Curriculum educators' perceived challenges in applying quality assessment criteria

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Article Info

ABSTRACT

This cross-sectional quantitative study investigates the implementation challenges of national quality assurance (QA) in Vietnam's higher medical education system, with a focus on faculty engagement and educator perception during medical curriculum redesign. Conducted at Pham Ngoc Thach University of Medicine, a public institution dedicated to professional healthcare qualifications, the study applies the Ministry of Education and Training (MOET) quality assessment framework, which defines 11 standards central to quality assessment implementation in various domains. Results reveal that standard 4 (teaching and learning approach) received the lowest average score, highlighting significant barriers to implementation. Standards 1, 3, and 5 also emerged as areas of concern. Difficulty in applying quality assessment criteria varied by educator characteristics: younger, less experienced faculty with limited academic credentials, and no prior quality assessment training reported greater difficulty, while senior educators with quality assessment training demonstrated higher compliance and ease in application. To strengthen educator compliance and enable effective QA implementation, the study recommends targeted training programs and support resources for faculty, particularly for early-career educators. These findings offer practical guidance for policymakers, administrators, and academic leaders involved in medical curriculum redesign and QA reforms within Vietnam's higher education landscape.

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1. INTRODUCTION

A medical curriculum encompasses not only syllabi and courses but also clearly defined aims, content, teaching methods, and evaluation processes that facilitate student learning [1]. Historically, conventional education systems differed significantly from modern ones, the former had a strong focus on traditional knowledge, rote learning, and limited student agency, rather than professional skills or critical thinking. Quality in medical education is commonly defined as the "state of reaching required standards as prescribed by external agencies, and meeting those standards time and time again" [2], highlighting that educational quality is relative to established benchmarks. In Vietnam, quality assurance (QA) in higher education was initiated in the early 21st century, with institutions aligning program learning outcomes (PLOs) to the National Vietnamese Qualifications Framework [3]. Some early efforts shared experiences in

aligning curricula with new standards and noted challenges in this process [4], [5]. However, systematic implementation of quality assessment standards in curricula has proven difficult.

The landscape of Vietnamese medical education is undergoing significant transformation supported by the Ministry of Education and Training (MOET) and the Ministry of Health (MOH). The basic medical education system comprises a 6-year undergraduate Doctor of Medicine (MD) program. Upon completion, graduates may pursue postgraduate medical degrees (master's or doctorate). Pham Ngoc Thach University of Medicine (PNTU) offers both undergraduate and postgraduate programs to train healthcare professionals. The master's curricula include both coursework and a research (thesis) component. Although all universities follow MOET's broad framework for postgraduate programs, in practice each institution's curriculum varies in structure and content [6]. Such variability exists despite a national framework, reflecting differences in institutional resources, areas of specialization, and educational priorities.

To ensure minimum standards, MOET issued Circular 04/2016/TT-BGDĐT, establishing 11 quality assessment standards (MOET-QA) for higher education programs (adapted from the ASEAN University Network Quality Assurance (AUN-QA)) [7]. These standards cover areas from program expected outcomes and curriculum design to teaching, assessment, resources, and program effectiveness. Implementing this quality assessment framework has presented various challenges. Universities face organizational, financial, cultural, and administrative hurdles in meeting the criteria. Academic staff may resist changes due to heavy workloads, resource limitations, or stress associated with new requirements [8]. Prior studies on Vietnamese higher education have indeed identified staff resistance and limited QA expertise as major barriers to QA implementation. Moreover, many faculty remain unconvinced of the relevance of certain quality assessment criteria, perceiving some externally imposed standards as lacking legitimacy. This skepticism can lead to inconsistent compliance with quality measures [9]. While Vietnam has officially adopted a comprehensive national quality assessment framework, this study uncovers a striking paradox: educators report full formal compliance with quality assessment standards, yet significant challenges persist in practical implementation. This discrepancy—a phenomenon that may be termed discrepant compliance—raises critical questions about the depth and authenticity of quality assessment adoption in higher education, particularly in postgraduate medical programs. Highlighting this paradox provides a critical lens through which educator perceptions can be examined. While earlier studies have explored general resistance to QA reforms, few have examined how individual quality assessment criteria are perceived by faculty directly involved in curriculum delivery. This study addresses that gap by disaggregating educator perspectives across all 11 MOET-QA standards to identify actionable implementation bottlenecks.

Given this context, there is a need to investigate how curriculum educators perceive the difficulty of applying each quality assessment criterion in practice. Such insight will illuminate which aspects of the quality assessment standards are most challenging on the ground and why. This case study focuses on the perceptions of lecturers involved in a medical master's program regarding each of the 11 criteria in the MOET-QA framework. The goal is to identify specific standards or criteria that educators find difficult to implement and to understand factors contributing to these difficulties. This study is among the first empirical investigations into how national quality standards are perceived and applied within a postgraduate medical education context in Vietnam. While earlier studies have explored general challenges in QA implementation, few have examined how individual criteria are understood and experienced by faculty directly involved in curriculum delivery. By disaggregating responses across all 11 MOET-QA standards, the study identifies specific areas of resistance or ambiguity. Notably, several national standards show conceptual alignment with international frameworks such as AUN-QA and World Federation for Medical Education (WFME), enhancing the relevance of the findings beyond the local context. By examining educators' views, the study also sheds light on faculty–administration collaboration during curriculum review and revision. The findings can inform targeted strategies to better support educators and improve curriculum quality, contributing to continuous improvement and faculty engagement in curriculum QA and optimizing institutional readiness for future accreditation efforts.

2. METHOD
2.1. MOET–QA, Circular 04/2016/TT-BGDDT
As noted earlier, a national QA body, MOET-QA, was introduced in 2016. Circular 04/2016/TT-BGDDT is a regulation issued by the MOET of Vietnam that establishes the 11 main standards for assessing the quality of higher education programs at all levels (undergraduate, master's, and doctoral), as illustrated in Table 1. For improved manageability and alignment with institutional quality assessment practices, these standards can be categorized into four broader thematic groups [7]. The first group focuses on learning outcome/objectives and curriculum, covering expected learning outcomes and curriculum design. The second group (teaching, learning, and student assessment) pertains to: i) course design; ii) teaching and learning activities; and iii) student assessment, including student support, teaching methodology, and evaluation of

learning outcomes. The third group addresses academic staff, employees, and learning resources, encompassing faculty qualifications, facilities, and financial and learning support. The final group relates to infrastructure including facilities and equipment; QA; and the student outcome. This grouping facilitates clearer division of responsibilities, streamlined reporting, and better integration with international frameworks such as AUN-QA. It should be noted that both AUN-QA and MOET-QA share a common philosophy of using standards, assessment, and continuous improvement to ensure that programs meet established quality benchmarks. While the specific categories may have different names, they generally address similar areas and promote a culture of continuous improvement within higher education institutions.

Circular 04/2016/TT-BGDDT is still in effect and remains mandatory as it applies to all higher education programs in Vietnam, including medical programs [7]. These 11 standards provide a comprehensive framework for assessing the quality of higher education programs, covering various aspects essential to effective program delivery and student success. There is a variation in the number of criteria within each standard. To evaluate these criteria, a 7-level scale ranging from "absolutely non-compliant" to "perfectly compliant" is used.

Table 1. Summary of Vietnam MOET quality assessment framework for higher education programs

WFME area	AUN-QA standards	MOET-QA standards (no of criteria)
1. Mission and outcomes	1. Expected learning outcomes	1. Objectives and graduation requirements (3)
2. Educational program	2. Program specification	2. Program summary (3)
3. Assessment of students	3. Program structure and content	3. Curriculum structure and contents (3)
4. Students	4. Teaching and learning approach	4. Teaching and learning approaches (3)
5. Academic staff/faculty	5. Student assessment	5. Assessment of students' learning outcomes (5)
6. Educational resources	6. Academic staff quality	6. Staff of lecturers and academics (7)
7. Program evaluation	7. Support staff quality	7. Employees (5)
8. Governance and administration	8. Student quality and support	8. Students and support given to students (5)
9. Continuous renewal	9. Facilities and infrastructure	9. Facilities and equipment (5)
	10. Quality enhancement	10. Quality improvement (6)
	11. Output	11. Student outcomes (5)

2.2. Context and participants

This study was conducted at PNTU, a public institution in Ho Chi Minh City, Vietnam. The university offers master's programs in 11 healthcare fields, developed in accordance with national frameworks set by the MOET regarding credit structure and the balance between theory and practice. Postgraduate medical education in Vietnam shares notable similarities with training models in other Southeast Asian countries, most of them use a modular, credit-based system. The programs are typically divided into core modules, specialty rotations, and a final research project or dissertation. There is a strong emphasis on clinical immersion and community-based learning [10]. The postgraduate curriculum at PNTU emphasizes both academic knowledge and hands-on clinical skills. Learners are trained in a dynamic environment that integrates modern medicine with community health care, in collaboration with Vietnam's leading public hospitals. To earn a master's degree, students must complete 60 credits across three modules: basic, specialist, and a 12-credit thesis. Clinical rotations cover key specialties such as internal medicine, pediatrics, obstetrics-gynecology, surgery, and infectious diseases, with opportunities to engage in internationally funded projects and collaborative research. This immersive training aims to produce competent physicians with advanced clinical expertise, critical thinking, and professional integrity.

We conducted a convenient sampling of 151 lecturers who had recently either directly involved in or provided support for the development of the master's degree program. Participants in this study were lecturers at PNTU, including both full-time faculty members and adjunct lecturers who were often physicians from major hospitals. Faculty members were offered the opportunity to participate in training workshops on curriculum design, which covered the development of learning outcomes, the creation of assessment tools based on rubrics, and the dissemination of regulations on educational QA.

2.3. Data acquisition

To ensure the validity of the research findings, the survey instrument was meticulously developed based on the 11 specific criteria for training program accreditation mandated by the MOET of Vietnam. This direct alignment with official national standards ensures the appropriateness of the survey content for assessing the intended constructions. Moreover, these criteria have previously been shown to be structurally and conceptually aligned with regional frameworks, particularly the AUN-QA model [11], thereby supporting the broader applicability and academic relevance of the national framework. For reliability, the survey utilized a consistent 7-point Likert scale across all 11 criteria, a widely accepted method for quantitative assessment.

The 11 assessment criteria were incorporated in an online survey. Participants first provided demographic data before assessing each of the 11 criteria based on their level of agreement regarding the difficulty of practical implementation, using a 7-point Likert scale, where 1 indicated 'strong agreement with high difficulty in implementation' and 7 indicated 'ease of implementation with minimal difficulty'. Responses on the 7-point Likert scale were numerically coded from 1 to 7 and treated as approximately interval data, enabling the computation of mean scores across multiple items measuring the same construct. This practice is widely accepted in educational and health research when Likert-scale items form a coherent scale with acceptable internal consistency [12]. For each criterion, the mean score was calculated by averaging all individual responses. Standards with lower mean scores were perceived as more challenging, whereas those with higher scores were considered easier to implement in practice. To complement the mean scores, the percentage distribution of responses across the 7-point scale was also calculated and presented in figures to visualize response patterns. Furthermore, additional data was gathered regarding participants' perceptions of the challenges associated with each criterion, their prior engagement in professional development or training programs, and the key factors contributing to the difficulties in aligning the training program with established standards.

The quantitative data were analyzed descriptively, such as the mean of the rating, which was interpreted as strong agreement that the criterion poses notable challenges in master's degree implementation at PNTU when the mean score was below 4. A comparative analysis was conducted to examine differences in perceived implementation difficulty. A Chi-square test of independence was performed to determine whether there was a statistically significant association between groups of participants with different characteristics. These tests help identify factors that contribute to generating different consensus on applying these criteria to the design of a medical master's program.

3. RESULTS AND DISCUSSION

3.1. Participants

A total of 151 lecturers participated in the study, with males comprising nearly twice the proportion of females (63.6% vs. 36.4%), as shown in Table 2. The age distribution was almost equal, indicating participation from both younger (<40 years: 49.7%) and older (≥40 years: 50.3%) academic staffs. Most respondents were full-time lecturers, while adjunct (7.9%), concurrent (2.6%), and retired teaching staff (1.3%) accounted for a small proportion. In terms of qualifications, the majority held a master's degree (63.6%) or higher. Notably, most participants had completed at least one professional specialization, with specialist II (40.4%) being the most common. Regarding teaching experience, 74.2% were involved in clinical practice, 57.0% in classroom-based theoretical teaching, and 8.6% in laboratory instruction. This study collected feedback on a master's level medical training program; therefore, the majority of participating lecturers held a master's degree or higher (accounting for 88.1%). In addition, most lecturers also possessed a specialist level I medical degree or higher, which reflects the advanced professional qualifications commonly required for teaching in this field. This also explains why only 7 out of 151 lecturers were under 30 years old, while 50.3% were aged 40 years or above.

The relatively balanced age distribution suggests a mix of less and more experienced educators. This finding is also consistent with the Vietnamese legal regulations on lecturer qualifications for the health science sector. Lecturers in the field of medicine are required to meet specific standards in both academic qualifications and clinical competence. According to Circular No. 12/2024/TT-BGDĐT issued by the MOET [13], they must hold at least a medical degree and, for postgraduate teaching, a master's or doctoral degree in the relevant discipline. Additionally, as stipulated in Decree No. 111/2017/ND-CP [14], lecturers involved in clinical teaching must possess a valid medical practice license and have at least 2 years of clinical experience. Beyond professional qualifications, lecturers are expected to engage in scientific research, publish in peer-reviewed journals, and demonstrate ethical integrity in both academic and medical practice. This demographic profile is typical for faculty involved in medical education, particularly in a clinical setting.

3.2. The agreement with the difficulty of quality assessment framework implementation

The mean score for each standard is illustrated in Figure 1. The radar chart presents the average scores for 11 different standards, with scores ranging approximately between 4.6 and 4.85 on a 7-point Likert scale. Highest scores are observed in standard 2–curriculum description and standard 7–administrative staff, suggesting that participants found these standards relatively easier to apply or had stronger agreement with them. Standard 4–teaching and learning approach–shows the lowest average score (4.62), indicating that participants might have found it more difficult to implement or had lower consensus on its criteria. Similarly, standards 1, 3, and 5, ranging from 4.63 to 4.74, also fall within the group with lower average scores, suggesting similar challenges in implementation.

Table 2. Descriptive characteristics of study participants (n=151)

Characteristic		n	%
Gender	Male	96	63.6
	Female	55	36.4
Age group	<40	75	49.7
	≥40	76	50.3
Lecturer group	Full-time	133	88.1
	Concurrent	4	2.6
	Retired full-time staff	2	1.3
	Adjunct	12	7.9
Academic title	Graduates	18	11.9
	Master	96	63.6
	Doctoral	30	19.9
	As. Professor/professor	7	4.6
Professional degree	Doctor	36	23.8
	Specialist I	23	15.2
	Internship	31	20.5
	Specialist II	61	40.4
Teaching experiences	Classroom theoretical lectures	86	57.0
	Clinical practice	112	74.2
	Laboratory practice	13	8.6
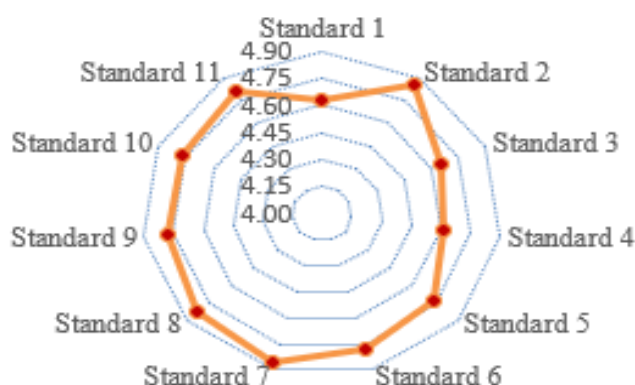
Figure 1. Mean scores for perceived difficulty of implementation across 11 standards
(Lower means indicate greater perceived challenge in practice)

Standard 1 addresses the criteria for learning outcomes and training objectives, specifying requirements such as clarity, alignment, appropriateness, responsiveness to stakeholder demands, being current, and transparency [7], [15]. Beyond standard 1, researchers have identified the relevance of other standards, specifically standards 2, 3, 4, 5, and 10, to learning outcomes in undergraduate programs across different disciplines [15]. Notably, their study revealed that a significant proportion of these programs failed to meet critical criteria, with over 35% of programs falling short on each criterion. They suggested that a contributing factor was the insufficient understanding among educational institution leaders regarding the effective design and development of training programs. Additionally, they highlighted the imperative to enhance the capabilities of university personnel involved in teaching, program creation, and QA [15]. Our current situation is quite similar, as the implementation of these standards has only been mandated in recent years. Furthermore, criterion 6.2, which addresses the student-to-faculty ratio and the workload of lecturers and researchers, also highlights the practical difficulties in implementation.

This study has highlighted the existing challenges in implementing the MOET-QA Standards for the master's program in medical education. Meeting these standards is a legal prerequisite in Vietnam for official program recognition and forms the groundwork for future improvements and readiness for WFME accreditation in both the undergraduate medical program and postgraduate training. Although the number of standards and their terminologies differ, both frameworks share a common educational philosophy: emphasizing clearly defined educational objectives aligned with expected learning outcomes, and ensuring that faculty, facilities, and teaching methods are structured to support students in achieving these outcomes [7], [16]. For example, standard 1 (program objectives and outcomes) corresponds to WFME's "mission and outcomes", both emphasizing clear goals linked to societal needs and professional competencies. In addition, standards 2 and 3 (curriculum content and structure) match WFME's "educational programme", requiring a scientifically sound and up-to-date curriculum aligned with expected outcomes. MOET-QA's standard 4

(teaching methods) aligns with both "assessment of students" and "educational resources" in WFME, highlighting applied knowledge, critical thinking, and practical experience. Finally, MOET's standard 5 (faculty) is consistent with WFME's "students" and "academic staff", focusing on the need for qualified faculty and continuous professional development.

The study findings indicate that, while all standards achieved an average score above 4, as shown in Figure 2, standards 1, 3, 4, and 5, as in Figures 2(a) and 2(b), were identified as those associated with greater challenges in the curriculum design and QA of the medical master's program. This data can help identify which standards are perceived as more challenging and may require additional support or clarification during implementation. Lighter shades (scores 4–7) take up a larger portion of each bar which indicating that participants mostly had positive or neutral responses. The number of criteria included within each standard varied. Based on participants' ratings of agreement with the difficulty of implementation (measured using a 7-point Likert scale), the score for each criterion is displayed in Figure 2. Most of the responses fall in the mid to upper Likert scale range (4 to 7), indicating moderate to strong agreement with the ease of applying these standards, suggesting that participants did not find significant difficulties in their implementation. Figures 2(a) and 2(b) highlight that certain sub-criterion namely 1.3, 3.3, 4.3, and 5.3—had a slightly higher proportion of low scores (particularly score 1), indicating the need for more targeted support. Figures 2(c) and 2(d), which depict standards on resources and quality assessment, show similar mid-to-high score distributions, though with marked variation in some sub-criteria. The percentage of participants who considered these criteria difficult to implement (with a score below 4) reached nearly 40%, highlighting a need for further clarification or capacity-building.
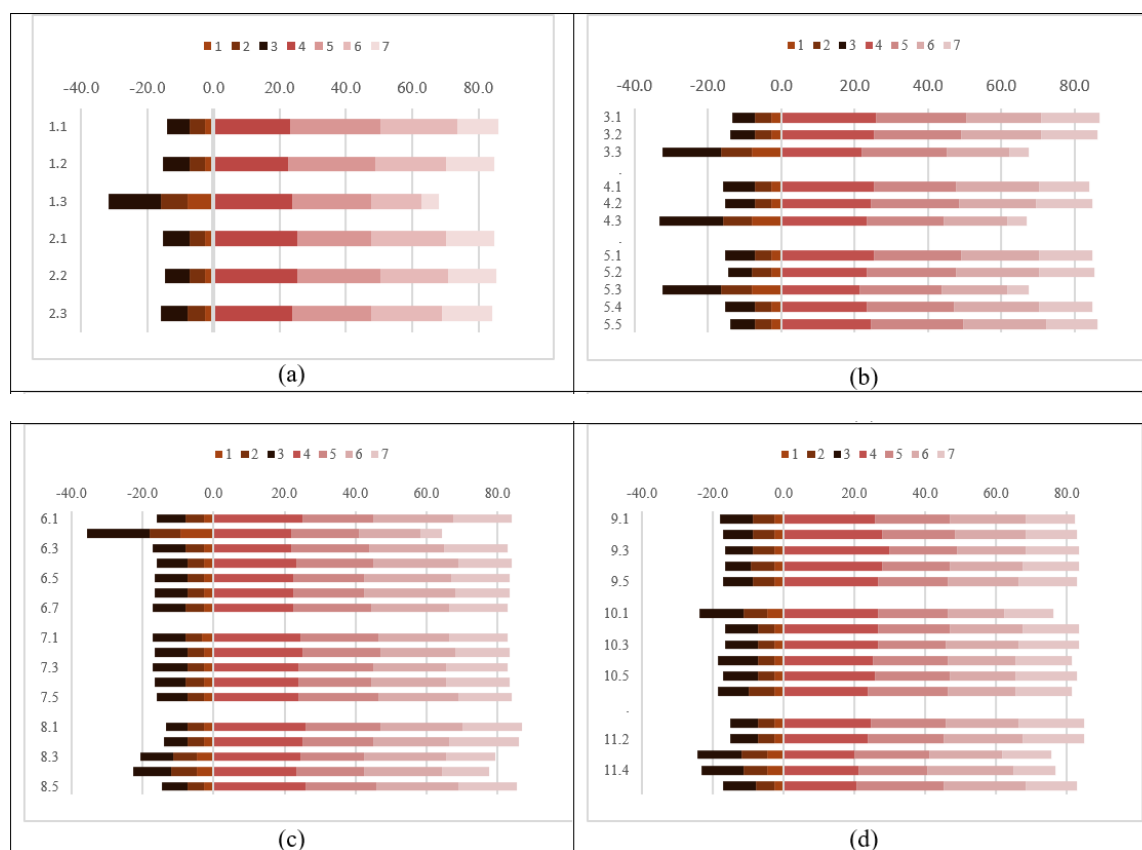

Figure 2. Percentage distribution of responses in perceived difficulty levels in implementing criteria across 11 standards, including (a) learning outcomes and curriculum; (b) teaching, learning, and student assessment; (c) human and learning resources; and (d) QA and continuous improvement

3.3. Challenges in applying accreditation criteria across demographic groups

We can observe some general trends reporting difficulty in applying the four criteria (1.3, 3.3, 4.3, and 5.2) presented in Figure 3, categorized by age group, academic title, professional degree, and training. A consistent trend across all four criteria indicates that a higher percentage of participants in the under 40 age group reported difficulty compared to those aged 40 and above. Individuals with the academic title of

associate professor or professor consistently show the highest percentage compared to other academic levels. Similarly, among professional degrees, those holding the initial doctor degree tend to have the highest percentages across the criteria. The patterns related to training levels appear to be more varied across the different criteria, however, participants who had attended relevant training courses generally reported less difficulty in applying the criteria compared to those who had not. These observed patterns regarding difficulty in application, particularly among younger faculty and those with certain academic and professional profiles, alongside the positive impact of training, resonate with established educational change literature. For instance, Rogers' diffusion of innovation theory [17] suggests that while younger individuals may be early adopters in some areas (e.g., technology), they might encounter greater structural or cultural barriers when adopting new practices in traditionally hierarchical institutions. Conversely, the effectiveness of relevant training aligns with Kotter [18] emphasis on effective communication and empowerment as crucial elements for successful organizational change.
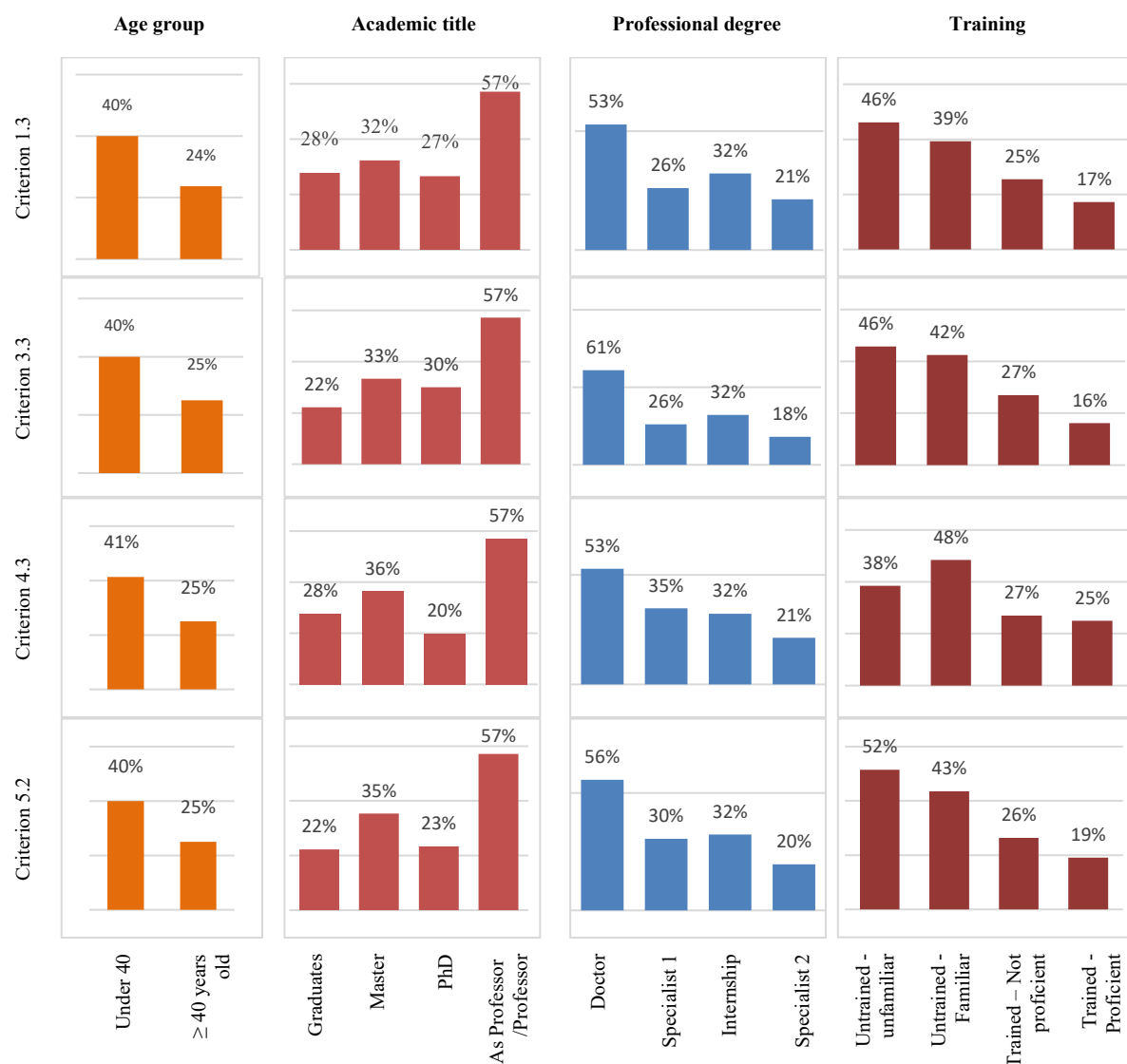
Figure 3. Percentage of participants reporting difficulty in applying quality assessment criteria by demographic and training characteristics

Standard 1.3 requires clearly defined, measurable program objectives and learning outcomes that align with societal needs and professional requirements and are publicly disclosed. According to Oraison *et al.* [19], program educational objectives should be designed to ensure that graduates are equipped

with not only advanced theoretical knowledge but also practical skills that are in demand in the job market. Supporting competency-based medical education requires a critical examination of future learner and community needs, followed by the design of supportive systems [20]. Similarly, our PLOs also encompass the integration of advanced knowledge and specialized techniques in the medical field, which may increase the complexity as these knowledge and skills are related to human life. This alignment with stakeholders' expectations enhances the employability of graduates. This increases the challenge for instructors in the process of designing the learning outcomes to ensure that the programs remain relevant in a rapidly changing professional landscape–a challenge that has also been noted in training programs within other academic disciplines or fields [21].

Like standard 1, the mean score of standard 3 in our study was also relatively low compared to the other standards. Among these, criterion 3.3 was identified by many instructors as particularly challenging. Circular No. 04/2016/TT-BGDĐT highlights criteria for curriculum design as the program's curriculum must be logically structured, aligned with its expected learning outcomes, and regularly updated to meet academic and professional demands [7]. In particular, standard 3.3 emphasizes that the curriculum should follow a coherent structure, ensure logical course sequencing, and integrate updated relevant content. One of the primary challenges in aligning these elements is balancing the long-term aspirations outlined in the vision with the practical constraints of educational program delivery [22]. The distinctive nature of the healthcare sector may amplify these difficulties. The emergence of recent pandemics, the shifts in disease patterns, and the rapid social transformations have posed additional challenges for medical education and training, while educational processes including curriculum development are slow. The question of how to design curriculum content that meets the needs of 21st-century societies continues to be a major concern for instructors.

What is difficult, however, is the rapid evolution of the healthcare delivery system, including the expansion of the private healthcare sector and the changing expectations of patients, society, and policymakers, who demand greater value in healthcare [23]. For example, health systems across the world are emphasizing a shift toward high-value and cost-effective care and making explicit the need to embrace populations of patients when providing care [24]. To effectively address these intricate challenges, it is incumbent upon medical educators, leaders, and policymakers to cultivate unorthodox conceptualizations [25].

The complexity and specificity of medical knowledge require not only theoretical understanding but also the mastery of clinical skills and critical decision-making [26], which are often difficult to fully develop through conventional teaching approaches-standard 4—teaching and learning methods. Additionally, creating authentic learning environments that allow students to engage in real-life clinical experiences is constrained by limited patient access, ethical considerations, and resource availability, which is reasonable to be inherent challenges at PNTU in Vietnam–a low–middle-income country. At PNTU, most of the adjunct lecturers are highly skilled medical doctors, holding specialist level I and level II qualifications. However, the proportion of lecturers with doctoral degrees is relatively low. The shortage of qualified clinical instructors, especially those proficient in modern pedagogical techniques, further exacerbates the situation. Only 51% of faculty in East and Southeast Asian doctoral nursing programs hold doctoral qualifications [27], and programs like SICME reveal that many health educators in Southeast Asia, including Vietnam, lack training in contemporary clinical pedagogical technique [28].

It is crucial to acknowledge that most postgraduate students, being inherently older, may be more accustomed to traditional teaching and learning methods. This often leads to discrepancies between pedagogical approaches and student learning preferences, potentially hindering academic achievement and engagement [29]. As some studies suggest, teacher-centered approaches, characterized by didactic lectures and passive learning, might not resonate with contemporary learners who tend to benefit more from interactive, student-centered methodologies [29], [30]. Consequently, a similar challenge could arise in which students' reliance on conventional learning styles complicates the teaching and assessment processes for instructors employing modern pedagogical techniques.

Criterion 5.3–The implementation of diverse assessment methods ensuring validity, reliability, and fairness–is a central element that significantly impacts the average score of standard 5. While active learning strategies such as problem-based learning, team-based learning, and simulation-based training are highly recommended in medical education, their effective implementation demands substantial time, infrastructure, and interdepartmental coordination, which many institutions still struggle to meet [26], [30]. Moreover, the assessment of practical competencies through structured and standardized methods, such as objective structured clinical examination (OSCE), also poses significant organizational and logistical challenges [31]. Recommendations for improving the active learning strategies and examination centered on addressing examiner behavior. This involves providing better training for examiners and actively working to eliminate any discriminatory practices towards students.

These findings offer significant insights beyond the immediate context of Vietnamese medical education. By identifying specific challenges in implementing accreditation standards, this study provides a vital framework for understanding the complexities faced by low-and middle-income countries (LMICs)

striving to enhance their medical education quality. Many LMICs grapple with similar constraints, including resource limitations (e.g., inadequate human and financial capital, infrastructure, and technology) [32], and a shortage of trained professionals or faculty with expertise in QA [33]. Additionally, operational and curriculum-related challenges such as unclear learning outcomes, misaligned assessments, and difficulties in implementing competency-based education are commonly reported across diverse LMIC settings. Vietnam's experience offers valuable lessons for LMICs transitioning to outcome-based postgraduate education under resource constraints.

4. CONCLUSION

In summary, this study revealed that medical educators at PNTU generally consider the national quality assessment standards achievable, but they face pronounced challenges in specific areas of curriculum design, teaching methods, and assessment. Standards related to defining clear learning outcomes, updating curriculum content, implementing student-centered teaching, and diversifying assessment were rated as the most difficult to comply with. These difficulties were more frequently reported by younger, less-experienced lecturers and those without prior training in educational QA. This suggests that investing in training and mentorship for educators is a pivotal strategy for improving the implementation of quality criteria. This study supports the inclusion of mandatory quality assessment training modules as part of the induction process for new faculty members. Institutions should also implement structured peer review and ongoing mentorship systems to reinforce continuous improvement and support early-career educators in navigating accreditation challenges. Ultimately, the study contributes a case example of how understanding educators' perspectives on quality criteria can inform strategic interventions to advance the quality of higher medical education. Future research could build on this work by exploring student perspectives on the curriculum changes or by evaluating the impact of implemented improvements on educational outcomes.

AUTHOR CONTRIBUTIONS STATEMENT

This journal uses the Contributor Roles Taxonomy (CRediT) to recognize individual author contributions, reduce authorship disputes, and facilitate collaboration.

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C	:	**C**onceptualization	I	:	**I**nvestigation
M	:	**M**ethodology	R	:	**R**esources
So	:	**So**ftware	D	:	**D**ata Curation
Va	:	**Va**lidation	O	:	Writing - **O**riginal Draft
Fo	:	**Fo**rmal analysis	E	:	Writing - Review & **E**diting

Vi	:	**Vi**sualization
Su	:	**Su**pervision
P	:	**P**roject administration
Fu	:	**Fu**nding acquisition

CONFLICT OF INTEREST STATEMENT
Authors state no conflict of interest.

INFORMED CONSENT
The implementation of this study was approved by the university leadership of Pham Ngoc Thach University of Medicine. Informed consent was obtained electronically via a Google Form platform. Participants were first presented with a detailed introduction outlining the purpose, procedures, and confidentiality measures of the study. Only those who voluntarily agreed to participate—by selecting the consent option—were automatically directed to the main questionnaire. Individuals who declined participation were thanked for their time and exited the survey without providing any data.

ETHICAL APPROVAL
Ethical approval for this study was obtained from the Ethics Committee in Biomedical Research at Pham Ngoc Thach University of Medicine (No: 1112/TDHYKPNT-HĐĐĐ, June 16, 2024).

DATA AVAILABILITY
The data that support the findings of this study are available from the corresponding author [TTDN], upon reasonable request. Due to confidentiality agreements and privacy considerations related to the study participants, the data are not publicly available.

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