Australian Medical Council Limited

Review of the Standards for Specialist Medical Programs: Consultation on detailed proposals for change

Part 2 - Response template

Your feedback

We would like to hear your perspectives on the detailed proposals for change to the Standards for Specialist Medical Programs.

We are seeking feedback by ~~**1 May 2026**~~ **15 May 2026**.

Please provide your response, by email, as a **word document** or non-protected PDF document using this template to standardsreview@amc.org.au.

This template

This template provides questions related to major themes arising in the standards review. This template should be read in conjunction with **Consultation paper - Standards for Assessment and Accreditation of Specialist Medical Programs detailed proposals for change**, which outlines the background and review process, major drivers shaping the review and key proposed changes to the structure and content of the standards. The full set of proposed revised standards are contained in **ATTACHMENT A**: Draft Standards for Assessment and Accreditation of Specialist Medical Programs for consultation.

We recognise that not all questions (either in whole or in part) below will apply to all stakeholders, please only respond to those that are of relevance to you. There are spaces for general comments.

Your information

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Note: The AMC may contact you to seek consent to publish your response on the AMC's website.

Consultation questions

Themes covered within these consultation questions are across all of the standards.

Questions relating to the standards for specialist medical programs
1. Alignment and responsiveness to community needs 1A. Proposed changes to the standards aim to strengthen the providers' role in serving their communities through education and training, including alignment with the needs of Aboriginal and/or Torres Strait Islander peoples and Māori and groups that experience health inequities such as the LGBTQIA+ community, as well as incorporating considerations of planetary health. Do the proposed standards adequately support meaningful engagement and partnership with diverse communities, and responsiveness to their needs, in the design and delivery of education and training? If not, what further revisions might be required?
ANZCA supports the intent of the proposed standards to strengthen community responsiveness, equity and partnership, including with Aboriginal and Torres Strait Islander peoples, Māori, LGBTQIA+ communities and those experiencing health inequities. We note, however, that the revised standards represent a significant expansion of colleges' accountability in areas where influence is often indirect and shared with employers, health services and jurisdictions (i.e. Australian Department of Health, state/territory Departments of Health, NZ Ministry of Health). Effective engagement requires both parties to contribute. While ANZCA can meaningfully contribute through curriculum design, accreditation processes, advocacy and partnerships, colleges do not control many determinants of the training environment or service delivery. Further clarification is needed regarding: ● The scope of college responsibility versus employer responsibility. ● What constitutes proportionate and achievable evidence of engagement. ● How expectations should be calibrated for binational colleges operating across different health systems. The standards would be strengthened by clearer guidance on acceptable models of partnership, including recognition of resource constraints and the need for appropriately funded and supported engagement with communities. To reduce risk of inconsistent interpretation, we recommend: ● Clarifying 'community need(s)' and the AMC's expectations for a 'methodology' and resourcing (Standards 1.1.1, 1.3.1, 1.3.2, 2.1.1, 5.1.1, 6.1.1). We note there is ambiguity and overlap between 1.3.1 and 1.3.2, and we recommend clarifying these requirements and specifying what constitutes an adequate approach. ● We note there is unintentional duplication where equivalent requirements sit in separate AMC frameworks (e.g., Model standards for specialist medical college accreditation of training settings vs the standards for assessment of specialist medical programs). We note that Standard 4 (education and training environment) may overlap with, or be redundant alongside, the Model Standards for specialist medical college accreditation of training settings. We ask the AMC to clarify the relationship between the two sets of standards. ● Resourcing and feasibility of Indigenous participation "at all levels": While ANZCA supports the focus, there is a practical constraint that needs to be recognised, including the limited Indigenous specialist workforce and the risk of overburdening a small number of individuals. We recommend the standards explicitly acknowledge workforce constraints, with consideration of appropriate

remuneration/resourcing for Indigenous leadership that allow scalable partnership models (including cross-college approaches).

1B. Proposed changes to the standards aim to support innovation and flexibility, and the expansion of training into rural and regional settings.

Do the draft standards sufficiently enable high-quality rural and regional training opportunities? Are there any potential unintended consequences that haven't been identified, in particular for the Aotearoa New Zealand context?

ANZCA supports the intent to expand and strengthen high-quality rural and regional training. We agree that flexibility and innovation are required to meet workforce needs while maintaining program quality.

We note that enabling rural training often requires collaboration with employers and health services, and standards should reflect this shared accountability.

We recommend the AMC:

- Clarify what is expected of colleges versus employers/jurisdictions in enabling rural training capacity. The majority of specialist medical colleges, including ANZCA, do not control funding, staffing, rostering, or HR processes that determine actual training capacity, and we request clearer boundary-setting within the standards.
- Provide guidance on how flexibility can be implemented without unintended impacts on training quality or progression.
- Provide guidance on what constitutes sufficient evidence of quality and supervision in rural and regional contexts.
- Provide a definition of 'generalism'.
- Acknowledge compressed workforce realities in smaller rural settings where separation of roles (supervisor/assessor/support) and conflict of interest management may require cross-site or external arrangements.
- Explicitly recognise bi-national and jurisdictional differences, particularly in Aotearoa New Zealand. It is important these standards are achievable and appropriate across the binational context, and that if standards extend into Aotearoa New Zealand, the differing legal/employment arrangements should be explicitly considered.

1C. Do you have any further comments in this area?

We encourage the AMC to clearly distinguish between aspirational direction-setting and accreditable requirements, to ensure standards remain achievable and meaningful across diverse contexts.

2. Cultural safety

2A. In relation to cultural safety, do the proposed revisions to the standards clearly identify what is required for the education and training of safe and competent specialist medical practitioners? If not, what further revisions might be required?

ANZCA strongly supports the emphasis on cultural safety and agrees this is a core capability of safe and competent specialist medical practitioners.

To strengthen feasibility, we recommend:

- Making resourcing explicit for relevant standards, recognising workforce capacity limitations, particularly the availability of Aboriginal, Torres Strait Islander and Māori experts; Indigenous input/leadership must be appropriately resourced and remunerated, not dependent on volunteer labour, particularly in smaller specialties.
- The AMC to consider whether these requirements sit more appropriately in the Model standards and procedures for specialist medical college accreditation of training settings.
- Explicitly support cross-college collaboration in this regard to help overcome workforce constraints in meeting cultural safety requirements and build shared capabilities.

2B. Do you have any further comments in this area?

We support the inclusion of a data sovereignty requirement (Standard 1.1.13) but note it is a complex area that will require clear AMC guidance on expected evidence and proportional implementation pathways across diverse college contexts.

We support strengthened cultural safety expectations, provided they are embedded in ways that are realistic, proportionate and sustainable.

3. Selection into training and retention

3A. Do the proposed revisions to standards sufficiently emphasise transparency in selection criteria and processes? If not, what further revisions might be required?

ANZCA supports the emphasis on transparency in selection criteria and processes. This aligns with current ANZCA reforms and the principles underpinning competency-based medical education.

Further guidance on minimum expectations for transparency and documentation would assist in ensuring consistent interpretation across colleges. We would also caution against the use of the word ‘prevent’ in contexts where colleges cannot guarantee absolute prevention.

3B. The proposed revisions to the standards require collection and analysis of selection data and its impact on progression. Do you have any further comments on evaluation of selection processes?

ANZCA supports the requirement to collect and analyse selection data to evaluate impact on progression and outcomes.

To support consistent implementation, we recommend the AMC:

- Provide guidance on proportional evidence expectations, noting that sophisticated data collection/analysis requires infrastructure and analytic capability, and may be challenging for colleges without dedicated resourcing.
- Clarify key terms such as ‘equity groups’ (Standards 1.3.3, 5.1.3, 5.2.3) to avoid inconsistent interpretation.
- Consider privacy and data governance obligations.
- Recognise the complexity of attributing outcomes to selection processes alone.

3C. Proposed revisions to the standards clarify that contribution to workforce is relevant for accreditation bodies within the National Law, this includes workforce development that promotes equitable access to services and a capable workforce across rural, regional and metropolitan settings in both Australia and Aotearoa New Zealand.

Do proposed revisions to standards support strategic priorities related to workforce needs in Australia and Aotearoa New Zealand?

We support the intent to link education and training to workforce distribution and equitable access to services.

It is recommended the AMC clarify:

- What 'workforce needs' means in practice, and how it should be used in selection policies (Standard 5.1.1) and broader program design (Standards 1.3.2, 6.1.1). We also seek clearer definitions and guidance, including whether the AMC referring to 'workforce supply/demand' concepts rather than 'needs'.
- The degree of expectation on colleges, noting workforce growth can be limited by system-level funding and incentives, beyond college selection processes alone.
- How binational workforce planning considerations will be incorporated.

3D. Do you have any further comments in this area?

The intent of these standards is supported, but clearer boundaries of responsibility and proportional expectations are essential.

We note the revised standards represent a material increase in operational expectations around complaints, reporting pathways, escalation and monitoring, which has direct resource implications and may require additional AMC guidance to support proportional implementation.

4. Curriculum content and specialist medical program outcome statements

Colleges define what the trainee has to learn in order to become qualified as a consultant in their specialty. As part of the work of this review, the AMC is developing specialist medical program outcome statements that are common across specialties. Colleges have done extensive work in this area, and the development of non-specialty specific statements does not diminish existing frameworks. The purpose of this work is to compare existing outcomes across colleges and identify commonality to provide a consistent level of expectations at the end point of all specialty programs. These draft outcome statements do not cross into the specialty-specific or technical skills space.

Draft outcome statements across specialties include but are not limited to the areas of communication, collaboration and interprofessional practice, professionalism, leadership and supervision, culturally safe and ethical practice, quality and safety and reflective practice, resource stewardship, digital capability and socioeconomic awareness. The AMC will consult on the specialist medical program outcome statements in the coming months.

The AMC is also planning to develop a process to support AMC monitoring of revised curriculum standards.

4A. Do you have any comments on the revised standards regarding curriculum content or specialist medical program outcome statements?

We note the AMC is developing common specialist medical program outcome statements across specialties and will consult on these separately.

To support consistent implementation, we ask the AMC to:

- Define and identify differences between program outcomes and graduate outcomes, particularly across the continuum of undergraduate, prevocational, and specialist training, to avoid ambiguity and duplication. Specifically, there is a lack of clarity regarding the level at which Program outcomes are defined. It is unclear whether these outcomes pertain to the position of the specialist program within the wider health service delivery system. Greater definition and distinction in this area would be helpful to ensure consistency and understanding across all levels of medical education and training.
- Clarify how the AMC expects colleges to align existing curricula and mapped outcomes with AMC's proposed common outcomes, including whether AMC will provide additional supporting guidance such as learning outcomes, recommended experiences, educational approaches/resources, or assessment blueprinting expectations.

5. Governance, leadership and resources

5A. Do the proposed revision to standards provide sufficient assurance that an education provider has appropriate resources and a framework to support training functions, including robust educational governance and meaningful representation in decision making? If not, what further revisions might be required?

ANZCA agrees that strong governance and resourcing are essential to quality training.

We note the revised standards substantially strengthen governance and accountability expectations, including wellbeing culture, broad representation, Indigenous participation in governance, appeals/review processes, and data sovereignty in the revised standards.

However, the revised standards represent a substantial shift in expectations regarding oversight of training environments, complaints management and stakeholder engagement.

We recommend the AMC:

- Provide clarity on what constitutes sufficient assurance where colleges are not employers
- Differentiate "do/ensure" versus "influence/monitor/escalate" in standards that implicate employer-controlled matters such as wellbeing/OHS, HR processes, rostering, workload, and local site culture.
- Explicitly build proportionality into evidence expectations and acknowledge resource implications, particularly for smaller faculties and constrained workforce environments.

5B. Do the proposed revisions to standards sufficiently emphasise meaningful engagement and partnerships with groups such as Aboriginal and/or Torres Strait Islander and Māori community and community organisations, and consumers and consumer organisations?

ANZCA supports meaningful engagement with Aboriginal, Torres Strait Islander and Māori communities, consumers and community organisations.

We note the standards expect significantly strengthened partnerships with consumer / community organisations and Aboriginal and Torres Strait Islander and Māori people / organisations, including participation at 'all' levels of the program and organisation, and partnership in specific aspects including defining program outcomes, curriculum and assessment design, and program evaluation.

We recommend the AMC to:

- Frame these expectations in ways that are feasible and avoid overburdening small Indigenous workforces, including explicit recognition of resourcing/remuneration and cross-college partnership models.

5C. Do you have any further comments in this area?

We note the timeframe and scope of change appears to be significant and ask the AMC to ensure the standards are achievable as an accreditation threshold, or otherwise clearly framed as aspirational with appropriate implementation guidance.

6. Trainee support, wellbeing and connection into colleges

6A. Proposed revisions to the standards emphasise the importance of psychologically safe training environments for trainees, support systems at the local and college level and safe and trusted pathways for reporting. While providers are not responsible for workplace health and safety, the standards recognise they are expected to demonstrate responsiveness to concerns raised by trainees and others.

Are the areas of trainee wellbeing, support and connection into colleges sufficiently emphasised across the standards? If not, what further revisions might be required?

ANZCA supports the emphasis on psychologically safe training environments and trusted reporting pathways.

We note the revised standards place substantially greater emphasis on trainee wellbeing, psychologically safe training environments, safe reporting pathways, partnerships with employers for resolution of concerns, and separating support from progression decisions.

While ANZCA supports the intent of these revised standards, we also wish to highlight feasibility issues as colleges lack direct control of workplace conditions and small training environments make separation of roles challenging.

Expectations regarding complaints handling, escalation and monitoring represent a significant operational shift and should be accompanied by guidance on proportional implementation.

We recommend the AMC:

- Provide clear guidance on distinguishing between college responsibilities and employer workplace health and safety obligations.
- Provide clear guidance on proportionate implementation of college responsibilities.
- Acknowledge that trainee wellbeing is the responsibility of employers too. The phrase in the introduction of standard 5 – “Trainee wellbeing is managed throughout the program and is based on a trusted relationship with those providing training settings” – could mean the program and/or the employer. Specialist medical training programs can advocate for their trainees but are fundamentally unable to control much inherent in workplace safety. Additionally, a program, and even an employer, cannot solely be responsible for underpinning trainee wellbeing.
- Reconsider the use of the word ‘prevent’ in relation to Standard 5.1.2, as it would not be possible for a college to control the absolute prevention of racism, discrimination, and bias. While ANZCA can implement policies to identify and address bullying, harassment, racism, and discrimination in order to modify the behaviour of ANZCA supervisors, it does not have jurisdiction over other professional groups with whom trainees work every day.

6B. Do you have any further comments in this area?

We would recommend revising wording that implies colleges can “prevent” workplace behaviours beyond their jurisdiction and recognising the shared responsibilities across multiple actors (colleges, employers, jurisdictions).

7. Assessment

7A. In the area of assessment, do the proposed revisions to the standards identify what is required for safe and competent specialist medical practitioners? If not, what further revisions might be required?

We support the focus on outcomes-based assessment and safe, competent practice. This aligns with ANZCA’s work in competency-based medical education.

We suggest the AMC consider:

- Clarifying what constitutes ‘reasonable adjustments’, ‘special consideration’ and ‘as required’ in, to enable consistent interpretation (Standard 3.1.7).
- Clarify expectations for ‘collaboration with others in the education and training sector, as this is currently open to interpretation (Standard 3.2.2).
- How information sharing should operate within privacy/confidentiality constraints (Standard 3.4.3).

7B. Do you have any further comments in this area?

We support stronger assessment governance and quality assurance expectations but emphasise that meeting these requirements will require adequate educational expertise, analytic capacity, and IT/data infrastructure, which may be particularly challenging for smaller specialties.

8. Training model reliant on supervisors

8A. The current training model is reliant on supervisors. To acknowledge this, the proposed revised standards place greater emphasis on supervisor support and connection to the college. The proposed revised standards align with the prevocational approach within the *National standards and requirements for prevocational (PGY1 and PGY2) training programs and terms*, requiring supervisors have training in specified areas. This would not need to be college specific training but ensures that supervisors have access to training in supervision, assessment and feedback, and cultural safety. This standard is also intended to support the collaboration of colleges in the area of supervision, such as the RANZCO-led Standardised Supervisor Training System (SSTS) initiative being developed by a consortium of specialist medical colleges and related initiatives.

Do you have any comments on potential opportunities or challenges in implementing this requirement, including any considerations about recognising prior training across the medical education continuum?

We support the increased emphasis on supervisor capability, training, and support, including the expectation that supervisors have training in supervision, assessment and feedback, and cultural safety.

We believe that:

- Small programs and rural settings may have limited supervisors, and separating supervisor, assessor and support roles and managing conflict-of-interest may require cross-site or external arrangements. The Standards should explicitly recognise this and enable suitable solutions.

- Recognising prior supervisor training across the medical education continuum is important.
- Expectations regarding supervisor oversight must reflect resourcing available.
- Provide definitions for “professionalism etc” (4.1.1.)
- Further define Standard 4.1.2, and whether this standard intends to address those involved in clinical supervision and formal teaching and, if intended, separate from supervision of training. Clinical teaching occurs in most training settings utilising most senior medical officers, and often “selection” of these individuals is up to the employer not the training program. Formal selection is important for those supervising training, although this is not actually stated.
- Review Standard 4.1.3 and 4.1.6 as they appear to overlap.
- Clarify of Standard 4.3.2 should refer to “wellbeing” (as opposed to “welfare”).
- Standard 4.3.2 (“…ensure trainees have access to educational resources…”) appears to overlap with Standard 4.2.5.

8B. Do you have any further comments in this area?

We support cross-college collaboration initiatives to support supervision training and recognise prior learning across the education continuum, and recommend AMC provide guidance on acceptable recognition of prior training and how it can be evidenced.

9. Accreditation of training sites

9A. The proposed revised standards provide the authorising environment for the *Model standards for specialist medical college accreditation of training settings* developed as part of the work to implement the recommendations within the *National Health Practitioner Ombudsman’s report on college accreditation of training sites*. Do you have any comments in this area?

We support aligning the specialist program standards with the Model standards/Procedures for accreditation of training settings. We note the revised Standard 4.3.1 explicitly requires colleges to adopt and apply the Model Standards/Procedures.

We recommend that the AMC:

- Align the terminology Replace “training sites” with “training settings” to match Model Standards terminology across the standards (e.g. Standards 1.1.6, 1.4.1, 4.3 and sub-standards).
- Clarify and avoid duplication: We note parts of Standard 4 (particularly 4.3.2) may be redundant given mandatory application of the model standards, and we ask the AMC to clarify the distinct role of Standard 4 relative to the Model Standards/Procedures.
- Clarify “jurisdictions” and “private health system” language in Standard 4.3.3 to avoid ambiguity and recognise the diversity of funding mechanisms and workforce planning arrangements across Australia and Aotearoa New Zealand.

10. Evaluation and safety and quality

10A. The proposed revised standards emphasise evidence informed reflection, evaluation and quality and safety across all of the standards. They require that providers articulate their overall approach to evaluation and continuous improvement (Standard 6), but also that they provide specific examples of analysis and reflection on various aspects of their education function.

Do the proposed revised standards sufficiently identify good evaluation and quality and safety practices? If not, what further revisions might be required?

We support the expectation that evaluations be aligned to workforce/community need, trainee wellbeing, cultural safety and equity, and incorporate broad stakeholder input.

However, we believe the higher expectations regarding data collection and analysis and community partnership represent a significant resource commitment.

We recommend that the AMC:

- Make proportionality explicit in evidence expectations.
- Recognise resourcing requirements for enhanced evaluation (IT systems, analytic capacity, consumer engagement).
- Provide guidance on acceptable evaluation methodologies and examples of good practice.
- Clarify or merge Standards 6.1.6 and 6.2.1, which appear to overlap and duplicate each other.

10B. Do you have any further comments in this area?

We believe that evaluation of de-identified appeals and complaints to resolve systemic issues (Standard 1.1.12) are conceptually sound, but will require clear AMC guidance on evidence thresholds and proportionality, and may require additional infrastructure.

Overall

11. Any other comments

11A. From your perspective, in your role or at your organisation, is there anything not covered in the consultation paper or in the consultation questions that you think needs to be a focus for the direction of changes to be made to the standards? Are there any additional opportunities you don't think have been identified?

Overall, we believe the proposed revised standards represent a substantive increase in expectations of specialist medical colleges regarding public accountability, equity and community responsiveness, transparency requirements, and oversight of the training environment – with significant operational and resourcing implications.

We support the overall direction of the revised standards, particularly the strengthened emphasis on cultural safety, community responsiveness, trainee wellbeing, and evaluation/continuous improvement.

We suggest the AMC can strengthen the final documents by:

- Clarifying scope, distinguishing what colleges must do/ensure versus what they can influence/monitor/escalate (given the legal and practical responsibilities that sit with employers/health services and jurisdictions).

- Achievability and implementation support: If these standards are to be used for accreditation decisions, they must be achievable and either confined to what colleges control or be accompanied by mechanisms that also hold employers/jurisdictions accountable for what they control.
- Embedding proportionality and feasibility, particularly for smaller specialties/faculties and for rural/regional settings where supervisor and workforce capacity is constrained.
- Improving the wording in instances as outlined above.
- Providing clearer definitions and guidance, especially for terms such as “community need(s)”, “workforce needs”, “equity groups”, and ambiguous phrases such as “reasonable” adjustments.
- Ensuring the revised standards align with the Model Standards/Procedures for accreditation of training settings, including consistent terminology (e.g. “training settings” rather than “training sites”).
- Clarify and defining ‘selection targets’ (5.1.2) and define how effective approaches to selection will be measured (standard 5.1.3).