying practices that could

be applied more broadly to strengthen the quality and consistency of clinical teaching and supervision across other Year 4–6 placements.

Year 6:

Final year MBBS students reported similarly, agreeing that they received appropriate supervision of clinical practice (Mode: 4 [47.7%] | Mean: 4.05 | Range: 2 to 5 | n = 44 responses) their involvement in patient care had increased appropriately with their training (Mode: 5 [45.5%] | Mean: 4.30 | Range: 2 to 5 | n = 44 responses).

However, qualitative feedback identified differences in the level of responsibility and active participation provided to Year 6 students across placements. One Year 6 student described their ICU rotation as “*mostly observation*,” compared with opportunities to “*independently assess patients during [their] Emergency Department shifts*,” which they felt was more aligned with the purpose of the rotation: “*preparing to be an intern*.” Another student noted that the “*scope of a 6th year student should be more clearly enforced*” across participating sites, describing this as “*poorly regulated*.” These responses highlight the importance of clear expectations regarding the scope of Year 6 practice, supporting students to participate at an appropriate level and prepare for the transition to internship.

Learning and Teaching (Standards 2.3.6 and 2.3.7)

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.

Methodology:

All students from Years 1–6 were asked to rate their level of agreement with the following statements:

- *The program provides meaningful opportunities to learn about the health needs, experiences, and strengths of Aboriginal and/or Torres Strait Islander peoples and communities.*
- *The program prepares me to provide inclusive, culturally safe, and respectful care for Aboriginal and/or Torres Strait Islander peoples and communities.*

Data:

Students across all cohorts agreed that the program provides meaningful opportunities to learn about the health needs, experiences, and strengths of Aboriginal and/or Torres Strait Islander peoples and communities (Mode: 4 [39.0%] | Mean: 3.96 | Range: 1 to 5 | n = 362 responses).

Similarly, students were positive that the program prepares them to provide inclusive, culturally safe, and respectful care for Aboriginal and/or Torres Strait Islander peoples and communities (Mode: 4

[37.0%] | Mean: 4.03 | Range: 1 to 5 | n = 362 responses). These findings represent a notable strength of the curriculum, demonstrating consistently positive perceptions across most year levels.

An exception to this trend was observed among Year 6 students, who expressed equivocal views on this statement (Mode: 3 [38.6%] | Mean: 3.52 | Range: 1 to 5 | n = 44 responses). As this cohort is the final year of the MBBS, this finding may reflect differences in curriculum structure and learning experiences.

Learning and Teaching (Standard 2.3.8)

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.*

Methodology:

Year 4–6 students undertaking full-time clinical placements were asked to rate their agreement with the following statements:

Throughout the medical program so far, I have had face-to-face learning experiences involving:

- *exposure to a variety of clinical disciplines.*
- *care for patients across the life course (from newborns to older adults).*
- *prevention, health promotion, and treatment, including in community-based settings.*
- *different locations, including metropolitan, rural, and (where possible) remote settings.*

Data:

This section represents a significant strength of the Adelaide Medical School curriculum. Students across the clinical years (Years 4–6) consistently agreed that they received face-to-face learning experiences providing exposure to a broad range of clinical disciplines (Mode: 4 [55.4%] | Mean: 4.16 | Range: 2 to 5 | n = 148 responses). They also agreed that these experiences involved caring for patients across the life course (Mode: 4 [47.0%] | Mean: 3.95 | Range: 2 to 5 | n = 149 responses) and included learning in health promotion and disease prevention (Mode: 4 [49.0%] | Mean: 4.09 | Range: 2 to 5 | n = 147 responses).

Particularly noteworthy was the consistently positive perception across both the BMD and MBBS clinical cohorts that their placements provided experience in diverse clinical settings, including metropolitan, rural, and regional locations (Mode: 5 [41.3%] | Mean: 4.15 | Range: 1 to 5 | n = 138 responses). These findings demonstrate that students value the breadth and diversity of clinical exposure provided throughout the medical program.

Standard 3: Assessment

Assessment Design (Standard 3.1.1 and 3.1.4)

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.*

3.1.4 – The system of assessment includes a variety of assessment methods and formats which are fit for purpose.

Methodology:

Students across Years 1–6 were asked to rate their level of agreement with following statements:

Assessment tasks I have undertaken in the medical program this year:

- *Are fair and conducted consistently across students.*
- *Appropriately assess the intended learning outcomes.*
- *Are clearly structured with expectations appropriate to my stage of training.*
- *Use formats that allow me to best demonstrate the knowledge and/or skills being tested (e.g., oral presentation, video recordings, case discussions).*

Data:

Positive perceptions were consistent across Years 1–6, with all cohorts agreeing that assessment tasks were fair, appropriately aligned with learning outcomes, clearly structured, and presented in suitable formats (Mode: 4 [42.4%] | Mean: 3.88 | Range: 1 to 5 | n = 362 responses).

Assessment Feedback (Standard 3.2.1)

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.

Methodology:

Years 1–6 students were asked to rate their level of agreement with following statements:

- *I am given opportunities to seek and discuss feedback on my clinical and academic performance which is beneficial for my learning and improvement.*
- *The feedback provided following assessments is:*
 - *Useful in guiding my learning.*
 - *Specific to my performance.*
 - *Helpful in improving my future practice.*

Data:

All Students:

Data were examined at both the individual year-level and overall cohort level. Students from Years 1–4 and Year 6 strongly agreed that they were provided with opportunities to seek and discuss feedback on their clinical and academic performance. Comparatively, Year 5 students were equivocal regarding these opportunities (Mode: 3 [40.5%] | Mean: 3.55 | Range: 1 to 5 | n = 42 responses). Across Years 1–6, students agreed that the feedback they received was useful and specific, and supported their individual development and future clinical practice. Given the consistently positive responses across year levels, data for these measures are not presented. Year 5 data has been presented separately where responses differed comparatively from the broader cohort.

Open Text Responses (Standard 3):

Students broadly rated assessment and feedback processes positively; however, the open-text responses identified recurring opportunities for improvement that are not fully captured by the overall agreement scores.

Feedback was often described as vague, generic or insufficiently actionable. Year 1 students generally valued in-person clinical feedback but identified written assignment feedback as an area for improvement. One student reported that *“many of us got the same feedback copy-pasted,”* while another described feedback such as *“meets expectations”* and *“continue to practice”* as providing limited guidance for improvement. Clinical-year students similarly sought more specific feedback to understand errors and guide future learning. One Year 5 student stated, *“If we are not given the opportunity to find out why our reasoning was wrong, we won’t be able to learn,”* while another requested more detailed MCQ feedback, including examples of commonly misunderstood questions, to help identify and address underlying knowledge gaps.

Assessment expectations and marking rubrics were also reported as unclear or inconsistent. A Year 3 student noted that expectations often required *“clarification by the student cohort”* through AMSS representatives contacting course coordinators. Year 2 students reported that *“some rubrics lacked detail”* and instances where *“a rubric has not even been provided.”* While students are expected to demonstrate academic independence, the recurrence of these concerns suggests an opportunity for greater consistency in communicating assessment requirements and criteria.

Students also questioned the extent to which assessment promotes meaningful learning. Some described assessments as a *“tick box”* exercise, with one Year 4 student describing it as *“a game of trying to work out what they want rather than actually providing a good assignment.”* Students advocated for greater emphasis on critical thinking, synthesis and clinical reasoning. Case write-ups were considered particularly valuable when focused on *“synthesis and evidence based medicine.”* Students similarly acknowledged that *“placement logbooks are helpful,”* but suggested that reducing their repetition could retain their educational value while allowing greater focus on meaningful clinical learning.

Alignment between teaching, learning outcomes and assessment was a further concern, particularly in the clinical years. One Year 5 student stated that *“what we are assessed on in the degree does not reflect what we are taught,”* while another reported that assessments *“very loosely correlate to the learning outcomes.”* Students identified examples of summative examination questions assessing content they had not been taught. While some questions were subsequently removed from scoring, these responses suggest value in strengthening pre-release assessment quality assurance to ensure alignment with taught content and learning outcomes.

Overall, students are seeking assessment experiences that are meaningful, clinically relevant and actionable, with clear expectations, individualised feedback, and stronger alignment between teaching and learning outcomes.

Standard 4: Students

Professionalism and Fitness to Practice (Standard 4.2.3)

4.2.3 – Students who require additional health and learning support, or reasonable adjustments/accommodations, are identified and receive these in a timely manner.

Methodology:

All students were asked to rate their level of agreement based on the following statements:

Students who require additional health or learning support during the medical program:

- *Can access appropriate support and adjustments from the University when needed.*
- *Are provided said support and adjustments in a timely manner.*
- *Receive support that meets their needs.*

Data:

Students across Years 1–6 agreed that those requiring additional health or learning support can access appropriate University support and adjustments when needed (Mode: 4 [40.8%] | Mean: 3.87 | Range: 1 to 5 | n = 287 responses). Students also generally agreed that these adjustments are provided in a timely manner (Mode: 4 [38.9%] | Mean: 3.80 | Range: 1 to 5 | n = 280 responses) and that the support provided adequately meets their needs (Mode: 4 [41.3%] | Mean: 3.83 | Range: 1 to 5 | n = 276 responses).

Open Text Responses (for Standard 4.2.3):

Qualitative feedback generally supported the quantitative findings, although several students identified practical barriers to accessing support when it was required. One Year 6 student described the process for obtaining leave from clinical placement as particularly challenging, stating that *“I have always felt that it is really hard to take leave”* and that they had attended placement *“when extremely unwell because of how difficult the process can be.”* A Year 4 student similarly reported issues obtaining reasonable adjustments for an unplanned absence from placement despite providing relevant documentation.

Lack of flexibility in academic timetabling was also raised as a concern, with one respondent commenting that *“time slots are not adjustable to a student's needs”* outside medical or compassionate circumstances. Students also related this to the challenges for those who rely on paid employment alongside their studies, with financial circumstances not always appearing to be sufficiently recognised by the University. Collectively, these responses suggest that while existing support services are generally viewed positively, greater flexibility regarding student unplanned absences and leave could further improve accessibility and better accommodate students' diverse health, personal and financial circumstances.

Student Cohorts and Selection Policies & Student Wellbeing (Standard 4.1.4 and 4.2.5)

4.1.4 – The medical education provider supports inclusion of students with disabilities.

4.2.5 – The medical education provider implements flexible study policies relevant to the students' individualised needs to support student success.

Methodology:

This question was specifically intended to capture the experiences and perspectives of students who identify as living with a disability. Students who identify as living with a disability were asked to rate their level of agreement with the following statements:

- *As a student with a disability, I feel the University takes steps to support my inclusion and that of other students with disabilities.*
- *As a student with a disability, I feel my health and wellbeing needs are consistently being met.*
- *As a student with a disability, I feel the University provides flexible study arrangements that support my individual learning needs and success in the program.*

Data:

Students who identified as living with a disability expressed equivocal views regarding whether the University takes appropriate steps to support their inclusion (Mode: 4 [50%] | Mean: 3.14 | Range: 1 to 5 | n = 14 responses). These students were also equivocal regarding whether their health and wellbeing needs were consistently met, with this item recording a mode of 2 (Mode: 2 [35.7%] | Mean: 2.93 | Range: 1 to 5 | n = 14 responses). Similarly, students expressed mixed views on whether flexible study arrangements adequately supported their individual learning needs and success within the program (Mode: 4 [35.7%] | Mean: 3.0 | Range: 1 to 5 | n = 14 responses).

Open Text Responses (for Standard 4.1.4 and 4.2.5):

Open-text responses identified ongoing concerns regarding access to timely disability and wellbeing support, reasonable adjustments, and flexible study arrangements. These concerns were raised both by students who identified as living with disability and by students who did not identify as living with disability but advocated on behalf of peers.

Students who identified as living with disability described concerns regarding the level of awareness and support available within the medical program. One Year 6 student commented that, *“as someone with ADHD, I felt support was not really emphasised,”* concluding that *“more could, and should be done.”* Similarly, a Year 1 student described a *“lack of autism and ADHD awareness,”* explaining that the *“high focus on professionalism and hyper-emphasis on social interactions”* can make university life difficult and stressful for neurodivergent students.

These students also raised concerns regarding the accessibility and timeliness of wellbeing support. One respondent commented that wellbeing *“needs to be a part of the curriculum, not an adjunct,”* describing it as an *“afterthought,”* while another described mental health support as *“severely lacking and has been for many years.”* Although students acknowledged the value of the University's psychology service and the excellent work of individual staff members, some reported that appointments could take more than a month to access, potentially limiting the effectiveness of support when timely intervention is required.

Several students who did not identify as living with disability, but advocated on behalf of their peers, described witnessing friends and classmates experience difficulties accessing reasonable adjustments, navigating access plans, and obtaining support that adequately met their needs. One student commented that they had *“heard of students within my cohort who have health issues/disabilities having very poor experiences throughout their studies,”* while another noted that *“it can be hard for these students to advocate for [themselves] and access services that help [their] journey through medical school.”* Another respondent highlighted the personal distress experienced by students when appropriate support is not accessible, stating, *“I see the distress this causes... I think that [disability] access plans can be improved upon.”* These responses demonstrate that concerns regarding disability support extend beyond the students directly affected.

These findings are particularly significant as they mirror concerns reported in the 2024 and 2025 AMC student submissions. The persistence of equivocal quantitative results and recurring qualitative concerns over three consecutive years suggests limited perceived improvement in disability support, reasonable adjustment processes, and flexible study arrangements. This remains a persistent area of concern and warrants further review by the University to ensure students living with disability can access timely, equitable and effective support throughout the medical program.

Standard 5: Learning Environment

Facilities (Standard 5.1.1 and 5.1.2)

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.

Methodology:

Students across all year levels were asked to rate their level of agreement with the following statements:

All educational facilities I use to engage in the medical program:

- *Are safe and well-maintained.*
- *Are accessible to myself and other students.*
- *Are sufficient in number for student use.*
- *Enable high-quality learning and teaching.*
- *Support my wellbeing and any additional needs.*

For Year 1 and 2 students, this question referred to educational facilities such as the AHMS building. For students in Years 3–6, examples also included GP practices, community-based placement sites, and hospital student spaces (e.g., the RAH student space).

Data:

Overall, students agreed that Adelaide University buildings and other relevant clinical placement facilities were safe and well maintained (Mode: 5 [47.6%] | Mean: 4.30 | Range: 1 to 5 | n = 357 responses). Students also agreed that these facilities were accessible to both themselves and their peers (Mode: 5 [46.2%] | Mean: 4.25 | Range: 1 to 5 | n = 357 responses).

Perceptions differed, however, when students were asked whether educational facilities were sufficient in number to meet their learning needs. Year 1–3 students reported positive responses, whereas responses from the senior clinical years were equivocal as shown:

- Year 4 – Mode: 4 [35.4%] | Mean: 3.38 | Range: 1 to 5 | n = 65 responses.
- Year 5 – Mode: 4 [42.9%] | Mean: 3.38 | Range: 1 to 5 | n = 42 responses.
- Year 6 – Mode: 2 [27.3%] | Mean: 2.89 | Range: 1 to 5 | n = 44 responses.

Despite these differences, students generally agreed that the educational facilities supported high-quality learning and teaching (Mode: 4 [31.8%] | Mean: 3.51 | Range: 1 to 5 | n = 355 responses), as well as their wellbeing and other relevant needs (Mode: 4 [42.0%] | Mean: 4.11 | Range: 1 to 5 | n = 352 responses).

Open Text Responses (for Standards 5.1.1 to 5.1.2):

A substantial number of open-text responses raised concerns regarding the adequacy of Adelaide University educational facilities, with the AHMS building emerging as the most frequently discussed learning environment. Students across all year levels (Years 1–6) identified limitations relating to study spaces, student amenities, assessment environments, building access, maintenance and clinical facilities, suggesting these concerns are widespread across the medical program.

Access to appropriate study and assessment spaces was a prominent concern. A Year 2 student commented that *“quiet study space in the AHMS can be hard to find, especially during busy times,”* and *“It’s even more difficult if you need access to a whiteboard for revision or group work.”* This was echoed by a Year 4 respondent, who wrote that *“the AHMS continues to fail to provide adequate study space,”* with *“often the only place to sit at peak times is the floor.”* Several students suggested that underutilised areas of the building could be repurposed, stating that *“the rooms on the outside parts of the building are wasted space. It would be great if... those spaces [became] more usable for students.”* A final-year student also concluded that *“students who travel significant distances to attend University at the AHMS should have adequate space to study privately, and currently they don’t. This needs to change.”*

AHMS student amenities and building functionality were also raised as concerns. Kitchen facilities were consistently identified as inadequate, with a Year 4 student stating that *“The AHMS fails to provide kitchen facilities for students,”* explaining that *“there is nowhere near enough microwaves,”* with *“[students] spending their entire lunch break waiting to heat up their lunch.”* This concern was echoed by five other students. Collectively, these comments suggest that current amenities do not adequately support students, considering many remain at the AHMS for extended periods of teaching or study. Specific safety concerns regarding the reliability of the AHMS escalators were also noted, with reports of being *“frequently broken”* made across multiple year levels. Students expressed concern that repeated escalator failures may pose a safety risk to students using the building, particularly given the high volume of student traffic through AHMS. The consistency of these concerns across year levels suggests that this warrants consideration beyond routine maintenance.

Students also raised concerns regarding the suitability and privacy of assessment environments. A Year 2 student reported that, following the University merger, *“the examination room was not ideal.... [held in a] small room, giving the feeling that people could easily see your screen.”* Another student echoed these worries, writing *“Our MCQ should not be sat in a lecture theatre where we don’t even have real desks,”* with screens *“easily visible”* to the people *“sat behind us.”*

Feedback also extended beyond AHMS to student facilities within the clinical environment. Several Year 4 students reported that *“locker space or general space for students is lacking within hospital environments,”* with one adding that *“it would be lovely to have a dedicated space”* for students to connect and reconvene at placement. A Year 6 student similarly stated, *“Would be nice if RAH... and LMH had a student space/common room like it used to,”* highlighting the value of these dedicated areas for student study, clinical preparation and rest.

Collectively, the responses indicate a consistent perception across year levels that current educational facilities do not adequately meet students' needs. This feedback highlights an opportunity for the University to increase the availability and accessibility of study and student spaces within AHMS for medical students. Given that students in Years 4–6 spend the majority of their degree undertaking clinical placements, the University should also consider working with local Adelaide health networks to ensure that students have access to safe, appropriate and dedicated spaces for study and clinical preparation while on placement.

Clinical Learning Environment (Standard 5.4.1 and 5.4.2)

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.

Methodology:

As these standards are principally concerned with clinical education and learning experiences involving real patients, the corresponding survey items were administered only to students undertaking clinical placements (Years 3–6).

One of the primary objectives of examining this standard was to explore students' experiences of the newly implemented Health Care Continuum (HCC) program, which was redesigned to place a greater emphasis on priority populations, including Aboriginal and Torres Strait Islander health. Accordingly, while responses from Years 3, 4, and 6 were analysed at the cohort level, Year 5 responses were analysed by clinical program (metropolitan Health Care Continuum, metropolitan Women's and Children's Health, ARCS Rural, and Denmark WCH) to enable evaluation of the different learning contexts established within the Year 5 curriculum.

Year 3–6 students were asked to rate their level of agreement with the following statements:

My clinical learning experiences this year have been:

- *Clinically relevant and of high quality.*
- *Supportive of active participation in patient care.*
- *Supportive of me achieving the required learning outcomes.*
- *Effective in allowing to partner with both University and external health providers e.g., GPs*
- *Providing adequate and culturally safe opportunities to care for Aboriginal and/or Torres Strait Islander peoples.*

Data:

Year 3:

Year 3 students demonstrated positive responses across four of the five assessed domains relating to

their GP clinical learning experiences, indicating that they generally perceived these placements as clinically relevant, supportive of active participation in patient care, conducive to achieving the required learning outcomes, and effective in facilitating partnerships with general practitioners. However, responses were equivocal regarding whether GP placements provided adequate and culturally safe opportunities to care for Aboriginal and Torres Strait Islander peoples (Mode: 3 [36.1%] | Mean: 3.67 | Range: 1 to 5 | n = 36 responses).

Year 4:

Year 4 students demonstrated positive responses across all five assessed domains, indicating that their clinical learning experiences were generally perceived as clinically relevant and of high quality, supportive of active participation in patient care and achievement of learning outcomes, effective in facilitating partnerships with external health providers, and providing adequate and culturally safe opportunities to care for Aboriginal and Torres Strait Islander peoples.

Year 5:

Across the four Year 5 clinical programs (WCH, HCC, ARCS Rural, and Denmark), students agreed that their clinical learning experiences were clinically relevant and of high quality, supported active participation in patient care, facilitated partnerships with both the University and external health providers, and provided adequate and culturally safe opportunities to care for Aboriginal and Torres Strait Islander peoples. Notably, students across all four programs reported positive perceptions regarding opportunities to provide culturally safe care for Aboriginal and Torres Strait Islander peoples. The strongest responses for this domain were observed among students undertaking the ARCS Rural and WCH programs:

- Rural – Mode: 5 [50.0%] | Mean: 4.25 | Range: 2 to 5 | n = 8 responses.
- Denmark – Mode: 4 [100%] | Mean: 4.0 | Range: 4 | n = 1 response.
- WCH – Mode: 4 [52.9%] | Mean: 4.0 | Range: 3 to 5 | n = 17 responses.
- HCC – Mode: 4 [63.6%] | Mean: 3.55 | Range: 2 to 4 | n = 11 responses.

The only domain in which responses differed between the Year 5 programs related to whether clinical placements supported students in achieving the required learning outcomes. Students undertaking the WCH, ARCS Rural, and Denmark programs agreed with this statement, whereas students completing the HCC program were equivocal (Mode: 4 [58.3%] | Mean: 3.42 | Range: 1 to 4 | n = 12 responses).

Given that the HCC program was newly implemented in 2026, these findings suggest opportunities for ongoing refinement as the program matures. Although HCC students reported positive perceptions regarding opportunities to provide culturally safe care for Aboriginal and Torres Strait Islander peoples, responses were comparatively less positive than those from the Rural and WCH cohorts. HCC students were also the only Year 5 cohort to report equivocal perceptions regarding achievement of the required learning outcomes. Continued evaluation of student feedback will be important in informing future program development.

Year 6:

Similar to the Year 4 cohort, Year 6 students reported positive responses across all five assessed domains (Mode: 4 [53.8%] | Mean: 3.94 | Range 1 to 5 | n = 44 responses).

Clinical Supervision (Standards 5.5.1, 5.5.2, and 5.5.4)

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.

5.5.4 – The medical education provider works with healthcare facilities to ensure staff have time allocated for teaching within clinical service requirements.

Methodology:

Students in Years 3–6 were asked to indicate their level of agreement with statements relating to the safety and involvement of their clinical supervisors, as well as the adequacy of at-placement teaching.

Year 3:

- *My GP supervisor(s) is aware and orientated to my level of training and scope of practice.*
- *My GP supervisor(s) is available and has sufficient time to provide teaching and supervision during consultations.*
- *I receive well-organised, safe and appropriate clinical supervision.*

Year 4–6:

- *My clinical supervisor(s) is aware and orientated to my level of training and scope of practice*
- *My clinical supervisor(s) is involved in my placement.*
- *My clinical supervisor(s) and/or other relevant hospital staff are available and have sufficient time allocated to teach within their clinical service requirement.*
- *I receive well-organised, safe and appropriate clinical supervision.*

Data:

Year 3:

Year 3 students agreed that their GP supervisors are orientated to their scope of practice (Mode: 4 and 5 [31.7% each] | Mean: 3.76 | Range: 1 to 5 | n = 41 responses). They also agreed their supervisor is available to teach (Mode: 5 [39.0%] | Mean: 3.90 | Range: 1 to 5 | n = 41 responses) and provided well-organised and safe supervision (Mode: 5 [41.5%] | Mean: 4.12 | Range: 2 to 5 | n = 41 responses).

Year 4–6:

Students from Years 4–6 agreed with each of the above statements. Given the consistently positive responses across these cohorts, data is presented collectively (Mode: 4 [63.2%] | Mean: 3.62 | Range: 1 to 5 | n = 151 responses).

Standard 6: Evaluation and Continuous Improvement

Continuous Review, Evaluation and Improvement & Feedback and Reporting (Standard 6.1.2 and 6.3.1)

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.

6.3.1 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.

Methodology:

All students were asked to evaluate University feedback processes based on the following statements:

- *The University actively seeks feedback from students regarding the medical program.*
- *Feedback that peers and/or myself have provided to the University is synthesised and used to improve the medical program.*
- *I am aware that the University has made and/or is planning to make changes to the medical program in accordance with feedback given from students.*
- *The University communicates the outcomes of student feedback back to the student body.*

Data:

All Students:

Overall, all respondents agreed that the University actively seeks student feedback on the medical program (Mode: 4 [41.2%] | Mean: 4.07 | Range: 1 to 5 | n = 362 responses). This finding is consistent with the results presented in Standard 1, where students agreed that the University supports and encourages them to share their opinions and insights about the medical program.

Students agreed that feedback from themselves and their peers is considered, synthesised and used to enhance the medical program (Mode: 4 [35.9%] | Mean: 3.63 | Range: 1 to 5 | n = 362 responses). However, this varied by year level, with Years 1–2 reporting positive perceptions (Mode: 4 [38.2%] | Mean: 4.03 | Range: 1 to 5 | n = 170 responses), compared with equivocal responses across Years 3–6, both when analysed by individual year and as a combined cohort (Mode: 4 [33.9%] | Mean: 3.28 | Range: 1 to 5 | n = 192 responses).

Students acknowledged that the University has made and plans to continue making changes to the medical program based on student feedback (Mode: 4 [38.7%] | Mean: 3.72 | Range: 1 to 5 | n = 362 from 362 responses). However, students were equivocal regarding whether the University communicates the changes made and outcomes resulting from student feedback (Mode: 4 [31.2%] | Mean: 3.44 | Range: 1 to 5 | n = 362 responses).

Open Text Responses (for Standard 6):

The free-text responses highlighted several positive examples of staff engagement with student feedback. One student expressed gratitude for the *“many phenomenal Faculty members that care so deeply about our learning,”* demonstrating that effective engagement and communication with students already exist across parts of the program. Particular staff members were named, including Precinct staff who support clinical year students across hospital and community sites, and Clinical Deans, particularly those involved in the Women’s and Children’s Year 5 course. These examples demonstrate that effective feedback and communication practices already exist within the program and provide a strong foundation for strengthening consistency across courses and year levels.

However, similar to student voice in Standard 1, respondents also identified limitations in the communication and visibility of feedback outcomes. A Year 3 BMD student stated, *“I feel the University does not communicate the outcomes of [our] feedback,”* noting that they *“generally only hear about the outcomes through word of mouth.”* Similarly, a Year 1 student commented, *“I have not seen any specific documents outlining the changes that have been made due to student feedback.”* Similar concerns regarding the visibility of feedback outcomes were identified in the 2024 and 2025 AMC student survey reports.

Students also raised concerns about whether their feedback is sufficiently reflected in Faculty decisions. A Year 4 student acknowledged that there are *“appropriate opportunities to provide feedback in this course,”* but expressed disappointment when *“the overall feeling of the cohort is not represented by the decisions of the Faculty.”* Many students cited particular examples where changes were implemented by the University but did not reflect what students had requested, such as *“decreasing contact teaching hours in clinical years”* and *“moving more teaching content online.”*

While students recognise the role of the AMSS in communicating feedback outcomes, they believe systemic or course changes arising from student input should be communicated directly by the University. A centralised portal or system outlining feedback received, actions taken, and where no action is taken, the rationale for this, would improve clarity and transparency. Strengthening this feedback loop is essential to ensuring students feel heard, their views are meaningfully considered, and their feedback is translated into tangible improvements across the medical program.