

Policy Document

Graduate Outcomes and Assessment (2026)



Executive Summary

The following policy concerns the specific outcomes medical graduates must be qualified to meet, and therefore the way institutions must be able to assess them to create skilled, competent and professional medical graduates. The Australian Medical Students' Association (AMSA) believes that graduate outcomes must be clearly outlined by the Australian Medical Council (AMC) and applied to all graduating cohorts from medical schools in Australia. Graduate competencies must also meet international standards. The policy revisits the way the Australian Graduate Outcomes have been evaluated by the AMC's medical school accreditation committee and comments on the approach taken by the AMC regarding consulting medical students, incoming graduates and medical schools on how prepared they feel upon graduating.

Notably, many proposed topics for AMC review have been updated to suit changing times, and the ones that have been discussed include the following:

Digital Health.

AMSA recognises the rapid expansion of digital health technologies, including electronic health records, telehealth, and artificial intelligence, within modern healthcare systems. This policy advocates for the formal integration of digital health competencies into graduate outcomes and accreditation standards set by the AMC. Graduates must be equipped with the knowledge and skills to safely and ethically implement digital tools in their clinical practice. This includes competencies in data literacy, patient privacy and consent, digital communication, and the appropriate use of emerging technologies such as Clinical Artificial Intelligence. AMSA further advocated for support to be provided for implementation and equitable access to digital health education and infrastructure, ensuring that all students, including those in rural and remote settings, are adequately prepared for a digitally enabled healthcare environment.

Social Accountability as an Accreditation Standard.

AMSA supports the formal recognition of social accountability as a core component of medical school accreditation standards. Medical education providers have a responsibility to align their teaching and research activities with the priority health needs of the communities they serve. This policy advocates for the development of clear, measurable graduate outcomes that reflect social accountability, including preparedness to work in rural and underserved areas, and the ability to address health inequities at both individual and systemic levels. AMSA further calls for accreditation standards to require medical schools to demonstrate meaningful community engagement and to provide students with

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opportunities for longitudinal, community-based clinical experiences that foster a commitment to equitable healthcare delivery.

First Nations Health.

AMSA acknowledges the medical profession's contribution to systematic discrimination, health outcomes, and intergenerational impacts against First Nations peoples, and strives to be part of a positive future. This policy celebrates the AMC's recent progress toward more culturally safe medical graduates and an equitable health future through refreshed accreditation standards. AMSA further advocates for integration of diverse First Nations leadership across accreditation processes, curriculum and assessment design, clinical training and stronger focus on the AMC supporting curriculum and assessment design. Specifically, AMSA supports the development of measurable standardised cultural safety outcomes, and structured cultural immersion placements in First Nations Community Controlled Health Organisations, according to local community capacity, to ensure the continual improvement of health outcomes for First Nations patients.

LGBTQIASB+ Health.

AMSA recognises the health inequities that are faced by LGBTQIASB+ communities. AMSA acknowledges the inconsistency of LGBTQIASB+ health education across medical school curriculums. This policy advocates for the inclusion of LGBTQIASB+ Health competencies within graduate outcomes and accreditation standards, ensuring that all graduates of Australian medical schools are equipped to provide care that is evidence-based, patient-centred, inclusive and affirming. Furthermore, AMSA supports that the development of assessments be undertaken in conjunction with leaders from LGBTQIASB+ communities, and those with lived experience.

Assessment of Students with Disabilities.

AMSA acknowledges that medicine has historically excluded people with disabilities, and that active changes are required to make medical education accessible. AMSA advocates for a strengths-based, inclusive approach to medical education that acknowledges the diverse ways in which students with disabilities may demonstrate they meet graduate outcomes, including through the use of reasonable accommodations.

AMSA supports the use of inclusive practices and universal design to ensure admission, teaching and learning, and assessment procedures are widely accessible. AMSA highlights the responsibility of medical schools to provide reasonable accommodations to students with disabilities, including in clinical placements and examinations. AMSA advocates for evidence-based accreditation processes that recognise diversity within the medical workforce and support equitable participation in medical training, including the inclusion of people with disabilities in the design of graduate outcomes and assessment.

Climate Change and the Environment.

AMSA believes that environmentally sustainable healthcare and climate change must be explicitly recognised within the medical graduate outcomes and

accreditation standards. It is imperative that medical graduates understand the health impacts of climate change, including infectious diseases, mental health impacts, heat-related illness and its disproportionate effect on vulnerable populations. Medical school curriculums should integrate climate-health competencies and environmentally sustainable healthcare practice into teaching, assessment, and clinical training to prepare future doctors for emerging global health challenges.



Policy Points

AMSA calls upon:

1. Australian Medical Council Medical School Accreditation Committee to:

- a. Continue to actively consult community stakeholders and assessors in the development of equitable, relevant graduate outcomes including but not limited to:
 - i. Australian and New Zealand Medical Schools and Education providers;
 - ii. Australian Medical Students' Association;
 - iii. Local, State, and National Health Departments;
 - iv. Health consumers;
 - v. Medical students from diverse (and underserved) backgrounds, including equity groups;
 - vi. Medical societies;
 - vii. Local, state, and national community health organisations including but not limited to:
 1. Aboriginal Community Controlled Health Organizations (ACCHOs), Australian Indigenous Doctors' Association (AIDA), and Aboriginal Medical Service (AMS);
 2. LGBTQIASB+ specific health services;
 3. Disability-specific health services;
 4. Environmentally focused health services;
 5. Digital health services;
 6. Climate change focused health services;
 7. Medical Student wellbeing services; and
 8. Rural and remote health services.
 - viii. First Nations people.
- b. Continue to ensure continuous medical student representation on the committee;
- c. Ensure the working group responsible for reviewing these standards includes a medical student representative and are consulted at every decision-making stage, without tokenism, and feedback implemented;
- d. Continue to follow the Australian Government's recommendation for the assessment of graduate outcomes as stated in the First Nations Health Curriculum Framework to include feedback from, but not limited to:
 - i. A registered First Nations medical clinician with a sound knowledge of clinical practice and experience in teaching and learning or clinical education;
 - ii. A non-Indigenous academic who has well developed cultural capability and requisite knowledge of the pedagogy of First Nations curriculum, reflexivity, facilitation skills, and strategies to work in intercultural partnerships, collaboration and engagement; and
 - iii. A First Nations academic in the same profession.
- e. Require evaluation of First Nations student learning outcomes via the

Wathaara Scale every two years and subsequent interpretation with First Nations co-governance;

- f. Commit to working with stakeholders from communities that have historically been underserved by the healthcare system in the consultation of graduate outcomes, with an emphasis on actively engaging those who have been historically underserved by the health system;
- g. Continue engaging medical societies and medical schools in the consultation periods for graduate outcomes;
- h. Continue to allow input into the changing scope of medical practice ensuring it aligns with evidence around patient safety and outcomes;
- i. Integrate digital health teaching into future accreditation standards;
- j. Ensure that specific graduate outcomes promote competency in provision of healthcare to community groups experiencing health inequities and that these are mandated in accreditation standards, and ensure that relevant assessments are developed and assessed by people from these groups, including but not limited to;
 - i. Culturally and linguistically diverse individuals;
 - ii. Those living in rural and remote areas;
 - iii. Refugees;
 - iv. People from LGBTQIASB+ communities;
 - v. Persons with disabilities; and
 - vi. Those experiencing financial disadvantage
- k. Ensure that the graduate outcomes and accreditation standards continue to be regularly reviewed at least every five years by the accreditation committee to reflect evolving health needs and practices, as well as educational and scientific developments, with continual and transparent oversight of necessary changes to be made to the outcomes;
- l. Further investigate the Australian Medical Council's review process on graduate outcomes and assessment of such to ameliorate the lack of current data;
- m. Create diverse working groups for the purposes of updating graduate outcomes to reflect the evolving health needs and practices, and educational and scientific developments; and
- n. Regularly update the AMC Guidance Matrix and encourage medical schools to use this resource to benchmark their own programs against:
 - i. With emphasis on detailing clear examples relating to the full range of groups experiencing health inequities described in the AMC Standards for Assessment and Accreditation of Primary Medical Programs; and
 - ii. Mapped to the full range of relevant existing standards.

2. Australian Medical Education Providers to:

- a. Continue their engagement as a key stakeholder in the consultation of graduate outcomes for medical students;
- b. Continue to integrate the health of marginalised communities as a central component of ongoing assessment and education;

- c. Incorporate digital health and climate change education into their curriculums and evaluate the success of this teaching through appropriate assessment of measurable outcomes;
- d. Integrate outcomes that promote competency in provision of healthcare to community groups experiencing health inequities, including but not limited to persons with disabilities, First Nations Australians, refugees, migrants, LGBTQIASB+ communities, and rural, remote and regional Australians, by:
 - i. Reporting teaching, assessment and clinical reinforcement of these competencies to the AMC such that examples may be included in the AMC Guidance Matrix;
 - ii. Identifying gaps in teaching, assessment and clinical reinforcement of these competencies and taking prompt action to address them;
 - iii. Supporting staff in allocated time and development of their own competencies, so that this work does not rely only on individual champions or unpaid student labour;
 - iv. Considering and contributing to emerging evidence in curriculum design, clinical exposure, assessment, student preparedness and implementation challenges relating to these competencies; and
 - v. Incorporate longitudinal community-based clinical placements as a mandatory part of their curriculum.
- e. Regarding First Nations health outcomes;
 - i. For First Nations health experts to lead the authorship and review of relevant curricula;
 - ii. To construct formal relationships with local First Nations Health Services in accordance with the Health Curriculum Framework;
 - iii. To provide students structured clinical placement within Aboriginal Community Controlled Health Organisations; and
 - iv. To implement measurable, strengths-based approaches regarding outcomes for cultural safety.
- f. Implement higher predictive value assessments in Miller's Pyramid of Clinical Competence, such as the OSCE or Long Case scenarios;
- g. Support medical students with diverse needs by guaranteeing the provision and validation of assistive technologies (e.g., electronic stethoscopes, speech-to-text, modified surgical tools) to meet graduate outcomes, and advocate to the AMC to ensure students receive the required accommodations;
- h. Give all students sufficient notice before re-accreditation occurs to allow students sufficient time to prepare statements for the AMC; and
- i. Ensure the feedback process is free from coercion and anonymous to protect students from repercussions from the medical school.

3. State and/or Territory health departments to:

- a. Continue their engagement as a stakeholder in the consultation of the graduate outcomes for medical students.

4. Australian Medical Student Societies to:

- a. Continue their engagement as a community stakeholder by working in collaboration with AMSA and medical education providers in the consultation of the graduate outcomes and assessment for medical students.



Background

THE AUSTRALIAN MEDICAL COUNCIL

The Australian Medical Council (AMC) oversees the accreditation of undergraduate and postgraduate programs in all 23 medical schools in the Australian and Aotearoa New Zealand Higher Education system[1] against one set of standards.[2] This accreditation process is purposed to regulate safe and competent practice across Australia and Aotearoa New Zealand, allowing graduates of these medical programs to seek general registration as a medical practitioner.[2]

The AMC's Medical School Accreditation Committee engages assessment teams to monitor, develop, and review the accreditation procedures of these medical programs, appropriate to their size and structure.[3] These include assessors from varying clinical disciplines, health professions, levels of governance, and geographic locations, incorporating consultation with community advisory committees where required.[2]

The quality of medical education is ratified through six accreditation standards covering[2]:

- Purpose, context and accountability;
- Curriculum;
- Assessment;
- Students;
- Learning environment; and
- Evaluation and continuous improvement.

GRADUATE OUTCOMES AND ASSESSMENT

Graduate outcomes describe the essential abilities of medical graduates at the conclusion of their degree.[2] These outcomes provide direction and clarity for the development of curriculum content, teaching and learning approaches, assessment programs, and guide relevant governance structures to provide resources and financial allocations.[2]

There are four main domains assessed as part of the graduate outcomes, being [2]:

1. Science and scholar;
2. Clinical practice;
3. Health and science; and
4. Professionalism and leadership.

Within these four domains, eight core clinical rotations are covered: emergency medicine/critical care, general practice, medicine, obstetrics and gynaecology, psychiatry, paediatrics, and surgery. These rotations include components that assess the interpretation of diagnostic procedures and application of procedural skills.[4]

Whilst it is acknowledged that students will not yet have the clinical experience, leadership skills, or advocacy of experienced practitioners, it is expected that they have a foundation in these areas prior to graduation.[5]

ASSESSMENT OF GRADUATE OUTCOMES

To achieve these graduate outcomes, the types of assessments utilised by Australian medical schools include, but are not limited to[5]:

- Objective structured clinical examinations (OSCE);
- Written clinical examinations;
- In-training assessment forms;
- Mini clinical evaluation exercises (Mini CEX);
- Case presentations; and
- Log books.

It is at the discretion of each medical school what assessment items they employ to assess their students' performance in achieving the graduate outcomes.[5]

APPLICATIONS OF GRADUATE OUTCOMES

Despite the push for increased assessment consistency between universities, there is currently no national barrier exam (NBE) in Australia.

There are variabilities in the assessment of graduate outcomes, which should continue to be addressed in order to standardise assessments in medical schools.[6] Despite this variability between medical schools, the literature proposes a common assessment framework.[7] This will ensure a common standard for graduates in lieu of a standardised NBE, while ensuring medical school curricula promote key graduate outcomes and underrepresented competencies like LGBTQIASB+ health. Additionally, continued collaboration between assessment frameworks should focus on higher predictive value assessments in Miller's Pyramid of Clinical Competence, such as through shared OSCE or long case scenarios.

According to the Medical Deans Australia and New Zealand (MDANZ), 'Given the variation in assessment blueprints provided from medical schools, using a common set of accreditation standards was viewed as the most appropriate way of developing a national clinical assessment blueprint relevant to all medical schools.'[6] This is due to a variety of reasons, mainly the variation in curricula across Australian medical schools, the timing of courses, and various medical schools' availability of examiners.[6] Many schools also use WBAs to judge clinical practice competence.[6]

The discussion around evidence for and against NBEs is an evolving area.[8] Some medical councils are considering implementing, or have implemented, such an exam.[9] In the UK, they have implemented a Medical Licensing Assessment, similar in function to the Australian Medical Council's (AMC) examinations for international graduates.[10] The AMC's job is to ensure that the various Australian medical school curricula are up to standard and ensuring that graduates achieve all graduate outcomes. Adding an NBE on top of this is superfluous and an extra cost for Australian medical students.

The variety of medical schools and areas of practice in Australia make a single NBE ineffective, and negatively impacts those who do their training in rural areas with different experiences that may not be covered by an NBE targeted towards metropolitan medicine. This is supported by MDANZ. Additionally, we believe that having an NBE diminishes the responsibility of individual medical schools to appropriately instruct and examine their students. If the entirety of medical school is assessed by a single external exam, one could argue that there is little point to attending medical school and being assessed internally.

Thus, AMSA believes that graduate outcomes across Australia should be held consistent by medical schools in conjunction with the AMC, and that an Australian- and NZ-wide common assessment framework should be the tool for ensuring this consistency.

GRADUATE OUTCOMES FOR INTERNATIONAL STUDENTS

The World Federation for Medical Education (WFME), overseen by the World Medical Association (WMA) and World Health Organisation (WHO), publishes global standards for medical education.[11,12] The AMC is accredited by the WFME until 2028, indicating that the Australian Graduate Outcomes are well-aligned with international policy.[13] The AMC has ongoing reporting obligations to the WFME to ensure continued compliance.[13]

REVIEW OF AUSTRALIAN GRADUATE OUTCOMES

The AMC graduate outcomes and accreditation standards are reviewed at a minimum of every 5 years, by committees composed of Australian and Aotearoa New Zealand medical education providers, peak professional bodies, medical students, health services, health consumers as well as Aboriginal and/or Torres Strait Islander and Māori people.[14,15] These teams report to the AMC's Medical School Accreditation Committee.[14]

The committee is responsible for overseeing the AMC's accreditation for primary medical education programs in Australia and Aotearoa New Zealand.[15] They advise the AMC on the guidelines, policy and procedures that comprise the assessment and accreditation process for medical programs, and encourage improvements in medical education that reflect evolving health needs, practices and scientific development.[15,2]

The committee also considers other relevant national and international reports and policies relating to education and training in medicine each review.[2]

Whilst the working committee itself contains stakeholders of key bodies, the AMC also consults further external stakeholders such as health jurisdictions, health consumers, health consumer representatives, and training sites, on the scope of the review.[1,3] Additionally, members of the public are invited to share their perspectives on the review's scope.[15]

It is important to note that all changes to accreditation standards and graduate outcomes must be considered by AMC committees, AMC's governing board and the AMC Directors, before implementation.[14] Membership of the current working group spans from senior AMC members, medical educationalists, medical practitioners, as well as a medical student from an AMC approved

program. It also included representation from at least one First Nations member and Māori member.[15] Moreover, under the National Law, the Medical Board of Australia approves accreditation standards developed by the AMC.[15]

The AMC's review occurs in three main phases. In Phase 1, the working committee conducts research and engages in consultation of stakeholders to confirm the scope of the review as well as the direction of key changes. In Phase 2, the working committee presents their specific proposal for change to the content and structure of the standards, and engages in further consultation to support this. During this phase, approval is also sought after via governance channels.[16] Phase 3 refers to the finalisation of the standards for implementation in which approval must be granted through AMC committees and AMC's governing board, the Directors.[14,16]

CONSULTATION FOR GRADUATE OUTCOMES

As part of the periodic review undertaken by the AMC, the incoming proposals are circulated to a range of stakeholders with a request for feedback.

The consultation process is 'iterative and responsive to the feedback received.'[17] Furthermore, the AMC specifies that medical students are entitled to participate in the development and review of medical school accreditation, and encourages students to develop their own submissions, discuss with members of the AMC assessment team, or contribute to their education provider's submission to the AMC.[18]

While there is currently a lack of research regarding the systematisation or prevalence of these practices, in 2019, the AMC conducted a joint survey with the MBA (Medical Board of Australia) on how well their medical education prepared them for internship. Of particular significance were areas reported by interns as 'underprepared', which included drug prescription and treatment of Indigenous patients; a report on this survey indicated the potential for these results to be integrated into future accreditation standards.[19,20] Likewise, it is known that a similar consultation process exists for the British medical education system headed by the GMC, with submissions from analogous peak bodies such as the Academy of Medical Educators.[21]

PROPOSED TOPICS FOR FUTURE AMC REVIEW

AMSA have identified key topics we believe should be addressed in future AMC reviews of the Standards for Assessment and Accreditation of Primary Medical Programs, chiefly in Digital Health, and Social Accountability. In consultation with stakeholders, LGBTQIASB+ health, Indigenous health, medical students living with a disability, and Climate Change and the environment have also been incorporated. This list is not intended to be comprehensive, but rather to provide important context for the work of advocacy. Moreover, while stakeholder groups have been discussed individually, it is important to apply an intersectional framework and recognise the compounding effects of overlapping identities when considering the impacts they may have on students' ability to meet graduate outcomes.

Digital Health.

Section D – Graduations & Internships, Action 4.4 of the AMC's Guidelines commits to supporting the "development of digital capabilities in medical education ... with the aim of developing a digitally capable medical workforce that drives higher standards of quality and improves access to healthcare." [22] However, in spite of the rapidly evolving digital health landscape, especially with the recent incorporation of artificial intelligence (AI) in healthcare, [23] the AMC's 2021 Digital Health in Medicine Capability Framework remains the most recent publication on accreditation for digital health learning in Australia. [24] Use of digital health also sparsely appears in the AMC's 2023 Standards for Assessment and Accreditation of Primary Medical Programs, both in terms of standards for students and medical education providers, focusing only on digital health literacy and equitable access. [2]

Despite the lack of formal institution of digital health into medical education curricula, a 2022 study found Australian undergraduate health profession students, especially younger students who used more digital devices and communication platforms in their everyday lives, were comfortable in their knowledge and use of health technologies. [25] This is a marked improvement from the 2019 Internship Preparedness Survey, in which participants reported low "Understanding the role of clinical informatics and data technology in improving healthcare", [26] reflecting how a higher baseline digital literacy seems to translate positively to eHealth literacy irrespective of formal training.

However, the onus of ensuring graduates are adequately equipped with digital health skills should be placed on medical educators, to ensure both staff and patient safety in a world where digital health technologies are increasingly dominating the workplace. [25] Within Australia, trial programs amongst nursing students have demonstrated enhanced preparedness to use digital health technologies in clinical practice. [27] Moreover, the burden of using electronic health systems has also been linked to clinician burnout, making competency a workforce wellbeing issue rather than just one of patient health. [28] Embedding digital health into the core curriculum, rather than requiring graduates to pick it up on the job, is essential. Competency in using electronic health records, electronic prescribing, and medical AI should be established before graduation, with structured export during clinical placements, and adopted as a nationally recognised graduate outcome, so that graduates are well-equipped to work as interns. Interestingly, in the 2022 study, socioeconomic status was not found to be associated with lower reported comfort using digital health technology; nevertheless, if access to paid services are required as part of training, such as clinical AI subscriptions, the responsibility should be on universities to make provisions to ensure equitable access. [25]

Promisingly, the Australian government has recently recognised the importance of embedding digital health education into university degrees and made steps to support a consistent approach at a national level. In 2025, the Australian Digital Health Agency in collaboration with the Australian Council of Senior Academic Leaders in Digital Health launched the National Digital Health Capability Action Plan to review current national competency frameworks and education course

content, develop standardised core topics, and support educators in teaching digital health.[29] They have provided medical educators with resources such as the Digital Health Train the Trainer Toolkit, to support integrating digital health into their curriculum.[30] Universities can also look to incorporate elements or adapt their current or previous courses.[31] Moreover, international studies have made comprehensive recommendations on implementation strategies and suggested graduate outcomes to assess the success of digital health education programs. Many common trends emerge, with some examples including domains of professionalism and communication in digital health.[32-35]

Additional consideration must be given to students in rural and remote locations with potentially limited access to digital health. Despite the prominent role of telehealth in these areas, there is unfortunately lower digital connectivity due to poorer infrastructure, which may lead to reduced access for students and opportunities to train in eHealth.[36,37] In rural settings, telehealth may also be used to have challenging conversations such as discussing treatment plans, or delivering bad news, that would ideally happen face-to-face. Thus, training in digital health should extend not only to skills in using technological platforms but also how to maintain rapport with patients. In order to produce graduates more prepared and empowered to practice rurally, medical schools model and incorporate elements of The Australian College of Rural and Remote Medicine's Framework and Guidelines for Telehealth Services.[38]

Digital health teaching must also be accessible for students with disabilities, and equip all graduates to use these systems with patients who have sensory or communication difficulties. This includes ensuring that telehealth platforms support interpreters and assistive technology, and that patient information can be adopted into easily read materials/read aloud.

Finally, the integration of AI tools raises ethical questions that medical schools are only beginning to address. While patient data may be inputted into AI for tasks such as summarising notes, or supporting diagnoses, graduates must understand the privacy and consent implications of doing so.[39] Outcomes addressing the safe and appropriate use of clinical AI should also be incorporated into any digital health curricula being developed.

Social Accountability as an Accreditation Standard.

Under the World Health Organization's definition of social accountability as "the obligation to direct their [medical schools'] education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have an authorization to perform", the AMA identifies a gap in the AMC's Standards for Assessment and Accreditation, which lacks clear defined and measurable outcomes for social accountability.[40,2] One such health concern specific to the Australian landscape is the access to and delivery of health services in rural, regional, and remote areas, due to lower access to both physical resources, and health practitioners.[36] There is clear evidence that medical students who have extended rural clinical experience are more likely to practice rurally in both the short and long term up to 5 and even 8 years post graduation.[41-43] However the only currently standards of social

accountability placed on medical schools are Standard 2.18, which requires graduates to “Critically evaluate their own professional practice ... to contribute to culturally safe health environments, with particular awareness of Aboriginal and/or Torres Strait Islander and Māori communities,” and Domain 3, which addresses health inequalities and systemic change “in a socially accountable and environmentally sustainable manner.”[2] In order to address the current imbalances in workforce distribution, medical schools should be required to empower graduates to practice rurally, by providing them with experience and training in the generalist competencies and skills required to practice in rural and remote communities.

First Nations Health.

The Australian Government Department of Health developed a Graduate Cultural Capability Model within the Aboriginal and Torres Strait Islander Health Curriculum Framework to support education providers in the five pillars of; respect; communication; safety and quality; reflection; and advocacy.[44] Accreditation of these outcomes falls under the Health Practitioner Regulation National Law Act,[45] which requires building of capacity for culturally safe healthcare and mandates programs be responsive to First Nations Peoples. There is capacity for this to be strengthened via development of dedicated working groups to review teaching, assessments, and curricula. AHPRA's Code of Conduct affirms practitioners' responsibility to acknowledge the multisystemic factors impacting individual and community health for First Nations Peoples, address individual biases, make space for self determination, and foster a safe working environment.[46] In parallel, a sub group of the AMC Aboriginal and/or Torres Strait Islander and Maori committee has been constituted to assist in leading the scoping, review and development work of the AMC.[16] reflected in the revised AMC Accreditation Standards.[2] These require Australian medical graduates to describe the ongoing impact of colonisation, intergenerational trauma, racism, systemic biases, implicit clinician biases, and structural barriers on First Nations and Maori healthcare. The standards mandate First Nations and Maori leadership for relevant curriculum innovation and authorship, alongside broader curriculum integration.[2]

LGBTQIASB+ Health.

LGBTQIASB+ communities in Australia experience significant health inequities and disparities relative to the general population,[47-49] with these outcomes compounded by a lack of inclusive medical and health care provider practices.[48,50,51] Current AMC standards provide an important broad pathway for LGBTQIASB+ health education through requirements relating to community groups experiencing health inequities, inclusive care, curriculum outcomes and assessment. However, LGBTQIASB+ health is not currently named as a distinct minimum competency or consistently assessable curriculum requirement.[2] This creates a grey zone: medical schools can include LGBTQIASB+ health within existing accreditation expectations, but the depth, quality and clinical applicability of that inclusion remain vulnerable to local interpretation, curriculum crowding and reliance on individual champions.

Australian research finds that students regard LGBTQIASB+ health education highly, yet lack confidence in preparedness to provide care for LGBTQIASB+ people, highlighting a gap less in understanding, but in practical application.[52] This is primarily the result of limited preclinical content coverage, including unfamiliarity with affirming terminology, inadequate understanding of gender-affirming care pathways, and potential unconscious bias.[52] Additionally, almost 90% of surveyed students across 21 Australian medical schools reported zero LGBTQIA+-specific clinical exposure or rotations, with teaching varying significantly between universities.[52] This aligns with international findings suggesting that without structured compulsory medical education, LGBTQIA+ health literacy amongst graduating doctors is inconsistent and largely dependent upon individual initiatives, or becomes the burden of those with lived experiences.[53,54]

Formal revision of the AMC graduate outcomes and accreditation standards relating to competency in provision of healthcare to LGBTQIASB+ communities is not scheduled to be considered in the near term.[17] However, meaningful progress can be made presently through interim changes to the AMC Guidance Matrix. The AMC states that “the aim of the Guidance Matrix is to share AMC accreditation expectations and current good practice related to the standards with medical schools, AMC assessment teams and reviewers, and other key stakeholders.”[55] Medical schools may provide examples of their inclusion of LGBTQIASB+ Health in curricula and assessment, mapped to the accreditation standards set for community groups experiencing health inequities, in submissions to the AMC. This will provide medical schools with accessible and realistic benchmarks for meeting the existing standards through inclusion of LGBTQIASB+ Health.

Assessment of Students with Disabilities.

The AMA recognises the benefit to patients of ensuring the medical workforce reflects the communities they serve, including those with lived experience of disability.[56] Assessment in medicine should take an outcomes-based approach, rather than examining the methods of accomplishment [57]. Students may demonstrate capacity through a broad range of strategies, including the use of reasonable adjustments that allow students to effectively and equitably demonstrate their capacity to meet graduate outcomes [58].

Medical Deans Australian and New Zealand emphasise the importance of making reasonable adjustments [59], which are personalised and tailored to meet the individual requirements and circumstances of students with disabilities [60]. This is reflected both internationally,[61] and in the AMC’s 2023 Standards for Assessment and Accreditation in Standard 4.2.3: “Students who require additional health and learning support, or reasonable adjustments/accommodations, are identified and receive these in a timely manner.”[2] A/Prof Laura Gray and the Australian Government highlight that for an adjustment to be deemed unreasonable, it must fundamentally alter the competency being assessed. Reasonability is not determined by the extent to which it mirrors the methods of a non-disabled student, nor by hypothetical reproducibility in any other contexts including but not limited to hospital settings

or training programs. The process of reasonable adjustment extends to teaching, learning, and assessment throughout all stages of medical education, including but not limited to admission, non-clinical and clinical examination, non-examination hurdles such as placement requirements, and all other components of the medical degree. In addition to generic educational provisions such as additional time and use of assistive technologies, support specific to medical training may include flexible placement hours, as suggested by the AMA's position statement, and review of technical graduate requirements.[56]

Some advancements have been made in addressing challenges to creating an inclusive learning environment - for instance, previously controversial requirements for graduates to demonstrate specific skills such as providing CPR in the 2019 AMC Standards for Assessment and Accreditation, which had been a point of objection in the 2022 AMSA Policy Statement about Medical Students With Disabilities, are no longer present in the current 2023 Standards.[2,62]

Climate Change & the Environment.

Another gap identified within the Australian Medical Council standards is the limited recognition of climate change, environmental determinants of health, and environmentally sustainable healthcare within graduate outcomes. Current standards only broadly reference "physical environment risk factors," which does not adequately reflect the health impacts of climate change on population health.[63] These include not only increasing burdens of heat-related illness, respiratory disease, infectious disease transmission, and disproportionate impacts on vulnerable populations, but also significant mental health consequences such as climate anxiety, trauma associated with natural disasters, and worsening psychological distress following climate-related events.[64] Evidence shows that climate-health education across medical schools remains inconsistent and insufficient, with major gaps in curriculum coverage identified across Australia and New Zealand.[65] Despite this, there is strong support from medical students and professional bodies for stronger integration of climate-health education into medical training. International frameworks demonstrate that climate-health competencies can be embedded within patient care, professionalism, and systems-based practice.[66-68] As the Australian Medical Council reviews its accreditation standards, there is a timely opportunity to incorporate explicit climate-health competencies into graduate outcomes, supported by curriculum integration and formal assessment including written examinations; OSCEs relating to climate-related health emergencies; and workplace-based assessments to ensure application in clinical practice. Such scenarios could include but are not limited to pollutant related asthma, heat stress, subtropical malaria, weather disasters, diarrhoea, and malnutrition.[69] The MDANZ Climate Change and Health Working Group could be used as a template for this review.[63]

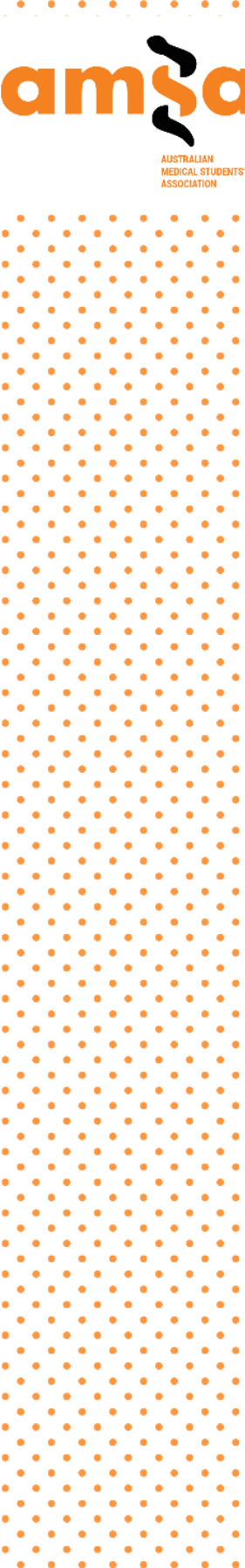
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Policy Details:

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History: Reviewed, Council 2, 2026

Waveney Wood (Lead Author), Akina Hanzhang Li (Lead Author), Rishi Adoni Sivakumar, Noriaki Jayasekara, Jordan Dennis, Helen Lovegrove, Zoya Saiid, Kahan Bhatt, Noriaki Jayasekara, Sahansa Udawatta; with Anna Baxter (National Policy Mentor), Sricharan Prassanna (National Policy Mentor), Santi Chua (National Policy Secretary), and Swetha Kumar (National Policy Officer).

Reviewed Council 3, 2022

Hemani Mahendra Raj (Lead Author), William Huang (Lead Author), Emily Crameri, Jahnvi Grover, Allen Xiao, with Leon Latt (National Policy Mentor), Alexandra Wilson (National Policy Mentor), and Ashraf Docrat (National Policy Officer).

Reviewed, Council 1, 2018

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Adopted 2010